Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

APR 23 2009

Report Number: A-01-08-00530

Mr. James Elmore
National Government Services
Regional Vice President, Contract Administration
Mail Stop: INA 102-AF13
8115 Knue Road
Indianapolis, Indiana 46250

Dear Mr. Elmore:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicare Part A Claims Paid by National Government Services for Interrupted Stays at Inpatient Psychiatric Facilities During Calendar Years 2005 and 2006." 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.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact David Lamir, Audit Manager, at (617) 565-2704 or through e-mail at David.Lamir@oig.hhs.gov. Please refer to report number A-01-08-00530 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management and Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART A CLAIMS PAID BY NATIONAL GOVERNMENT SERVICES FOR INTERRUPTED STAYS AT INPATIENT PSYCHIATRIC FACILITIES DURING CALENDAR YEARS 2005 AND 2006

Daniel R. Levinson
Inspector General

April 2009
A-01-08-00530

Office of Inspector General

http://oig.hhs.gov

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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. The prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF.

The IPF prospective payment system includes a 3-day policy for interrupted stays to discourage inappropriate discharges and readmissions to IPFs. An interrupted stay occurs when a patient is discharged from an IPF and admitted to the same or a different IPF within 3 consecutive days of the discharge from the original IPF stay. For payment purposes, the stay is considered to be continuous for applying the variable per diem adjustment. The variable per diem rate is a standardized Federal rate that factors in higher payments at the beginning of a stay to cover the higher cost of admission-related services, such as psychiatric evaluations, and declines over time as treatment progresses.

To ensure proper payment, CMS instructed IPFs to bill for interrupted stays using a specific occurrence span code with a "from" date that equals the day of discharge from the IPF and a "through" date that is the last day the patient was not present in the IPF at midnight. In the IPF Prospective Payment System Final Rule, CMS stated that the interrupted stay rule would apply to circumstances in which a patient was discharged from one IPF, admitted to an intermediate facility, and then discharged again to a second IPF. In addition, in a Medicare Claims Processing Manual (Pub. 100-04) provision, CMS used the following examples to explain IPF billing requirements for interrupted stays:

- ". . . [A] patient leaves IPF on 1/1 and returns to the same IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed."

- "In the cases where an IPF patient is discharged from IPF 'A' and within 3 days is readmitted to IPF 'B,' and IPF 'B' does not know about the patient's immediately preceding hospitalization in IPF 'A,' then 2 bills will be allowed."

National Government Services (NGS) is the Medicare Part A fiscal intermediary for selected providers in Connecticut, Delaware, and New York. In calendar years (CY) 2005 and 2006, NGS had administrative responsibility for processing and paying claims submitted by institutional providers, including IPFs.

OBJECTIVE

Our objective was to determine whether IPFs billed claims paid by NGS in compliance with Medicare prospective payment system regulations for interrupted stays.

SUMMARY OF FINDINGS

IPFs did not always bill claims paid by NGS in compliance with Medicare prospective payment system regulations for interrupted stays. Specifically, our sample of 100 claims drawn from 2,211 claims that were potentially incorrectly billed as new stays indicated that, for 60 claims, IPFs had incorrectly billed the second discharge as new stays rather than as part of interrupted stays. For each of these claims, according to CMS guidance, the IPF should have known of the beneficiary's immediately preceding stay at the same or a different IPF. These 60 claims resulted in overpayments totaling $17,027. For 38 of the remaining 40 sampled claims, we were unable to determine whether the second IPF was aware of the beneficiary's preceding stay in the first IPF. Therefore, we were unable to determine whether these claims resulted in payment errors. The other two sampled claims were for incorrectly billed stays during the IPFs' transition to the prospective payment system.

Based on these sample results, we estimate that NGS overpaid IPFs $393,440 for incorrectly billed interrupted stays in CYs 2005 and 2006. We attribute the overpayments to internal control weaknesses at the IPF billing level and NGS.

RECOMMENDATIONS

We recommend that NGS:

- adjust the claims for the 60 sampled stays that resulted in overpayments totaling $17,027 and review the claims for 38 of the remaining 40 sampled stays to determine whether these claims resulted in payment errors,

- review our information on the additional 2,111 IPF interrupted stays with potential overpayments estimated at $393,440 and work with the IPFs that provided the services to recover any overpayments,

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

- strengthen its education process and emphasize to IPFs the importance of reporting the correct occurrence span code to identify beneficiaries who were discharged from an IPF and readmitted to the same or a different IPF within 3 consecutive days.

