DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-03-00086 October 21, 2003

Mr. Robert L. Shoptaw
President and Chief Executive Officer
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201

Dear Mr. Shoptaw,

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Arkansas Blue Cross and Blue Shield." **A** copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported 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 present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Report Number A-05-03-00086 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

James Rudolph Farris, M.D. – CMS Regional Administrator
Centers for Medicare & Medicaid Services – Region VI
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ARKANSAS BLUE CROSS AND BLUE SHIELD

October 2003
A-05-03-00086

Office of Inspector General

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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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

OBJECTIVE

The audit objective was to determine the extent of ineligible Medicare Skilled Nursing Facilities (SNF) payments contained in our database of payments made under the administrative responsibility of Arkansas Blue Cross and Blue Shield (BCBS).

FINDINGS

We estimate that the Medicare program improperly paid $1.1 million to SNF providers that should be recovered by Arkansas BCBS. Based on a sample of 200 SNF stays, we estimate that 87 percent of the Arkansas BCBS database is not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of SNF admission.

The absence of automated cross-checking, within the Centers for Medicare and Medicaid Services' (CMS) Common Working File (CWF) and Arkansas BCBS 's claims processing systems, allowed ineligible SNF claims to be paid. Because a comparison of the actual dates of the inpatient stay on the hospital claim to the inpatient hospital dates on the SNF claim did not occur, a qualifying three-day hospital stay preceding the SNF admission was not verified. Neither the CWF nor Arkansas BCBS have an automated means to match an inpatient stay to a SNF admission and to generate a prepayment alert that a SNF claim does not qualify for Medicare reimbursement. As a result, unallowable SNF claims amounting to $1.1 million were paid without being detected.

RECOMMENDATIONS

We recommend that Arkansas BCBS:

- Initiate recovery actions estimated to be $1.1 million or support the eligibility of the individual stays included in the database.

- Initiate SNF provider education to emphasize Medicare interpretations which establish an eligible three-day inpatient hospital stay and qualify a SNF admission for Medicare reimbursement.

In a written response to our draft report, Arkansas BCBS contends, based on their separate analysis of two months of inpatient hospital and SNF claims, that only two percent of our database was improperly paid. The intermediary's contention is inappropriate and misleading because their two percent ratio is not a comparable measure to our 87 percent error rate. Arkansas BCBS's analysis disregarded the methodology described in our report, whereby we isolated only those SNF claims with unqualified hospital stays. The intermediary analyzed all SNF claims finalized in their two month period. Consequently, rather than calculating the rate of improperly paid claims due to unqualified hospital stays, Arkansas BCBS calculated the rate that such improper payments will occur among all payments that the intermediary made to SNF providers. A summary of Arkansas BCBS's response and our comments begin on page 5 of the report. The full text of Arkansas BCBS's response is included as Appendix B to this report.

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Glossary of Abbreviations and Acronyms

BCBS	Blue Cross and Blue Shield
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
FI	Fiscal Intermediary
HIC	Health Insurance Claim
INPL	Inpatient Listing
SNF	Skilled Nursing Facility

INTRODUCTION

BACKGROUND

Skilled Nursing Facilities

A SNF is an institution primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care and the rehabilitation for the injured, disabled, and sick. To qualify for Medicare reimbursement, a SNF stay must be preceded by an inpatient hospital stay of at least three consecutive days, not counting the date of discharge, which is within 30 days of the SNF admission.

Regulations

The legislative authority for coverage of SNF claims is contained in Section 1861 of the Social Security Act; governing regulations are found in Title 42 of the Code of Federal Regulations (CFR); and CMS coverage guidelines are found in both the Intermediary and Skilled Nursing Facility Manuals.

Data Analysis of Ineligible SNF Stays Nationwide

In a previous, self-initiated review of SNF compliance with the three-day inpatient hospital stay requirement in the State of Illinois, we identified improper Medicare payments for calendar year 1996 of approximately $1 million (CIN A-05-99-00018). Because of the significance of the improper payments in one state, we expanded our review to calendar years 1997 through 2001 and to SNF stays nationwide. In order to quantify the extent of improper SNF payments nationwide, we created a database of SNF claims that were paid even though CMS's automated systems did not support the existence of a preceding three-day inpatient hospital stay. Using the claim data from the CMS National Claims History Standard Analytical File, we matched SNF and inpatient hospital claims and identified 60,047 potentially ineligible SNF claims with potentially improper reimbursements of $200.8 million.

In developing our nationwide database, all SNF claims, with service dates between January 1, 1997 and December 31, 2001, were extracted from the CMS National Claims History Standard Analytical File. We excluded all SNF claims with a zero dollar payment or identification with a Health Maintenance Organization. We also extracted inpatient hospital claims, with dates of service between January 1, 1996 and December 31, 2001, which were associated with the beneficiary Health Insurance Claim (HIC) numbers on the extracted SNF claims.

We created a file of inpatient hospital stays using the hospital admission and discharge dates for the extracted inpatient claims and created a SNF file by combining all the extracted SNF claims indicating an admission date within 30 days of a previous discharge. The files of inpatient hospital and the SNF stays were then sorted by HIC number and compared to determine whether an inpatient hospital stay actually occurred within 30 days of SNF admission. We extracted all SNF stays with an inpatient stay within 30 days of SNF admission, but less than three days in

length. Based on our previous review in Illinois, we excluded all SNF stays with no inpatient hospital stay prior to admission. These situations likely pertained to the beneficiary having either a Veterans Administration or private-pay qualifying inpatient hospital stay which made the SNF stay eligible for Medicare reimbursement.

By arraying the database by the Fiscal Intermediary (FI) responsible for the SNF payments, we determined that Arkansas BCBS is responsible for 304 potentially ineligible SNF stays, consisting of 485 SNF claims and reimbursed by Medicare in the amount of $1.2 million.

