



JUL 9 2007

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CIN: A-01-07-00510

Janet Kyle
Vice President Medicare
Mutual of Omaha Medicare
P.O. Box 1602
Omaha, NE 68101

Dear Ms. Kyle:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Review of Mutual of Omaha Medicare Payments to Long Term Care Hospitals From January Through May 2003."

Final determination as to actions taken on all matters will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should include any comments or additional information that you believe may have a bearing on the final determination.

In accordance with 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 are made available to members of the public to the extent information contained therein is not subject to exemptions under the Act (See 45 CFR Part 5).

To facilitate identification, please refer to report number A-01-07-00510 in all correspondence.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Page 2 – Janet Kyle

Direct Reply to HHS Action Official:

Tom Lenz
Regional Administrator
Centers for Medicare & Medicaid Services – Region VII
U.S. Department of Health and Human Services
Richard Bolling Federal Building, Room 235
601 East 12th Street
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Review of Mutual of Omaha
Medicare Payments to
Long-Term Care Hospitals
From January Through
May 2003**



Daniel R. Levinson
Inspector General

(June 2007)
A-01-07-00510

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

Before October 1, 2002, Medicare paid long-term care hospitals (LTCH) based on reasonable costs pursuant to Section 1886(d) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982. The Centers for Medicare & Medicaid Services (CMS) implemented this system for cost reporting periods beginning on or after October 1, 2002.

Under the prospective payment system, Medicare continues to provide each beneficiary 90 regular Part A covered benefit days for an episode of inpatient hospital care. Each beneficiary also has 60 lifetime reserve days that may be used to cover additional days of an episode of care after the beneficiary has used the 90 regular benefit days. When using lifetime reserve days, beneficiaries pay a coinsurance amount equal to one half of the inpatient hospital deductible.

The LTCH prospective payment system uses long-term care diagnosis-related groups (DRGs) as a patient classification system. Each DRG has a predetermined average length of stay that is used to determine when a beneficiary's LTCH stay qualifies for a full DRG payment. Medicare pays LTCHs a full DRG payment for a stay that exceeds five-sixths of the average length of stay for the DRG. If a beneficiary does not have enough regular covered days to reach the threshold, the beneficiary must use his or her available lifetime reserve days to continue Medicare coverage. If a beneficiary uses all of his or her Medicare-covered days, including lifetime reserve days, before the stay qualifies for a full DRG payment, Medicare pays LTCHs only for the beneficiary's covered benefit days. This type of DRG payment is called a short-stay outlier payment. The beneficiary is responsible for the remaining days of the stay.

The Medicare program requires fiscal intermediaries to be responsible for making DRG payments, including short-stay outlier payments. The fiscal intermediary is also responsible for ensuring that LTCHs include the appropriate codes on the claims when these codes are needed and for requesting that LTCHs resubmit their claims if they have not included the appropriate codes on the original claim.

Mutual of Omaha (the Intermediary) is the fiscal intermediary for 183 LTCHs in 34 states. Until May 31, 2003, the Intermediary used the Arkansas Part A Standard System to process Medicare claims. Since June 1, 2003, the Intermediary has used the Fiscal Intermediary Shared System. We reviewed payments that the Intermediary made to LTCHs from January 1 through May 31, 2003.

OBJECTIVE

The objective of our review was to determine whether the Intermediary paid LTCHs' claims in accordance with Medicare requirements when beneficiaries had used all of their regular covered benefit days.

SUMMARY OF FINDINGS

The Intermediary did not always pay LTCH claims in accordance with Medicare requirements when the beneficiaries had used all of their regular covered benefit days. Specifically, of the 47 claims that we reviewed, the Intermediary made full DRG payments for (1) 8 claims that should have been reduced to a short-stay outlier payment and (2) 25 claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. As a result, the Intermediary made overpayments totaling \$374,945 for 33 claims to 21 LTCHs for services provided from January 1 through May 31, 2003. Payment errors occurred because the Intermediary misunderstood the requirements for ensuring that LTCHs' claims contained the appropriate coverage status codes when beneficiaries had used all of their covered benefit days before their length of stay qualified for a full DRG payment.

