DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

APR 6 2006

Report Number: A-01-05-00521

Ms. Sally T. Wood
President
United Government Services, LLC
401 West Michigan St.
Milwaukee, WI 53203-2804

Dear Ms. Wood:

Enclosed are two copies of the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Fiscal Year-End Billing for Inpatient Rehabilitation Claims Under the Administrative Responsibility of United Government Services, LLC for 2002." A copy of this report will be forwarded to the HHS action official noted below 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 the HHS action 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.

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If you have any questions or comments about this report, please do not hesitate to contact me at (617) 565-2684 or through e-mail at Michael.Armstrong@oig.hhs.gov. To facilitate identification, please refer to report number A-01-05-00521 in all correspondence.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services - Region V
233 North Michigan Avenue Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FISCAL YEAR-END BILLING FOR INPATIENT REHABILITATION CLAIMS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF UNITED GOVERNMENT SERVICES, LLC FOR 2002

Daniel R. Levinson
Inspector General

APRIL 2006
A-01-05-00521

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

The Centers for Medicare & Medicaid Services (CMS) implemented a prospective payment system for inpatient rehabilitation facilities (IRFs) for cost-reporting periods beginning on or after January 1, 2002. The prospective payment system provides for a predetermined payment per discharge. To receive this payment, the IRF must submit a single discharge bill for an entire inpatient stay. The payment encompasses all inpatient operating and capital costs with few exceptions.

CMS instructions state that when a beneficiary's stay overlaps the time in which the IRF becomes subject to prospective payment system rules, the payment will be based on the patient's date of discharge. An IRF should not split bills for these patients into separate fiscal years.

OBJECTIVE

Our objective was to determine whether IRFs under the administrative responsibility of United Government Services, LLC (UGS) billed fiscal year-end inpatient rehabilitation claims in accordance with Medicare requirements during the transition to the prospective payment system in 2002.

SUMMARY OF FINDINGS

Thirty-four IRFs did not bill 340 fiscal year-end claims in accordance with Medicare requirements. Specifically, the IRFs split claims for 170 IRF stays with discharge dates that occurred after the transition to the prospective payment system into two separate claims. As a result, the IRFs received two separate payments for each IRF stay that spanned the transition to the new system. In accordance with Medicare requirements and CMS guidelines, the entire IRF stay should have been billed as a single claim based on the date of discharge on the CMS Form 1450 (UB92). As a result, Medicare made net overpayments of $516,303 to these 34 IRFs for claims submitted during their transition to the prospective payment system in 2002. This total reflects overpayments of $590,481 to 28 IRFs and underpayments of $74,178 to 6 IRFs.

The payment errors occurred because some IRFs did not have adequate controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare requirements. Additionally, two IRFs stated that they had received inaccurate information from UGS.

RECOMMENDATIONS

We recommend that UGS:

- make the appropriate adjustments to paid claims that resulted in net overpayments of $516,303 to the 34 IRFs, and

- continue education efforts for IRF and UGS personnel to ensure compliance with Medicare requirements and CMS instructions for billing IRF services.

We will provide UGS with the incorrectly billed claims identified by our review.

UNITED GOVERNMENT SERVICES' COMMENTS

UGS agreed with our findings and recommendations. UGS stated in its response that it has been working with several IRFs to adjust the incorrectly billed claims and recover the net overpayments. Additionally, UGS stated that it held two educational sessions for IRF personnel during fiscal year 2005. In response to this audit report, UGS will hold two teleconferences for IRFs and an educational session for internal personnel during fiscal year 2006. We have included UGS's comments as an appendix.

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INTRODUCTION

BACKGROUND

The Social Security Amendments of 1983 established the prospective payment system for most inpatient services but excluded certain specialty hospitals such as inpatient rehabilitation facilities (IRFs) and distinct part rehabilitation units in hospitals.[1] As a result, IRFs continued to be paid pursuant to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982. These rules based payments to IRFs on the Medicare reasonable costs per case, limited by a hospital-specific target amount per discharge.

To control escalating costs, section 1886(j) of the Social Security Act established a prospective payment system for IRFs that the Centers for Medicare & Medicaid Services (CMS) implemented for cost-reporting periods beginning on or after January 1, 2002.

The payment system provides for a predetermined payment per discharge. To receive this payment, the IRF must submit a single discharge bill for an entire inpatient stay. CMS instructions state that when a beneficiary's stay overlaps the time in which the IRF becomes subject to the prospective payment system rules, the payment will be based on the patient's date of discharge. Further, provider instructions in the "Medicare Inpatient Rehabilitation Facility Prospective Payment System Training Manual" (the Manual) state that a facility should not split bills that overlap the start of the fiscal year in which the IRF becomes subject to the prospective payment system.

