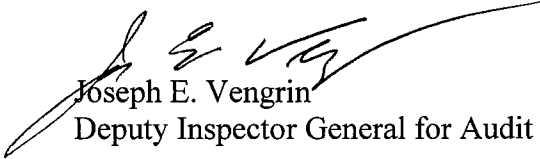




APR 22 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of Interrupted Stays at Inpatient Rehabilitation Facilities for
Calendar Years 2004 and 2005 (A-01-08-00502)

The attached final report provides the results of our review of interrupted stays at inpatient rehabilitation facilities (IRF) for calendar years (CY) 2004 and 2005.

Medicare reimburses IRFs through a prospective payment system, which provides for a predetermined, per-discharge payment. Adjustments may apply to the prospective payment in certain circumstances, such as an interrupted stay in which a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. In that case, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment.

Our prior review (A-01-04-00525) found that IRFs did not always bill for interrupted stays in compliance with Medicare prospective payment system regulations during CYs 2002 and 2003. In response to one of our recommendations, the Centers for Medicare & Medicaid Services (CMS) implemented an edit in its Common Working File on April 1, 2005, to identify all interrupted stays billed as two or more claims.

Our objectives were to determine whether:

- IRFs billed correctly for interrupted stays with discharge dates during CYs 2004 and 2005 and
- the new Common Working File edit detected incorrectly billed interrupted stays and prevented overpayments.

IRFs did not always bill correctly for interrupted stays with discharge dates during CYs 2004 and 2005. Our nationwide computer match showed that 448 IRFs billed incorrectly for 986 interrupted stays during that period. We determined that the correct value of the stays was

\$17.5 million, rather than the \$21.7 million that the IRFs billed. As a result, Medicare made net overpayments of \$4.2 million to the IRFs. The payment errors occurred because the IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, until April 2005, the Common Working File did not have an edit designed to identify all interrupted stays billed as two or more claims.

After its adoption, the new Common Working File edit effectively detected incorrectly billed interrupted stays and prevented overpayments to IRFs.

We recommend that CMS direct its fiscal intermediaries to recover the \$4.2 million in net overpayments that our review identified.

In its written comments on our draft report, CMS concurred with our recommendation. We have provided CMS with detailed claim information to assist in the recovery process.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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-01-08-00502 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF INTERRUPTED STAYS
AT INPATIENT REHABILITATION
FACILITIES FOR CALENDAR
YEARS 2004 AND 2005**



Daniel R. Levinson
Inspector General

April 2009
A-01-08-00502

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:

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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

Inpatient rehabilitation facilities (IRF) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS) implemented the prospective payment system for cost reporting periods beginning on or after January 1, 2002.

The prospective payment system provides for a predetermined, per-discharge payment. The payment system uses information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource needs. Adjustments may apply to the case-mix-group payment in certain circumstances, such as an interrupted stay in which a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. In that case, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment.

Our prior review (A-01-04-00525) found that IRFs did not always bill for interrupted stays in compliance with Medicare prospective payment system regulations during calendar years (CY) 2002 and 2003. In response to one of our recommendations, CMS implemented an edit in its Common Working File on April 1, 2005, to identify all interrupted stays billed as two or more claims.

OBJECTIVES

Our objectives were to determine whether:

- IRFs billed correctly for interrupted stays with discharge dates during CYs 2004 and 2005 and
- the new Common Working File edit detected incorrectly billed interrupted stays and prevented overpayments.

SUMMARY OF FINDINGS

IRFs did not always bill correctly for interrupted stays with discharge dates during CYs 2004 and 2005. Our nationwide computer match showed that 448 IRFs billed incorrectly for 986 interrupted stays during that period. We determined that the correct value of the stays was \$17.5 million, rather than the \$21.7 million that the IRFs billed. As a result, Medicare made net overpayments of \$4.2 million to the IRFs. The payment errors occurred because the IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, until April 2005, the Common Working File did not have an edit designed to identify all interrupted stays billed as two or more claims.

After its adoption, the new Common Working File edit effectively detected incorrectly billed interrupted stays and prevented overpayments to IRFs.