RECOMMENDATIONS

We recommend that the Intermediary recover the overpayments made to 21 LTCHs for 33 claims totaling \$374,945 and work with CMS to determine the appropriate actions for recovering the portion of the overpayments related to the beneficiaries' coinsurance payments.

AUDITEE'S COMMENTS

In its comments on our draft report, the Intermediary generally agreed to implement our recommendation. However, the Intermediary noted that it would need assistance from CMS to determine the appropriate actions for recovering the portion of this overpayment related to the beneficiaries' coinsurance. In addition, it requested that we modify our explanation of the cause of the overpayments to reflect that it had misunderstood the requirements.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We revised our recommendation to reflect the Intermediary's concern regarding the need for CMS involvement. We also amended our explanation of the cause of the overpayments in response to the Intermediary's request for clarification.

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AUDITEE’S COMMENTS

INTRODUCTION

BACKGROUND

Medicare Payment Regulations

Before October 1, 2002, Medicare paid long-term care hospitals (LTCH) based on reasonable costs pursuant to Section 1886(d) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982. To control escalating costs, the Balanced Budget Refinement Act of 1999 mandated a new discharge-based prospective payment system for LTCHs. The Centers for Medicare & Medicaid Services (CMS) implemented this system for cost reporting periods beginning on or after October 1, 2002.

Under the prospective payment system, Medicare continues to provide each beneficiary 90 regular Part A covered benefit days for an episode of inpatient hospital care. LTCH patients often begin an episode of care in an acute care hospital and thus may have used part or all of their covered benefit days before they are admitted to the LTCH. However, each beneficiary also has 60 lifetime reserve days. These lifetime reserve days may be used to cover additional days of an episode of care after the beneficiary has used the 90 regular benefit days. When using lifetime reserve days, beneficiaries pay a coinsurance amount equal to one half of the inpatient hospital deductible.

The LTCH prospective payment system uses long-term care diagnosis-related groups (DRG) as a patient classification system. Each beneficiary's stay in an LTCH is assigned to a specific DRG based on the beneficiary's diagnosis, procedures, age, gender, and discharge status. Each DRG has a predetermined average length of stay that is used to determine when a beneficiary's LTCH stay qualifies for a full DRG payment.

Medicare pays LTCHs a full DRG payment for a stay that exceeds five-sixths of the average length of stay for the DRG. When the beneficiary's length of stay in the LTCH is not long enough to qualify for a full DRG payment, the beneficiary must use available covered benefit days to continue Medicare coverage until the stay reaches the threshold for a full DRG payment. If a beneficiary does not have enough regular covered days to reach the threshold, the beneficiary must use his or her available lifetime reserve days to continue Medicare coverage. If a beneficiary uses all of his or her Medicare-covered days, including lifetime reserve days, before the stay qualifies for a full DRG payment, Medicare pays LTCHs only for the beneficiary's covered benefit days. This type of DRG payment is called a short-stay outlier payment. The beneficiary is responsible for the remaining days of the stay.

Hospital Billing and Fiscal Intermediary Payment

CMS's "Medicare Claims Processing Manual" requires LTCHs to submit claims data for both Medicare covered and noncovered days to fiscal intermediaries on Form CMS-1450. The LTCHs are responsible for correctly coding their claims on this form to reflect the beneficiaries' coverage status.

The Medicare program requires fiscal intermediaries to be responsible for making DRG payments, including short-stay outlier payments. The fiscal intermediary is also responsible for ensuring that LTCHs include the appropriate codes on the claims when these codes are needed and for requesting that LTCHs resubmit their claims if they have not included the appropriate codes on the original claim.