United Government Services, LLC (UGS) is the Medicare Part A fiscal intermediary for IRFs in Wisconsin, California, Virginia, Michigan, Hawaii, and West Virginia. In 2002, 142 IRFs were under UGS's administrative responsibility. To inform IRFs of the changes that would occur when the payment system was implemented, UGS provided training sessions in Virginia, Wisconsin, Michigan, and California in late 2001. Additionally, UGS mailed a Medicare Memo to all IRFs to communicate pertinent information regarding the transition to the new payment system.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether IRFs under the administrative responsibility of UGS billed fiscal year-end inpatient rehabilitation claims in accordance with Medicare requirements during the transition to the prospective payment system in 2002.

[1] We refer to these inpatient rehabilitation facilities and distinct part rehabilitation units collectively as IRFs throughout the report.

Scope

The audit included a review of 340 Medicare payments totaling $3,558,399 made to 34 IRFs for inpatient stays that spanned the hospital's fiscal year-end during the transition to the prospective payment system in 2002.

We limited our review of internal controls to obtaining an understanding of the selected IRFs' internal control structure for submitting claims that spanned the hospital's fiscal year-end.

We performed our fieldwork from September through December 2005. Our fieldwork included visiting or telephoning selected IRFs in Wisconsin, California, Virginia, and Michigan. Although UGS also has administrative responsibility for a small number of IRFs in West Virginia and Hawaii, we found no incorrect transition payments to those IRFs.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare requirements and CMS guidance;
- extracted paid claims data for December 2001[2] and calendar year 2002 from CMS's National Claims History and identified a universe of 340 inpatient rehabilitation claims that were incorrectly billed by 34 IRFs during the transition to the prospective payment system for cost reporting years beginning or after January 1, 2002;
- reviewed the applicable detailed records for the claims from CMS's Common Working File to verify that the claims represented a single inpatient rehabilitation stay;
- performed an on-site visit to 1 IRF in Michigan and sent inquiries to 18 others to determine the cause of the incorrect billing;
- calculated the effect of incorrect billing by using CMS's Pricer Program or information from UGS; and
- discussed the results of our review with UGS.

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

[2] Since several IRFs transitioned to the prospective payment system on their cost reporting date of January 1, 2002, we extracted claims data for December 31, 2001, to identify the first of the two payments made to those IRFs.

FINDINGS AND RECOMMENDATIONS

Thirty-four IRFs did not bill 340 fiscal year-end claims in accordance with Medicare requirements. As a result, Medicare made net overpayments of $516,303 to these 34 IRFs for claims submitted during their transition to the prospective payment system in 2002. This total reflects overpayments of $590,481 to 28 IRFs and underpayments of $74,178 to 6 IRFs.

Most of the payment errors occurred because the IRFs did not have adequate controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare requirements. Additionally, several IRFs stated that they had received inaccurate information from UGS.

INTERIM BILLING REQUIREMENTS

Pursuant to 42 CFR § 412.600(b), the IRF prospective payment system provides for a predetermined per-discharge payment. To receive this payment, an IRF must submit a single discharge bill for an entire inpatient stay. The payment encompasses all inpatient operating and capital costs with few exceptions. CMS guidance states that when a beneficiary's stay overlaps the time in which the IRF becomes subject to the prospective payment system rules, the payment will be based on the patient's date of discharge. Furthermore, provider instructions contained in the Manual state that an IRF should not split bills that overlap the start of the fiscal year in which the IRF becomes subject to the prospective payment system.

FISCAL YEAR-END CLAIMS SPLIT

Thirty-four IRFs did not bill 340 fiscal year-end claims in accordance with Medicare requirements. Specifically, the IRFs split claims for 170 IRF stays with discharge dates that occurred after the transition to the prospective payment system into two separate claims. As a result, the IRFs received two separate payments for each IRF stay that spanned the transition period. In accordance with Medicare requirements and CMS guidelines, IRFs should have billed the entire stay as a single claim based on the date of discharge on the CMS Form 1450 (UB92).

PAYMENT ERRORS RESULTING FROM INCORRECT BILLING

Medicare made net overpayments of $516,303 to the 34 IRFs for claims submitted during their transition to the prospective payment system in 2002. This total reflects overpayments of $590,481 to 28 IRFs and underpayments of $74,178 to 6 IRFs. Underpayments occurred when the combining of two claims into a single claim caused certain thresholds to be exceeded. When these thresholds were exceeded, outlier payments were due or full payments were warranted instead of reduced transfer or short stay payments. An IRF's prospective payment is adjusted to account for situations such as transfers to other facilities and short stays of 3 days or less.