NATIONAL GOVERNMENT SERVICES COMMMENTS

In comments on our draft report, NGS concurred with our findings. NGS agreed that for the 60 sampled claims, the second IPF could have known of the beneficiary's prior IPF stay. However,

NGS stated that it could not implement all of our recommendations without further guidance from CMS. NGS said that it is unaware of a Common Working File or Fiscal Intermediary Shared System edit that recognizes when a beneficiary is discharged from one IPF and readmitted to a second IPF. In addition, NGS stated that the Fiscal Intermediary Shared System is not programmed to allow adjustments when a beneficiary is discharged from one IPF and readmitted to a second IPF and reduce payments to correct the overpayment to the second IPF. NGS maintained that, as a result, it is unable to adjust most of the sampled claims identified as overpayments as well as the 2,111 claims identified as potential overpayments without additional instruction from CMS or programming modifications to the Fiscal Intermediary Shared System. NGS also stated that it would develop educational materials for IPFs after CMS provides additional billing instructions as to how the second IPF should bill its claims.

NGS's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge the current lack of Common Working File or shared system edits in place to identify claims for which a beneficiary is discharged from one IPF and readmitted to a second IPF within 3 days and ensure the appropriate payment for the second part of the interrupted stay. Until sufficient edits are established to ensure compliance with the Medicare regulations, we encourage NGS to work with CMS to implement our recommendations.

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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. The prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF. CMS implemented the IPF prospective payment system over a 3-year transition period. For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the prospective payment system per diem rate. Before that date, payment was based on a blend of the prospective payment system rate and the rate payable under the old, facility-specific methodology.

The IPF prospective payment system uses a variable per diem rate, which is a standardized Federal rate that includes higher payments at the beginning of a stay to cover the higher costs of providing admission-related services, such as psychiatric evaluations, and declines over time as treatment progresses. The IPF prospective payment system also uses outlier payments to provide payment adjustments for IPF stays that have extraordinarily high costs.

The IPF prospective payment system includes a 3-day policy for interrupted stays to discourage inappropriate discharges and readmissions to IPFs. An interrupted stay occurs when a patient is discharged from an IPF and admitted to the same or a different IPF within 3 consecutive days of the discharge from the original IPF stay. For example, if a patient is discharged from an IPF on March 10 after an initial stay of 7 days and admitted to another IPF on March 12 (before midnight of the third consecutive day), the "readmission" is considered a continuation of the initial stay. Therefore, day 1 of the readmission will be considered day 8 of the combined stay for purposes of the variable per diem rate and any applicable outlier payments.

To ensure that interrupted stays are considered continuous for applying the variable per diem adjustments, CMS instructed IPFs to bill for interrupted stays using a specific occurrence span code with a "from" date that equals the day of discharge from the IPF and a "through" date that is the last day the patient was not present in the IPF at midnight. In the IPF Prospective Payment System Final Rule, CMS stated that the interrupted stay rule would apply to circumstances in which a patient was discharged from one IPF, admitted to an intermediate facility, and then discharged again to a second IPF. In addition, in a Medicare Claims Processing Manual (Pub. 100-04) provision, CMS used the following examples to explain IPF billing requirements for interrupted stays:

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[1]The prospective payment system applies for inpatient services of psychiatric hospitals and psychiatric units of acute-care hospitals. See the Medicare Claims Processing Manual, Pub. 100-04, § 190.1.

- ". . . [A] patient leaves IPF on 1/1 and returns to the same IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed."

- "In the cases where an IPF patient is discharged from IPF 'A' and within 3 days is readmitted to IPF 'B,' and IPF 'B' does not know about the patient's immediately preceding hospitalization in IPF 'A,' then 2 bills will be allowed."

National Government Services

National Government Services (NGS) is the Medicare Part A fiscal intermediary for selected providers in Connecticut, Delaware, and New York. In calendar years (CY) 2005 and 2006, NGS had administrative responsibility for processing and paying claims submitted by institutional providers, including IPFs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether IPFs billed claims paid by NGS in compliance with Medicare prospective payment system regulations for interrupted stays.

Scope

We reviewed Medicare Part A claims totaling $49.8 million for 2,211 new stays that were within the 3-day window of a prior discharge from an IPF. The 2,211 claims were submitted by 157 IPFs and paid by NGS during CYs 2005 and 2006.

