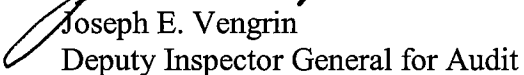




AUG 27 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Claims Submitted by Inpatient Psychiatric Facilities During the Transition to the Prospective Payment System in 2005 (A-01-07-00520)

The attached final report provides the results of our review of Medicare claims submitted by inpatient psychiatric facilities (IPF) during the transition to the prospective payment system in calendar year 2005.

The Centers for Medicare & Medicaid Services (CMS) implemented a prospective payment system for IPFs for cost-reporting periods beginning on or after January 1, 2005. Under the prospective payment system, IPFs must submit to the fiscal intermediaries a single discharge bill for an entire inpatient stay. CMS instructions state that if the beneficiary's stay begins before and ends on or after the date on which the IPF becomes subject to the prospective payment system (a "transition stay"), the fiscal intermediary must base its payments to the facility on prospective payment rates and rules. The instructions also state that IPFs that split the stay and submit two separate claims must cancel the split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

Our three prior reviews to determine whether IPFs had properly billed for transition stays during 2005 identified overpayments totaling \$3.9 million for split bills paid by three fiscal intermediaries. This review covered the remaining 2,215 transition stays that IPFs nationwide split-billed to Medicare in 2005.

Our objective was to determine whether the remaining IPFs nationwide that split-billed transition stays subsequently canceled the split bills and rebilled CMS using prospective payment rates and rules.

IPFs that split-billed transition stays did not always cancel the split bills and rebill CMS using prospective payment system rates and rules as required. Specifically, for 62 of the 100 incorrectly billed transition stays that we sampled, the IPFs had not canceled the split bills and resubmitted correct bills before our audit. These 62 stays resulted in overpayments of \$408,224.

For the remaining 38 stays in our sample, the IPFs had canceled the split bills and resubmitted correct bills.

Based on our sample results, we estimated that incorrectly billed transition stays for which IPFs had not canceled split bills and resubmitted correct bills resulted in about \$9 million in overpayments in 2005. The overpayments occurred because the IPFs did not have adequate controls to ensure that incorrectly billed claims for transition stays were canceled and resubmitted in accordance with Medicare requirements. Additionally, the fiscal intermediaries did not have procedures to identify incorrectly billed IPF claims for transition stays and ensure that the claims were properly adjusted.

We recommend that CMS instruct the fiscal intermediaries to:

- adjust claims for the sampled stays that resulted in overpayments of \$408,224;
- review our information on the 2,115 stays not included in our sample, which had potential overpayments estimated at \$8,633,933 (\$9,042,157 less \$408,224), and work with the IPFs to recover any overpayments; and
- analyze postpayment data for claims submitted after our review to ensure that IPFs billed the claims properly and fiscal intermediaries paid them correctly.

In its written comments on our draft report, CMS agreed with our recommendations.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

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-01-07-00520 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE CLAIMS
SUBMITTED BY INPATIENT
PSYCHIATRIC FACILITIES
DURING THE TRANSITION TO
THE PROSPECTIVE PAYMENT
SYSTEM IN 2005**



Daniel R. Levinson
Inspector General

August 2008
A-01-07-00520

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.

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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.

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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
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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

As mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, together with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) developed and implemented a prospective payment system for inpatient psychiatric facilities (IPF). The IPF prospective payment system was effective for cost-reporting periods beginning on or after January 1, 2005. Before that date, Medicare paid IPFs for services provided to beneficiaries pursuant to section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Specifically, Medicare based payments to IPFs on a reasonable cost per discharge, as determined by IPFs' Medicare cost reports, subject to the limits imposed by the TEFRA. The IPF prospective payment system, in contrast, provides a standardized Federal per diem payment per discharge.

CMS contracts with fiscal intermediaries to process and pay Medicare Part A claims submitted by institutional providers, including IPFs. Under the prospective payment system, IPFs must submit to the fiscal intermediaries a single discharge bill for an entire inpatient stay. CMS instructions state that if the beneficiary's stay begins before and ends on or after the date on which the IPF becomes subject to the prospective payment system (a "transition stay"), the fiscal intermediary must base its payments to the facility on prospective payment rates and rules. The instructions also state that IPFs that split the stay and submit two separate claims must cancel the split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

Our three prior reviews to determine whether IPFs had properly billed for transition stays during 2005 identified overpayments totaling \$3.9 million for split bills paid by three fiscal intermediaries. This review covered the remaining 2,215 transition stays that IPFs nationwide split-billed to Medicare in 2005.

OBJECTIVE

Our objective was to determine whether the remaining IPFs nationwide that split-billed transition stays subsequently canceled the split bills and rebilled CMS using prospective payment rates and rules.