CAUSES OF INCORRECT BILLING

Our fieldwork at 19 of the 34 IRFs found that controls at some IRFs were inadequate to facilitate proper billing during the transition to the prospective payment system. Of the 19 IRFs that we surveyed, 17 had billing staff that were not aware of the change in billing requirements and therefore had not established the necessary controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare requirements.

At these 17 IRFs surveyed, some or all of the billing staff were unaware that a single bill should have been submitted for those patients in the IRF during the transition to the prospective payment system. As a result, some transition stays may have been billed correctly, while others at the same IRF were billed incorrectly.

The remaining 2 of the 19 IRFs surveyed stated that they had received inaccurate information from UGS. These two IRFs stated that UGS had instructed them to split-bill the transition claims as they had done under the previous payment system.

RECOMMENDATIONS

We recommend that UGS:

- make the appropriate adjustments to paid claims that resulted in net overpayments of $516,303 to the 34 IRFs, and

- continue education efforts for IRFs and UGS personnel to ensure compliance with the Medicare requirements and CMS instructions for billing IRF services.

We will provide UGS with the incorrectly billed claims identified by our review.

UNITED GOVERNMENT SERVICES' COMMENTS

UGS agreed with our findings and recommendations. UGS stated in its response that it has been working with several IRFs to adjust the incorrectly billed claims and recover the net overpayments. Additionally, UGS stated that it held two educational sessions for IRF personnel during fiscal year 2005. In response to this audit report, UGS will hold two teleconferences for IRFs and an educational session for internal personnel during fiscal year 2006. We have included UGS's comments as an appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PART A INTERMEDIARY NATIONAL FQHC INTERMEDIARY MEDICARE
REGIONAL HOME HEALTH INTERMEDIARY PHONE 414-226-2813 ▼ FAX 414-226-2647

SALLY T. WOOD
PRESIDENT

March 29, 2006

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General
Region I, Room 2425
John F. Kennedy Federal Building
Boston, MA 02203

RE: OIG Report A-01-05-00521

Dear Mr. Armstrong:

United Government Services, LLC (UGS) received the above referenced draft OIG audit report entitled "Review of Fiscal Year-End Billing for Inpatient Rehabilitation Facility Claims Under the Administrative Responsibility of United Government Services, LLC for 2002." We have reviewed the report and do not have any additional comments at this time. The report also included two recommendations. Attached are our responses to those recommendations.

If you have any questions regarding our responses, please feel free to contact Cheryl Leissring, Regional Vice President of Program Management for UGS at 414-226-5884.

Sincerely,

Sally T. Wood

STW/maf

Copy: Cheryl Leissring, UGS
Steve Holubowicz, UGS
Barb Hensley, UGS
Juliette Chenian, UGS
James Cope, UGS
Art Lurvey, UGS
Wendy Perkins, UGS
Paula Brunmeier, UGS
Dave Strzyzewski, UGS

Recommendation
UGS should make the appropriate adjustments to paid claims that resulted in net overpayments of $516,303 to the 34 Inpatient Rehabilitation Facilities.

Response
UGS agrees with the recommendation. We have already worked with three of the providers and adjusted 30 claims with a net recovery of $36,125.85. It should be noted that as the Medicare contractor, we are unable to simply combine the two processed claims to accomplish the adjustments and recovery. In many instances, the diagnoses and Health Insurance Prospective Payment System (HIPPS) codes differ between the two existing claims and we are unable to determine which is the more appropriate coding for the entire stay. Therefore, we will cancel the claim with the shortest stay and work with the providers to adjust the remaining claim to reflect the full stay.

Recommendation
UGS should continue education efforts for IRF and UGS personnel to ensure compliance with Medicare requirements and CMS instructions for billing IRF services.

Response
UGS agrees with the recommendation. During Fiscal Year 2005, UGS held teleconference education sessions for IRF personnel on October 27, 2004 and May 19, 2005. For the October 2004 session, 54 providers registered, with 27 actually attending. For the May 2005 session, 38 providers registered, with 24 attending. In addition, in response to this audit report, UGS will hold two teleconference education sessions for IRF personnel during Fiscal Year 2006. Those sessions will be four hours each and are scheduled for May 24, 2006 and June 5, 2006. The sessions will be open to all IRF providers under the administrative responsibility of UGS. A special notice will be sent to the providers in early April informing them of the training schedule. In addition, the UGS website will be updated to include the dates of the training sessions.

UGS will also be conducting an education session for internal personnel. We are in the process of scheduling the internal session and expect it to be completed no later than May 31, 2006.