Our objective did not require an understanding or assessment of the complete internal control structure at IPFs or NGS. Therefore, we limited our review of internal controls at IPFs and NGS to obtaining an understanding of (1) IPFs' procedures for submitting claims for beneficiaries who were admitted to an IPF within 3 consecutive days of discharge from the same or a different IPF and (2) NGS's policies and procedures for paying such claims.

We performed our fieldwork from June through October 2008. Our fieldwork included site visits to five IPFs in New York.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare regulations and CMS guidance regarding IPF billing and fiscal intermediary payments for interrupted stays,

- extracted paid claims data from CMS's National Claims History file for CYs 2005 and 2006,

- developed a computer application to identify stays billed as new stays and paid by NGS for beneficiaries who were discharged from an IPF and readmitted to the same or a different IPF within 3 consecutive calendar days,

- selected a statistical random sample of 100 claims from the population of 2,211 potential interrupted stays identified by the computer application to determine whether the stays were paid correctly (Appendix A),

- reviewed the applicable Common Working File records for the selected claims to validate the parameters of our computer match and to verify that the selected claims had not been canceled,

- reviewed incorrectly coded claims in our sample for beneficiaries discharged from one IPF and admitted to a different IPF to determine whether the second IPF could have reasonably been expected to know of the first IPF stay,

- contacted five IPFs to determine their procedures for submitting claims for interrupted stays,

- calculated the effects of the incorrect billing by using CMS's PRICER program and NGS's provider-specific information,

- estimated the total value of overpayments based on our sample results (Appendix B), 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

IPFs did not always bill claims paid by NGS in compliance with Medicare prospective payment system regulations for interrupted stays. Specifically, our sample of 100 claims drawn from 2,211 claims that were potentially incorrectly billed as new stays indicated that, for 60 claims, IPFs had incorrectly billed the second discharge as new stays rather than as part of interrupted stays. For each of these claims, according to CMS guidance, the IPF should have known of the beneficiary's immediately preceding stay at the same or a different IPF. These 60 claims resulted in overpayments totaling $17,027. For 38 of the remaining 40 sampled claims, we were unable to determine whether the second IPF was aware of the beneficiary's preceding stay in the first IPF. Therefore, we were unable to determine whether these claims resulted in payment

errors. The other two sampled claims were for incorrectly billed stays during the IPFs' transition to the prospective payment system.[2]

Based on these sample results, we estimate that NGS overpaid IPFs $393,440 for incorrectly billed interrupted stays in CYs 2005 and 2006. We attribute the overpayments to internal control weaknesses at the IPF billing level and NGS.

PROGRAM REQUIREMENTS

Under IPF regulations, the Federal per diem payment is based on facility-level adjustments applicable to the IPF, patient-level adjustments, and other policy adjustments as specified in 42 CFR § 412.424. One such policy adjustment is made for an interrupted stay in which a patient is discharged from an IPF and is admitted to the same or another IPF within 3 consecutive calendar days. The second stay is considered a continuation of the first stay for the purposes of determining (1) the appropriate variable per diem adjustment and (2) whether the total cost meets the criteria for outlier payments.

In the IPF prospective payment system final rule, published in the Federal Register (69 Fed. Reg. 66922 (Nov. 15, 2004)), CMS illustrated the application of the IPF interrupted stay policy using an example of a patient who is discharged from a psychiatric unit of a hospital to receive acute care and is then transferred to a freestanding psychiatric hospital at the completion of the hospital stay rather than returning to the psychiatric unit. Under the interrupted stay policy, if the patient is admitted to the psychiatric hospital within 3 days of the initial psychiatric unit stay, Medicare will not pay the psychiatric hospital the variable per diem adjustments for the initial days of the original psychiatric unit stay that would otherwise apply to the stay. In such a case, CMS "would not pay the psychiatric hospital the variable per diem adjustments for the initial days of original psychiatric stay otherwise applicable to the stay" because "the transferring hospital would send the psychiatric hospital the patient's medical record that will include information regarding the prior psychiatric stay in accordance with the hospital condition of participation for discharge planning (§ 482.43)." The purpose of this policy, CMS explained, is to prevent "the 'shuffling' of patients from hospital to hospital."

In addition, in its Medicare Claims Processing Manual, Pub. 100-04, chapter 3, section 190.7.1, CMS used the following examples to further explain IPF billing requirements:[3]

- ". . . [A] patient leaves IPF on 1/1 and returns to the same IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed."

[2]These two claims resulted in overpayments totaling $8,832 and were not included in our estimated total value of overpayments for incorrectly billed interrupted stays. Incorrectly billed stays during the IPF transition to the prospective payment system are the subject of a previous Office of Inspector General report dated August 27, 2008 (A-01-07-00520).