Mutual of Omaha

Mutual of Omaha (the Intermediary) is the fiscal intermediary for 183 LTCHs in 34 states. Until May 31, 2003, the Intermediary used the Arkansas Part A Standard System to process Medicare claims. Since June 1, 2003, the Intermediary has used the Fiscal Intermediary Shared System.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the Intermediary paid LTCHs' claims in accordance with Medicare requirements when beneficiaries had used all of their regular covered benefit days.

Scope

Our review covered payments that the Intermediary made to LTCHs from January 1 through May 31, 2003.

Our objective did not require an understanding or assessment of the complete internal control structure at the Intermediary. Therefore, we limited our review to obtaining an understanding of the Intermediary's controls related to processing and paying LTCH claims.

We performed our review from October 2005 through February 2006.

Methodology

To accomplish our objective, we:

- reviewed laws, regulations, and Medicare program guidance related to the processing of LTCH claims;
- extracted data from CMS's National Claims History on LTCH claims that the Intermediary paid for beneficiaries who had used all of their regular covered benefit days to compare the number of Medicare-covered days in a beneficiary's stay with the number of days in the DRG threshold;
- verified LTCH payment data for claims that had the highest payment amounts with payment data from CMS's Common Working File and analyzed claims details;

- identified 47 claims paid by the Intermediary during our audit period that were at high risk of overpayment because the coverage status codes indicated that the beneficiaries had used all of their regular covered benefit days before their length of stay qualified for a full DRG payment; and
- discussed the results of our review with officials at the Intermediary.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The Intermediary did not always pay LTCH claims in accordance with Medicare requirements when the beneficiaries had used all of their regular covered benefit days. Specifically, of the 47 claims that we reviewed, the Intermediary made full DRG payments for (1) 8 claims that should have been reduced to a short-stay outlier payment and (2) 25 claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. As a result, the Intermediary made overpayments totaling \$374,945 for 33 claims to 21 LTCHs for services provided from January 1 through May 31, 2003. Payment errors occurred because the Intermediary misunderstood the requirements for ensuring that LTCHs' claims contained the appropriate coverage status codes when beneficiaries had used all of their covered benefit days before their length of stay qualified for a full DRG payment.

PROGRAM REQUIREMENTS

Pursuant to 42 CFR § 412.529, a short-stay outlier is a length of stay between one day and up to and including five-sixths of the average length of stay for the DRG to which the episode of care is assigned. Under the prospective payment system, Medicare pays LTCHs only for covered benefit days until the length of stay exceeds five-sixths of the average length of stay, which results in a full DRG payment.

The Medicare Benefit Policy Manual (the Manual), Chapter 5, section 10, states that each Medicare beneficiary who has used 90 days of services in a benefit period for hospital inpatient care is entitled to draw upon a lifetime reserve of 60 days of inpatient hospital services covered under Medicare Part A. A benefit period is a period of consecutive days during which medical benefits for covered services are available to the beneficiary. Section 30.6 of the Manual states that when a beneficiary has run out of regular benefit days before reaching the short-stay outlier threshold, the remaining days of the stay will be counted against the beneficiary's available lifetime reserve days (unless the beneficiary chooses not to use them).

Section 1813 of the Social Security Act provides for an inpatient hospital deductible and certain coinsurance amounts to be subtracted from the amount that Medicare pays for inpatient hospital services furnished to a beneficiary. The daily coinsurance amount for lifetime reserve days is one-half of the inpatient hospital deductible.

OVERPAYMENTS FOR LONG-TERM CARE HOSPITAL CLAIMS

The Intermediary made overpayments to 21 LTCHs for 33 claims for services provided from January 1 through May 31, 2003. Specifically, the Intermediary made full DRG payments for 8 claims that should have been reduced to a short-stay outlier payment and 25 claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. The Intermediary paid the remaining 16 claims correctly.

Claims Not Reduced to Short-Stay Outlier Payment

The Intermediary made full DRG payments for eight claims that qualified only for short-stay outlier payments. In other words, the Intermediary should have paid LTCHs only for the beneficiaries' covered benefit days. In each of these cases, the beneficiary had used all covered benefit days, including available lifetime reserve days, before the LTCH stay reached the threshold for qualifying for a full DRG payment.