SUMMARY OF FINDING

IPFs that split-billed transition stays did not always cancel the split bills and rebill CMS using prospective payment system rates and rules as required. Specifically, for 62 of the 100 incorrectly billed transition stays that we sampled, the IPFs had not canceled the split bills and resubmitted correct bills before our audit. These 62 stays resulted in overpayments of \$408,224. For the remaining 38 stays in our sample, the IPFs had canceled the split bills and resubmitted correct bills.

Based on our sample results, we estimated that incorrectly billed transition stays for which IPFs had not canceled split bills and resubmitted correct bills resulted in about \$9 million in

overpayments in 2005. The overpayments occurred because the IPFs did not have adequate controls to ensure that incorrectly billed claims for transition stays were canceled and resubmitted in accordance with Medicare requirements. Additionally, the fiscal intermediaries did not have procedures to identify incorrectly billed IPF claims for transition stays and ensure that the claims were properly adjusted.

RECOMMENDATIONS

We recommend that CMS instruct the fiscal intermediaries to:

- adjust claims for the sampled stays that resulted in overpayments of \$408,224;
- review our information on the 2,115 stays not included in our sample, which had potential overpayments estimated at \$8,633,933 (\$9,042,157 less \$408,224), and work with the IPFs to recover any overpayments; and
- analyze postpayment data for claims submitted after our review to ensure that IPFs billed the claims properly and fiscal intermediaries paid them correctly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendations. We have included CMS's comments in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Prospective Payment System for Inpatient Psychiatric Facilities

As mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, together with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) developed and implemented a prospective payment system for inpatient psychiatric facilities (IPF).¹ The IPF prospective payment system was effective for cost-reporting periods beginning on or after January 1, 2005.² Before that date, Medicare paid IPFs for services provided to beneficiaries pursuant to section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).³ Specifically, Medicare based payments to IPFs on a reasonable cost per discharge, as determined by IPFs' Medicare cost reports, subject to the limits imposed by the TEFRA. These fixed payments did not vary from day to day or from patient to patient.

For IPF cost-reporting periods from January 1, 2005, to January 1, 2008, while the new prospective payment system was being phased in, Medicare payments comprised a blend of the estimated payment under the new system and the fixed TEFRA payment. Now that it is fully implemented, the IPF prospective payment system provides a standardized Federal per diem payment per discharge. The amount of this payment is based on several factors, including the patient's age and diagnosis and the hospital's characteristics. The prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF.

CMS contracts with fiscal intermediaries to process and pay Medicare Part A claims submitted by institutional providers, including IPFs. Under the prospective payment system, IPFs must submit to the fiscal intermediaries a single discharge bill for an entire inpatient stay. CMS instructions issued in Transmittal 384 state that if the beneficiary's stay begins before and ends on or after the date on which the IPF becomes subject to the prospective payment system (a "transition stay"), the fiscal intermediary must base its payments to the facility on prospective payment rates and rules. The instructions also state that IPFs that split the stay and submit two separate claims must cancel the split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

¹Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. No. 106-113 § 124 (mandating a prospective payment system for inpatient services of psychiatric hospitals and psychiatric units of acute-care hospitals for cost-reporting periods beginning on or after October 1, 2002) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 405(g) (authorizing distinct-part psychiatric units of critical access hospitals and mandating that payment for such services be made under the IPF prospective payment system for cost-reporting periods beginning on or after October 1, 2004).

²42 CFR § 412.400(a). See 69 Fed. Reg. 66922, 66923–66924 (Nov. 15, 2004) (regarding delay in implementing the prospective payment system for IPFs).

³TEFRA, P.L. No. 97-248 § 101(a), Social Security Act § 1886, 42 U.S.C. § 1395ww.

Prior Office of Inspector General Reports

Our three prior reviews to determine whether IPFs had properly billed for transition stays during 2005 identified overpayments totaling \$3.9 million for split bills paid by three fiscal intermediaries: AdminaStar Federal (A-01-07-00500), Riverbend Government Benefits Administrator (A-01-07-00505), and Palmetto GBA (A-01-07-00507). The results of these reviews indicated that IPFs nationwide were likely to have split bills for transition stays.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the remaining IPFs nationwide that split-billed transition stays subsequently canceled the split bills and rebilled CMS using prospective payment rates and rules.

Scope

Our review covered the 2,215 transition stays not included in our previous reviews that IPFs nationwide split-billed to Medicare in 2005. These transition stays were billed as 4,430 Part A claims by 427 IPFs. Medicare paid a total of \$27,989,117 for these stays.