RECOMMENDATION

We recommend that CMS direct its fiscal intermediaries to recover the \$4.2 million in net overpayments that our review identified.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our recommendation. CMS requested that we provide the contractor-specific data necessary to initiate and complete recovery action. We have provided CMS with the requested data.

CMS's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

The Prospective Payment System for Inpatient Rehabilitation Facilities

Inpatient rehabilitation facilities (IRF) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS) implemented the prospective payment system for cost reporting periods beginning on or after January 1, 2002.

The prospective payment system provides for a predetermined, per-discharge payment. The payment system uses information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource needs. Adjustments may apply to the case-mix-group payment in certain circumstances, such as an interrupted stay in which a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. In that case, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment. Other adjustments to the case-mix-group payment include outlier payments to compensate the IRF for cases incurring extraordinarily high costs, transfer adjustments that may apply when a patient is transferred from an IRF to another facility, and short-stay adjustments that apply when the IRF stay lasts 3 days or less and does not involve a transfer.

Medicare paid \$6.6 billion for 500,264 claims involving 1,233 IRFs in calendar year (CY) 2004 and \$6.3 billion for 442,461 claims involving 1,243 IRFs in CY 2005.

Prior Office of Inspector General Report

Our prior review (A-01-04-00525) found that IRFs did not always bill for interrupted stays in compliance with Medicare prospective payment system regulations during CYs 2002 and 2003. We recommended, among other actions, that CMS strengthen the edit in its Common Working File to detect all interrupted stays incorrectly billed as two or more claims and to prevent associated payments. In its written comments on that draft report, CMS stated that it had implemented the recommended edit as of April 1, 2005.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether:

- IRFs billed correctly for interrupted stays with discharge dates during CYs 2004 and 2005 and

- the new Common Working File edit detected incorrectly billed interrupted stays and prevented overpayments.

Scope

We reviewed 1,991 nationwide Medicare claims totaling \$21.7 million for interrupted IRF stays with discharge dates during CYs 2004 and 2005.

We limited our review of CMS's internal controls to obtaining an understanding of the controls in the Common Working File to detect improperly billed interrupted stays and prevent overpayments to IRFs. At the 10 IRFs that we contacted, we limited our review of internal controls to the development and submission of Medicare claims that included interrupted stays.

Our fieldwork consisted of contacting the 10 IRFs by phone, mail, and/or site visits during June–August 2008.

Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- reviewed controls in the Common Working File intended to detect improperly billed interrupted stays and prevent overpayments;
- extracted paid claim data from CMS's National Claims History for CYs 2004 and 2005;
- developed a computer match to identify situations in which IRFs submitted two or more claims for a single IRF interrupted stay by flagging instances in which the "from" date of a claim was within the 3-day window for interrupted stays when compared with the "through" date of a previous claim for the same patient;
- reviewed the Common Working File detail for the interrupted stays identified by our computer match to validate the results of our match and to verify that the selected claims had not been canceled;
- calculated the effect of incorrect billing by combining each incorrectly billed interrupted stay into a claim for payment for a single discharge and either (1) repricing the interrupted stay using CMS's PRICER program or (2) repricing the interrupted stay manually using information from the IRF's fiscal intermediary and Medicare regulations if we did not find an IRF's provider-specific information in CMS's PRICER program;
- judgmentally selected a sample of 50 incorrectly billed interrupted stays from 10 IRFs and contacted representatives from these IRFs by phone, mail, and/or site visits to identify control weaknesses and validate our data; and

- discussed the results of our review with CMS 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 objectives.

FINDINGS AND RECOMMENDATION

IRFs did not always bill correctly for interrupted stays with discharge dates during CYs 2004 and 2005. Our nationwide computer match showed that 448 IRFs billed incorrectly for 986 interrupted stays during that period. We determined that the correct value of the stays was \$17.5 million, rather than the \$21.7 million that the IRFs billed. As a result, Medicare made net overpayments of \$4.2 million to the IRFs. The payment errors occurred because the IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, until April 2005, the Common Working File did not have an edit designed to identify all interrupted stays billed as two or more claims.