For five of these eight claims, LTCHs used incorrect coverage status codes that prevented the Arkansas Part A Standard System from identifying that the beneficiaries had used all of their Medicare-covered days. For the remaining three claims, the LTCHs used the correct coverage status codes to indicate that the beneficiaries' Medicare-covered days were exhausted, but the Intermediary mistakenly reimbursed the LTCHs for a full DRG payment rather than a short-stay outlier payment.

Claims Not Reduced to Short-Stay Outlier Payment: An Example

When Beneficiary A transferred to an LTCH after spending more than a month in an inpatient rehabilitation facility recovering from a stroke, he had already used all of his 90 regular Medicare-covered benefit days and 43 of 60 available lifetime reserve days for the same episode of care. He spent the next 86 days in the LTCH. Because Beneficiary A had no regular benefit days left to draw on and his 17 remaining lifetime reserve days did not exceed the 38-day threshold for a full DRG, the Intermediary should have limited the LTCH payment to a short-stay outlier payment for the 17 lifetime reserve days that Beneficiary A had available when he entered the LTCH. However, the Intermediary made a full DRG payment of \$42,364 to the LTCH instead of reducing the amount to a short-stay outlier payment of \$15,302. Thus, the Intermediary overpaid the LTCH \$27,062 for the claim.

Claims Not Reduced by Beneficiaries' Coinsurance Amounts

The Intermediary made full DRG payments for 25 claims that it should have reduced by the coinsurance amounts that beneficiaries pay for each lifetime reserve day that they use. The beneficiaries of these 25 claims had used all of their regular covered benefit days but had enough remaining lifetime reserve days to qualify for a full DRG payment. The Intermediary should have instructed the LTCHs to use the beneficiaries' lifetime reserve days and reduced the LTCHs' payments by the beneficiaries' coinsurance amounts, as Medicare requires. Instead, the Intermediary instructed the LTCHs to enter the wrong coverage status codes and then processed

the claims to generate full DRG payments without using the beneficiaries' available lifetime reserve days.

Claims Not Reduced by Coinsurance Amounts: An Example

When Beneficiary B entered an LTCH after spending 33 days in an acute care hospital with severe respiratory complications, she had 8 regular covered benefit days and all 60 lifetime reserve days available. She stayed in the LTCH for 60 days. Although she had used her remaining 8 regular covered benefit days before her stay reached the 42-day threshold for her DRG, she had enough lifetime reserve days available for her stay to qualify for a full DRG payment. However, the Intermediary did not use Beneficiary B's available lifetime reserve days when it calculated the amount that it paid the LTCH and thus did not reduce Medicare's liability by the amount of the beneficiary's coinsurance payment for the lifetime reserve days. Specifically, the Intermediary made a full DRG payment of \$87,349 instead of reducing the amount to \$65,509 to account for the beneficiary's coinsurance amount for the 34 lifetime reserve days that she needed to use to qualify for a full DRG payment. Thus the Intermediary overpaid the LTCH \$21,840 for the claim.

MEDICARE OVERPAYMENTS

The Intermediary made overpayments totaling \$374,945 for 33 claims to 8 LTCHs for services provided from January 1 through May 31, 2003. Specifically, the Intermediary overpaid LTCHs \$127,159 for 8 claims that it paid as full DRGs rather than as short-stay outlier adjusted payments and \$247,786 for 25 claims that it should have reduced by beneficiaries' coinsurance amounts for available lifetime reserve days.

CAUSES OF PAYMENT ERRORS

Payment errors occurred because the Intermediary did not always follow Medicare requirements for determining DRG payments to LTCHs for beneficiaries who had used all of their regular Medicare-covered benefit days. Instead, the Intermediary mistakenly understood that the requirements for applying beneficiaries' Medicare-covered days in calculating DRG payments for LTCHs were the same as the requirements used for acute care hospitals.¹ The LTCHs then made corrections to claims based on this misunderstanding, which resulted in their receiving full DRG payments.