[3]CMS also distributed this guidance in its Medicare Claims Processing Bulletin, Transmittal 384, CR 3541 (December 1, 2004).

- "In the cases where an IPF patient is discharged from IPF 'A' and within 3 days is readmitted to IPF 'B,' and IPF 'B' does not know about the patient's immediately preceding hospitalization in IPF 'A,' then 2 bills will be allowed."

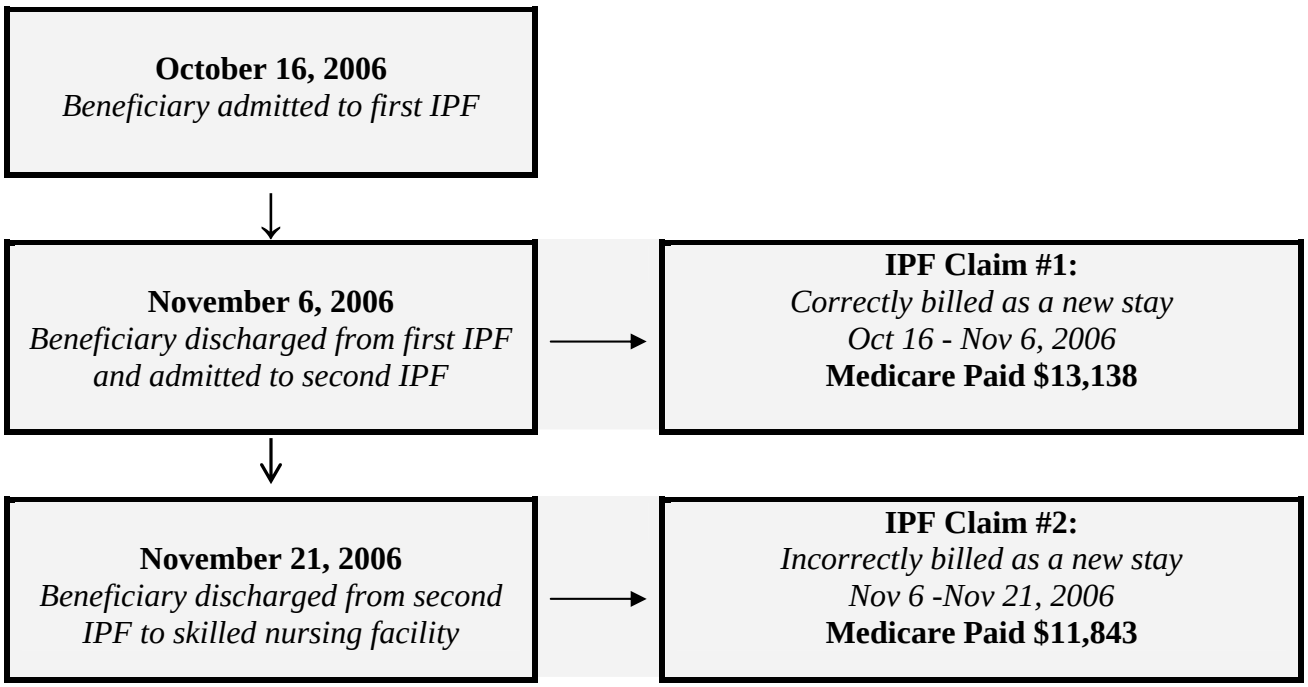
SECOND PART OF INTERRUPTED STAYS INCORRECTLY BILLED AS NEW STAYS

Our sample of 100 Medicare Part A claims that were potentially incorrectly billed as new stays indicated that IPFs had not billed 60 of these claims in compliance with the IPF interrupted stay provision of the prospective payment system. Specifically, IPFs incorrectly billed 60 stays after the interruption as new stays and thus received full payment for the second part of the interrupted stays instead of the adjusted payments that IPF regulations require. For 2 of the 60 stays, the beneficiary was readmitted to the same IPF. For the remaining 58 incorrectly billed stays, the beneficiary was readmitted to a different IPF. In each of these 58 cases, billing the stays as new stays was contrary to CMS's guidance in the final rule because either (1) the coding on the claim showed that the beneficiary was discharged from the first IPF directly to the second IPF or (2) the beneficiary's claim history showed that the beneficiary was discharged directly from an intermediate stay at an institutional provider to the second IPF, which would have received the beneficiary's medical records. Therefore, in both circumstances the second IPF should have billed the claim correctly because, as stated in CMS's guidance in the IPF prospective payment system final rule, the transferring hospital would have sent the patient's medical record, thus informing the second IPF about the beneficiary's immediately preceding stay at the first IPF.