After its adoption, the new Common Working File edit effectively detected incorrectly billed interrupted stays and prevented overpayments to IRFs.

BILLING FOR INTERRUPTED STAYS

Federal Regulations

Federal regulations (42 CFR § 412.602) define an interrupted stay at an IRF as a stay during which a Medicare inpatient is discharged from the IRF and then readmitted to the same IRF before midnight of the third day after discharge. Pursuant to 42 CFR §§ 412.618(a) and 412.624(g)(2), IRFs receive one discharge payment for an interrupted stay based on the case-mix-group classification that is determined by the patient assessment performed at the initial admission.

Interrupted Stays Incorrectly Billed as Two or More Claims

We found that IRFs did not always bill for interrupted stays in compliance with prospective payment system regulations. During CYs 2004 and 2005, 448 IRFs incorrectly billed 986 interrupted stays.¹ IRFs billed each of the interrupted stays as two or more separate claims, with each claim representing the portion of the stay either before or after an interruption.²

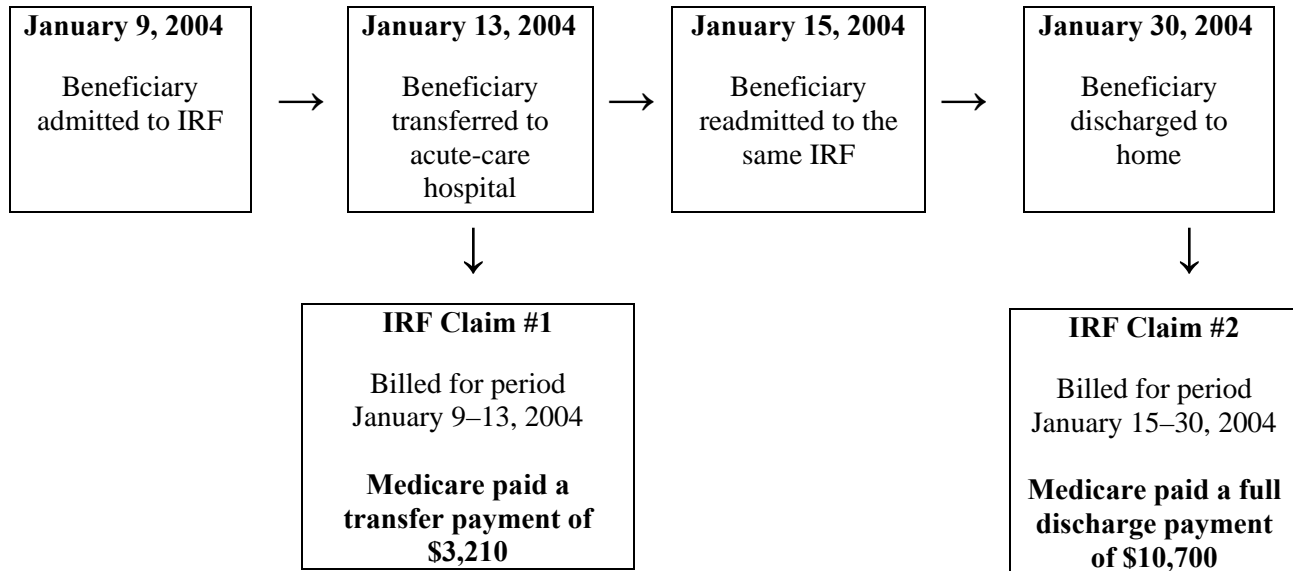
In the following example, an IRF received both a per diem transfer payment (\$3,210) and a full case-mix-group payment (\$10,700) instead of a single payment of \$10,700 because it billed an

¹Most of the interrupted stays occurred because the beneficiary had an intervening stay in an acute-care hospital.

²For a stay billed as three separate claims, the beneficiary's IRF stay was interrupted twice.

interrupted stay as two separate claims.³ As a result, Medicare overpaid the IRF \$3,210 for the interrupted stay.