These errors are unlikely to recur because the Intermediary no longer uses the Arkansas Part A Standard System to process claims. Its current claims processing system does not allow the LTCHs to enter inappropriate codes to incorrectly process claims for beneficiaries who have used all of their regular covered benefit days before their length of stay qualifies for a full DRG payment.

¹ For acute care hospitals, Medicare pays the full DRG payment if the beneficiary has at least one Medicare-covered benefit day available at the time of admission.

RECOMMENDATIONS

We recommend that the Intermediary recover the overpayments made to 21 LTCHs for 33 claims totaling \$374,945 and work with CMS to determine the appropriate actions for recovering the portion of the overpayments related to the beneficiaries' coinsurance payments.

AUDITEE'S COMMENTS

In its comments on our draft report, the Intermediary generally agreed to implement our recommendation. However, the Intermediary noted that it would need assistance from CMS to determine the appropriate actions for recovering the portion of this overpayment related to the beneficiaries' coinsurance. In addition, the Intermediary requested that we modify our explanation of the cause of the overpayments to reflect that it had misunderstood the requirements.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We revised our recommendation to reflect the Intermediary's concern regarding the need for CMS involvement. We also amended our explanation of the cause of the overpayments in response to the Intermediary's request for clarification.

APPENDIX



MUTUAL of OMAHA INSURANCE COMPANY
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1 877 647 6528
mutualmedicare.com
A CMS Contracted Intermediary

APPENDIX
Page 1 of 2

June 15, 2007

Michael Armstrong, Regional Inspector General
Office of Audit Services
Region 1
JFK Federal Building
Boston, MA 02203

Re: Re: OIG Audit Report # A-01-07-00510

Dear Mr. Armstrong:

This letter is in response to the OIG draft report entitled "Review of Mutual of Omaha Medicare Payments to Long-Term Care Hospitals From January Through May 2003". In the draft report, OIG noted their objective was to determine whether the Intermediary paid LTCHs' claims in accordance with Medicare requirements when beneficiaries had used all of their regular covered benefit days.

The OIG recommended that Mutual of Omaha:

- Recover the overpayment made to 21 LTCHs for 33 claims totaling \$374,945.

Our office wants to emphasize the impact of the collection of overpayments on the correct co-insurance amount due from the beneficiary and the deceased beneficiaries estates. If possible when the final report is issued, please consider recommending that Mutual of Omaha work with Centers for Medicare and Medicaid Services (CMS) to determine the appropriate action to be taken in collecting the overpayment.

Please consider each of our responses listed below when preparing the Final Report.

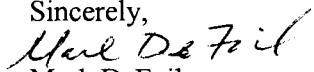
Claims Not Reduced by Beneficiaries' Coinsurance Amounts

OIG Comments - The Intermediary made full DRG payments for 25 claims that it should have reduced by the coinsurance amounts that beneficiaries pay for each lifetime reserve day that they use. The beneficiaries of these 25 claims had used all of their regular covered benefit days but had enough remaining lifetime reserve days to qualify for a full DRG payment. The Intermediary should have instructed the LTCHs to use the beneficiaries' lifetime reserve days and reduced the LTCHs' payments by the beneficiaries' coinsurance amounts, as Medicare requires. Instead, the Intermediary instructed the LTCHs to enter the wrong coverage status codes and then processed the claims to generate full DRG payments without using the beneficiaries' available lifetime reserve days.

Mutual of Omaha Medicare's Comments – We believe the following statement more accurately reflects the situation. When processing these 25 claims, the Intermediary misunderstood the requirements and used the wrong code for the dates of service after the beneficiaries' regular covered days had been exhausted. The provider then made corrections to claim based on this misunderstanding, which resulted in issuance of full DRG.

Please feel free to contact me (402-351-6915) or Michelle Routt (402-351-8293) if you have any questions or concerns.

Sincerely,



Mark DeFoil

First Vice President
Medicare Compliance