Our objective did not require an understanding or assessment of the IPFs' and fiscal intermediaries' complete internal control structures. We limited our review of internal controls to obtaining an understanding of IPFs' procedures for submitting claims for transition stays and fiscal intermediaries' policies and procedures for paying such claims.

We performed our fieldwork in January 2008. Our fieldwork included site visits to selected IPFs and fiscal intermediaries in New York and Florida.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare requirements and CMS guidance regarding IPF billing and fiscal intermediary payments for transition stays;
- identified from CMS's National Claims History File for 2005 a nationwide population of 2,215 split-billed IPF stays that (1) began on the IPF's transition date and (2) were for a beneficiary who had an immediately preceding stay at the same facility;
- excluded from the population all claims with no payment amounts and all claims from the three fiscal intermediaries included in our previous reviews;

- selected a simple random sample of 100 stays from the population of split-billed IPF transition stays to determine whether the split bills had been subsequently canceled and properly rebilled (Appendix A);
- calculated the effect of the incorrect billing by using CMS's Pricer program and the fiscal intermediaries' provider-specific information;
- estimated, as detailed in Appendix B, the total value of overpayments based on our sample results; and
- reviewed information from our three previous reviews and contacted 10 additional IPFs to determine the causes of the split billing and two additional fiscal intermediaries to determine whether they had established controls to detect the incorrect billings and prevent or recover overpayments.

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

IPFs that split-billed transition stays did not always cancel the split bills and rebill CMS using prospective payment system rates and rules as required. Specifically, for 62 of the 100 incorrectly billed transition stays that we sampled, the IPFs had not canceled the split bills and resubmitted correct bills before our audit. These 62 stays resulted in overpayments of \$408,224. For the remaining 38 stays in our sample, the IPFs had canceled the split bills and resubmitted correct bills.

Based on our sample results, we estimated that incorrectly billed transition stays for which IPFs had not canceled split bills and resubmitted correct bills resulted in about \$9 million in overpayments in 2005. The overpayments occurred because the IPFs did not have adequate controls to ensure that incorrectly billed claims for transition stays were canceled and resubmitted in accordance with Medicare requirements. Additionally, the fiscal intermediaries did not have procedures to identify incorrectly billed IPF claims for transition stays and ensure that the claims were properly adjusted.

PROGRAM REQUIREMENTS

Pursuant to 42 CFR § 412.422, the IPF prospective payment system provides a standardized Federal per diem payment per discharge. To receive this payment, an IPF must submit a single discharge bill for an entire inpatient stay.

CMS guidance, as set forth in Transmittal 384, dated December 1, 2004, states that when a beneficiary's stay overlaps the date on which the IPF becomes subject to the prospective

payment system, the payment must be based on the prospective payment system rates and rules.⁴ The guidance also states that IPFs may not split the stay and submit two separate bills. IPFs that do so must cancel all split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

SPLIT BILLS FOR TRANSITION STAYS NOT CANCELED

Our review of 100 transition stays that were originally split-billed identified 62 stays for which the IPFs had not canceled the split bills and resubmitted correct bills before our audit. The fiscal intermediaries overpaid the IPFs \$408,224 for the 62 stays.

For example, for one beneficiary's 57-day stay that overlapped an IPF's January 1, 2005, transition to the prospective payment system, the IPF billed one claim of \$23,625 for November 17 through December 31, 2004, and another claim of \$13,125 for January 1 through January 13, 2005. The total reimbursement was \$36,750. To comply with Medicare requirements, the IPF should have billed one claim under the prospective payment system for one inpatient stay totaling \$20,348. Because the IPF split the stay into two claims and did not subsequently cancel the split bill as required, Medicare overpaid the IPF \$16,402 for this stay.

Based on our sample results, we estimated that incorrectly billed transition stays for which IPFs had not canceled split bills and resubmitted correct bills resulted in about \$9 million in overpayments in 2005.

INTERNAL CONTROL WEAKNESSES

The overpayments occurred because the IPFs did not have adequate controls to ensure that incorrectly billed claims for transition stays were canceled and resubmitted in accordance with Medicare requirements. Additionally, the fiscal intermediaries did not have procedures to identify incorrectly billed IPF claims for transition stays and ensure that the claims were properly adjusted.

RECOMMENDATIONS

We recommend that CMS instruct the fiscal intermediaries to:

- adjust claims for the sampled stays that resulted in overpayments of \$408,224;
- review our information on the 2,115 stays not included in our sample, which had potential overpayments estimated at \$8,633,933 (\$9,042,157 less \$408,224), and work with the IPFs to recover any overpayments; and

⁴Because of an error, Transmittal 384 appears to apply only to psychiatric hospitals and psychiatric units of acute-care hospitals. However, Transmittal 444, dated January 21, 2005, corrected the error and made it clear that psychiatric units of critical access hospitals are also reimbursed under the IPF prospective payment system. In addition, Transmittal 495, dated March 4, 2005, corrected some aspects of Transmittal 444 and made it clear that, as stated in Transmittal 384, split billing is not allowed.