Example: Interrupted Stay Billed as Two Claims



Payment Errors Resulting From Incorrect Billing

During CYs 2004 and 2005, Medicare made net overpayments totaling \$4.2 million to IRFs nationwide for the 986 interrupted stays billed as two or more claims. Approximately 84 percent of the incorrect billings resulted in overpayments. However, some IRFs received underpayments when they failed to combine two or more claims into a single claim that would have exceeded certain payment thresholds. In those cases, high-cost outlier payments or full case-mix-group payments would have been warranted, instead of the reduced transfer payments or short-stay payments that CMS made based on the incorrect billings.

The following table summarizes the payment errors that resulted from incorrectly billed interrupted IRF stays.

Incorrectly Billed Interrupted Stays

Period	Overpayments		Underpayments		Net Overpayments
	No.	Amount	No.	Amount	
CY 2004	764	\$4,318,111	139	(\$474,819)	\$3,843,292
CY 2005	67	415,654	16	(40,969)	374,685
Total	831	\$4,733,765	155	(\$515,788)	\$4,217,977

³A transfer payment is appropriate only if the patient’s IRF stay is shorter than the average stay for the case-mix group and the beneficiary is transferred to another facility (42 CFR § 412.602).

Causes of Incorrect Billing

Our review at 10 IRFs found that payment errors continued to occur because the IRFs did not have adequate billing controls. Additionally, until April 2005, Medicare payment controls in the Common Working File were not designed to identify all interrupted stays billed as two or more claims and to prevent improper payments.

EFFECTIVENESS OF NEW COMMON WORKING FILE EDIT

The Common Working File edit implemented on April 1, 2005, effectively detected incorrectly billed interrupted stays and prevented overpayments to IRFs. We found no incorrectly paid interrupted stay claims processed in 2005 after the edit was implemented.

RECOMMENDATION

We recommend that CMS direct its fiscal intermediaries to recover the \$4.2 million in net overpayments that our review identified.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our recommendation. CMS requested that we provide the contractor-specific data necessary to initiate and complete recovery action. We have provided CMS with the requested data.

CMS's comments are included in their entirety as the Appendix.

APPENDIX



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 19 2009

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

FROM: Charlene Frizzera
Acting Administrator

Charlene Frizzera

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Interrupted Stays at Inpatient Rehabilitation Facilities for Calendar Years 2004 and 2005" (A-01-08-00502)

OFFICE OF THE
INSPECTOR GENERAL
2009 MAR 24 AM 9:41

Thank you for the opportunity to review and comment on the above-referenced OIG draft report.

Medicare reimburses inpatient rehabilitation facilities (IRFs) through a prospective payment system, which provides a predetermined, per-discharge payment. Adjustments may apply to the prospective payment amount if an interrupted stay occurs. An interrupted stay happens when a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. When this occurs, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment. In a prior audit covering calendar years 2002 and 2003, the OIG did find that IRFs did not always bill for interrupted stays in compliance with Medicare prospective payment system regulations.

In this most recent audit of IRFs, the OIG performed a computer match on 986 interrupted stays during calendar years 2004 and 2005 and found that 448 IRF bills were improperly paid. This resulted in an overpayment to IRFs in the amount of \$4.2 million. The OIG also found that the payment errors occurred because the IRFs lacked the necessary controls to identify interrupted stays and that the Common Working File edit to identify interrupted stays billed under multiple claims was not implemented until the year 2005.

OIG Recommendation

The OIG recommends that CMS direct its fiscal intermediaries to recover the \$4.2 million in net overpayments that the OIG review identified.

Page 2 – Joseph E. Vengrin

CMS Response

We concur. CMS shall direct the Medicare fiscal intermediaries and Medicare administrative contractors to recover the \$4.2 million in overpayments. CMS plans to recover the overpayments identified consistent with the Agency's policies and procedures. CMS requests that the OIG furnish, for each overpayment or potential overpayment, the data necessary (provider numbers, claims information including the paid date, health insurance claim numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor-specific data should be written to separate CD-ROMs in order to better facilitate the transfer of information to the appropriate contractors.

We thank the OIG for conducting this audit and find their input to be very valuable.