For 38 of the remaining 40 sampled claims, we were unable to determine whether the second IPF was aware of the beneficiary's preceding stay in the first IPF because the first IPF coded the claims as "beneficiary discharged to home." Our further review of paid claim history did not identify an intervening stay at an institutional provider followed by a discharge directly to the second IPF. Therefore, we were unable to determine whether these claims resulted in payment errors. The other two sampled claims were for incorrectly billed stays during the IPFs' transition to the prospective payment system.

In the following example, the second IPF received a full payment of $11,843 instead of an adjusted payment of $11,150 because it incorrectly billed Medicare for a new stay rather than for the second part of an interrupted stay.

Interrupted Stay Billed as Two New Stays



Pursuant to Federal regulations, the second IPF's claim for the stay for November 6 through November 21, 2006, should have been considered a continuation of the first stay for determining the appropriate variable per diem adjustment.

PAYMENT ERRORS RESULTING FROM INCORRECT BILLING

To identify the effect of the incorrect billing, we combined each incorrectly billed interrupted stay into a continuous stay and repriced the resulting continuous stays. Additionally, for interrupted stays during which beneficiaries were readmitted to the same IPF, we combined the charges for each stay to determine whether outlier payments would have been warranted. We found that, during CYs 2005 and 2006, NGS made overpayments totaling $17,027 to IPFs for the 60 incorrectly billed interrupted stays.

Based on our sample results, we estimate that NGS overpaid IPFs a total of $393,440 for incorrectly billed interrupted stays in CYs 2005 and 2006.

INTERNAL CONTROL WEAKNESSES

IPFs were either unaware of or did not follow Medicare regulations and therefore had not established the necessary controls to ensure that they coded claims correctly to prevent overpayments for interrupted stays. Additionally, NGS did not have procedures to identify IPF interrupted stays and ensure that the claims were correctly paid.

RECOMMENDATIONS

We recommend that NGS:

- adjust the claims for the 60 sampled stays that resulted in overpayments totaling $17,027 and review the claims for 38 of the remaining 40 sampled stays to determine whether these claims resulted in payment errors,

- review our information on the additional 2,111 IPF interrupted stays with potential overpayments estimated at $393,440 and work with the IPFs that provided the services to recover any overpayments,

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

- strengthen its education process and emphasize to IPFs the importance of reporting the correct occurrence span code to identify beneficiaries who were discharged from an IPF and readmitted to the same or a different IPF within 3 consecutive days.

NATIONAL GOVERNMENT SERVICES COMMMENTS

In comments on our draft report, NGS concurred with our findings. NGS agreed that for the 60 sampled claims, the second IPF could have known of the beneficiary's prior IPF stay. However, NGS stated that it could not implement all of our recommendations without further guidance from CMS. NGS said that it is unaware of a Common Working File or Fiscal Intermediary Shared System edit that recognizes when a beneficiary is discharged from one IPF and readmitted to a second IPF. In addition, NGS stated that the Fiscal Intermediary Shared System is not programmed to allow adjustments when a beneficiary is discharged from one IPF and readmitted to a second IPF and reduce payments to correct the overpayment to the second IPF. NGS maintained that, as a result, it is unable to adjust most of the sampled claims identified as overpayments as well as the 2,111 claims identified as potential overpayments without additional instruction from CMS or programming modifications to the Fiscal Intermediary Shared System. NGS also stated that it would develop educational materials for IPFs after CMS provides additional billing instructions as to how the second IPF should bill its claims.

NGS's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge the current lack of Common Working File or shared system edits in place to identify claims for which a beneficiary is discharged from one IPF and readmitted to a second IPF within 3 days and ensure the appropriate payment for the second part of the interrupted stay. Until sufficient edits are established to ensure compliance with the Medicare regulations, we encourage NGS to work with CMS to implement our recommendations.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

OBJECTIVE

Our objective was to determine whether inpatient psychiatric facilities (IPF) billed claims paid by National Government Services (NGS) in compliance with Medicare prospective payment system regulations for interrupted stays.

POPULATION

Our population consisted of Medicare Part A claims for interrupted IPF stays that were paid by NGS in calendar years (CY) 2005 and 2006.

SAMPLING FRAME

The sample frame was a database of 2,211 stays for CYs 2005 and 2006.