- analyze postpayment data for claims submitted after our review to ensure that IPFs billed the claims properly and fiscal intermediaries paid them correctly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendations. CMS stated that it would recover the overpayments consistent with its policies and procedures and requested that we furnish the data necessary for CMS to review claims and recover the overpayments. We have included CMS's comments in their entirety as Appendix C.

As CMS requested, we will provide the data necessary for CMS to initiate its review and recovery effort.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

OBJECTIVE

Our objective was to determine whether the remaining inpatient psychiatric facilities (IPF) nationwide that split-billed transition stays subsequently canceled the split bills and rebilled the Centers for Medicare & Medicaid Services using prospective payment rates and rules.

POPULATION

The population consisted of 2,215 stays that (1) began on the IPF's transition date and (2) were for a beneficiary who had an immediately preceding stay at the same facility. These 2,215 transition stays had been split billed as 4,430 claims.

SAMPLING FRAME

The sampling frame was a database of 2,215 split-billed transition stays for calendar year 2005.

SAMPLE UNIT

The sample unit was a split-billed IPF transition stay across the IPF's transition date to the new prospective payment system.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We randomly selected 100 split-billed transition stays.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the frame from 1 to 2,215. After generating 100 random numbers, we selected the corresponding frame items for our sample.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the potential overpayments.

SAMPLE RESULTS AND ESTIMATES

Frame Size	Sample Size	Sample Results		Value of Unallowable Split-Billed Stays
		Value of Sample	Number of Unallowable Split-Billed Stays	
2,215	100	\$1,487,533	62	\$408,224

Estimated Unallowable Payments*(Limits calculated for a 90-percent confidence interval)*

Point estimate	\$9,042,157
Lower limit	\$6,162,395
Upper limit	\$11,921,919



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: JUL 03 2008

Office of the Administrator
Washington, DC 20001TO: Daniel R. Levinson
Inspector GeneralFROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: Review of Medicare Claims
Submitted by Inpatient Psychiatric Facilities during Transition to the
Prospective Payment System in 2005 (A-01-07-00520)
 RECEIVED
 2008 JUL -7 PM 2:25
 OFFICE OF INSPECTOR
 GENERAL

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on this draft report. We would like to thank the Office of Inspector General (OIG) for its recommendations on this issue.

The CMS contracts with fiscal intermediaries (FIs) to process and pay Medicare Part A claims submitted by institutional providers, including Inpatient Psychiatric Facilities (IPFs). Under the prospective payment system (PPS), IPFs must submit to the FIs a single discharge bill for an entire inpatient stay. CMS' instructions state that if the beneficiary's stay begins before, and ends on or after, the date on which the IPF becomes subject to the PPS (a "transition stay"), the FI must base its payments to the facility on prospective payment rates and rules. The instructions also require IPFs that split the stay and submit two separate claims to cancel the split bills and then rebill the FI after the cancellation has been accepted.

In this draft report, OIG indicated that IPFs that split-billed transition stay days did not always cancel the split bills and rebill CMS using PPS rates and rules, as required.

OIG Recommendation

Adjust claims for the sampled stays that resulted in overpayments of \$408,224.

CMS Response

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

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OIG Recommendation

Review OIG's information on the 2,115 stays not included in its sample, which had potential overpayments estimated at \$8,663,933 (\$9,042,157 less \$408,224), and work with the IPFs to recover any overpayments.

CMS Response

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

The OIG will be requested to furnish for each overpayment or potential overpayment the data necessary (provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate cd-roms to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Analyze post payment data for claims submitted after OIG's review to ensure IPFs billed the claims properly and FIs paid them correctly.

CMS Response

The CMS' goal is always to ensure payments were appropriate and all applicable principles, policies, and rules were followed. CMS has issued instructions to the Medicare contractors to implement the Progressive Corrective Action process whenever problems are identified. This process is designed to ensure contractor's medical review activities are focused on identified problem areas. If data analysis or other sources identify inpatient psychiatric services as a potential problem, the contractors must perform medical review on inpatient psychiatric claims. If it is determined that the problem is widespread for a specific service or provider, the provider's claims may be subjected to post-payment review to identify and recover any overpayments.

The CMS appreciates OIG's effort in conducting this review. We look forward to your continued support as we address the report recommendations.