SAMPLE UNIT

The sample unit was the second part of an IPF stay in which a beneficiary was discharged from one IPF and admitted to the same or another IPF within 3 days.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

We randomly selected 100 IPF claims (50 for CY 2005 and 50 for CY 2006).

SOURCE OF 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 2,211. 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

Sample Results

Frame Size	Sample Size	Value of Sample	Number of Unallowable Interrupted Stays	Value of Unallowable Interrupted Stays
2,211	100	$1,273,443	60	$17,027

Estimated Unallowable Payments

(Limits calculated for a 90-percent confidence interval)

Pont estimate	$393,440
Lower limit	$298,845
Upper limit	$488,035

National Government Services

PO Box 4846
Syracuse, New York 13221-4846
www.NGSMedicare.com

A CMS Contracted Agent

Medicare

April 10, 2009

Mr. Michael Armstrong
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Re: NGS Response to A-01-08-00530 OIG Audit – IPF Interrupted Stays

Dear Mr. Armstrong:

This letter is in response to the revised draft report dated March 13, 2009, entitled "Review of Medicare Part A Claims Paid by National Government Services for Interrupted Stays at Inpatient Psychiatric Facilities During Calendar Years 2005 and 2006."

According to your findings, Inpatient Psychiatric Facilities (IPFs) did not always bill claims paid by NGS in compliance with Medicare prospective payment system regulations for interrupted stays. Specifically, your computer match identified 2,211 claims that were potentially incorrectly billed as interrupted stays. Your sample of 100 claims indicated that for 60 claims, IPFs incorrectly billed the second part of the interrupted stay as a new stay rather than as part of the interrupted stay. According to your findings, these 60 claims resulted in overpayments totaling $17,027. For 38 of the remaining 40 sampled claims, you were unable to determine whether the second IPF was aware of the beneficiary's preceding stay in the first IPF. The other two sampled claims were for incorrectly billed stays during the IPFs transition to the prospective payment system.

According to CR 3541, "An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay. Interrupted stays are to be considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for outlier payment. For example, patient leaves IPF on January 1st and returns to the same IPF on January 3rd. This is considered an interrupted stay and the Occurrence span code 74 will show January 1-2. Should the patient return to the IPF on January 4th, two bills will be allowed. In the cases where an IPF patient is discharged from IPF "A" and within 3 days is readmitted to IPF "B", and IPF "B" does not know about the patients immediately preceding hospitalization in IPF "A", then two bills will be allowed."

Based on your investigation with the IPF's and the patient status codes submitted on the claims by Psychiatric provider "A", NGS agrees that for the 60 claims sampled, the second IPF could have known

that there was an interrupted stay prior to their admission. NGS also agrees that for the remaining 38 sampled claims we were unable to determine whether the second IPF was aware of the beneficiary's preceding stay. Finally, we agree that the remaining two sampled claims were for incorrectly billed stays during the IPF's transition to the prospective payment system.

As stated in our previous response on January 29, 2009, we are unaware of a Common Working File or Fiscal Intermediary Shared System (FISS) edit that has been set up to recognize when a provider is discharged from provider "A" and readmitted to provider "B". Furthermore, currently the FISS system is not programmed to allow adjustments from an "A" to "B" provider and reduce payments as a result of an overpayment in this situation.

In late January, our Senior Reimbursement Analyst, Luke Disabato spoke with Matthew Quarrick, CMS Central office IPF policy, and he confirmed the statement above. He stated that the FISS system is currently not set up to reduce per diem DRG reimbursement. The system would have no way to identify what day to begin paying Psych "B" as Occurrence code 74 only identifies days away, but does not show that the patient was at Psychiatric "A" for "X" number of days. Therefore, based on this information, we are unable to adjust the 60 claims identified, without additional instruction from CMS or programming modifications to the FISS system. In addition, in order to inform the provider community on future billing requirements CMS would also need to provide additional instructions as to how these claims should be billed when this situation occurs.

As a result of this audit NGS will do the following:

- Adjust the four claims where the patient was discharged from facility "A" and returned to facility "A" for an overpayment recovery.
- Work with the CMS J13 Contracting Office for guidance on addressing the additional 2,111 claims and Post payment Audits as it relates to this particular situation.
- Assist Provider Education in developing educational materials to the provider community on correct billing requirements once instruction has been given.

If you have any additional questions, please contact Sandra Logan at 513-419-3746.

Sincerely,

David Crowley dmjs

David C. Crowley
Staff Vice President
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director,
Scott Kimbell, J13 Project Director,
Sandra Logan, Claims Manager