OBJECTIVE, SCOPE AND METHODOLOGY

The audit objective was to determine the extent of ineligible Medicare SNF payments made under the administrative responsibility of Arkansas BCBS.

We performed our audit in accordance with generally accepted government auditing standards. This audit is part of a nationwide review of ineligible SNF payments. Accordingly, this report is part of a series of reports to be issued to the FIs identified in our national database. In addition, a roll-up report will be issued to CMS, combining the results of the FI audits. Our review was limited to testing the extent of ineligible Medicare SNF payments associated with the financial and administrative responsibility of Arkansas BCBS. Our database identified 304 potentially ineligible SNF stays, which included 485 SNF claims reimbursed in the amount of $1.2 million under Arkansas BCBS's responsibility.

Because of the limited scope of our review, we did not review the overall internal control structure of Arkansas BCBS. Our internal control testing was limited to a questionnaire relating to the claim processing system edits in place at Arkansas BCBS for SNF claim payments.

Our fieldwork was performed in the Chicago Regional Office during June 2003.

Methodology. Since our substantial data analysis established a database of SNF claims that were paid even though CMS's National Claim History File did not support the existence of a preceding three-day inpatient hospital stay, our audit testing was limited to determining whether any other sources supported the required inpatient stay. In essence, our validation process consisted of determining whether any eligible SNF stays were inadvertently included in the database. We selected a statistical sample of 200 SNF stays from the Arkansas BCBS database (reimbursed at $813,123) and compared the SNF admission to inpatient information on the CWF system. For each of the 200 SNF stays selected in our sample, we reviewed the Inpatient Listing (INPL) claims screen from the various CWF host sites to identify any inpatient stays omitted from our database which would make the SNF stay eligible for Medicare reimbursement.

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Unrestricted Variable Appraisal Program, we projected the amount of SNF payments eligible for Medicare reimbursement. Since our database was intended to quantify only ineligible Medicare reimbursements, we used the "difference estimator" estimation method to measure the amount of eligible Medicare reimbursements that were inadvertently

included in the database. Using the difference estimator, we adjusted the database of ineligible SNF payments and calculated the upper and lower limits at the 90 percent confidence level. We estimate that the lower limit of the 90th percentile of ineligible SNF payments under Arkansas BCBS's responsibility amounted to $1.1 million during the period January 1, 1997 to December 31, 2001. Details of our sample methodology and estimation are presented in the Appendix.

FINDINGS AND RECOMMENDATIONS

We estimate that the Medicare program improperly paid SNF providers $1.1 million that Arkansas BCBS should recover. Eighty-seven percent of the 304 SNF stays in the Arkansas BCBS database were not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of the SNF admission. In accordance with 42 CFR, section 409.30, a SNF claim generally qualifies for Medicare reimbursement only if the SNF admission was preceded by an inpatient hospital stay of at least three consecutive calendar days, not counting the date of discharge, and was within 30 calendar days after the date of discharge from a hospital. The majority of the potentially ineligible SNF payments within our database did not have the required inpatient stay and should be recovered.

No Automated Matching

We attribute the significant amount of improper Medicare SNF payments to the lack of automated procedures within the CWF and Arkansas BCBS's claims processing systems. SNF claims are not matched against a history file of hospital inpatient claims to verify that a qualifying hospital stay preceded the SNF admission. Consequently, neither the CWF nor Arkansas BCBS have an automated means of assuring that the SNF claims are in compliance with the three consecutive day inpatient hospital stay regulations and eligible for Medicare reimbursement.

Instead of an automated match of inpatient and SNF claims data, SNFs are on an honor system. The automated edits, in place in the CWF and Arkansas BCBS claims processing systems, merely ensure that the dates of a hospital stay have been entered on the SNF claim form. As the SNF claim is processed, edits ensure that the hospital dates on the SNF claim indicate a stay of at least three consecutive days. If the SNF mistakenly enters inaccurate hospital dates reflecting a three consecutive day hospital stay, the edits are unable to detect the errant data that renders the claim ineligible for Medicare reimbursement. Consequently, the ineligible SNF claim is processed for payment.

Relative to the improper SNF payments that we identified in our database, some SNFs may not understand that a particular day in a beneficiary's hospital stay may not be considered an inpatient day under Medicare regulations. We determined that occasionally a beneficiary's hospital stay of three consecutive days will include a day of outpatient services, such as emergency room or observation care preceding the actual inpatient services. When this situation occurs, the Medicare Hospital Manual, section 400D, states that the outpatient services, rendered during the hospital visit, are treated as inpatient services for billing purposes only. The first day of inpatient hospital services is the day that the patient is formally admitted as an inpatient, which is subsequent to the

patient's release from the emergency room or from observational care. A SNF's misunderstanding of these Medicare regulations will result in an incorrect claim of a three consecutive day hospital stay. The hospital's related inpatient claim will appropriately reflect two days of inpatient care. Since SNF claims are not matched against a history file of hospital inpatient claims, the disparity in the hospital days listed on the SNF and the hospital claims are not detected.

Although we have detected a weakness in the claims processing systems that enables a significant dollar amount of ineligible SNF claims to be paid, the processing of the SNF and inpatient claims by different contractors and delayed claims submission practices by Medicare providers may preclude an effective prepayment matching routine for SNF claims. Hospital providers may have their claims processed by FIs different than those processing the related SNF claims, and Medicare providers have up to 27 months, after the date of service, to submit a claim. Under these circumstances, the FI processing the SNF claims would not have the inpatient claim data necessary for an effective and efficient prepayment matching with SNF claims. While the CWF system would have all the inpatient hospital claim data and SNF claim data necessary for a matching procedure, the time allowed by Medicare regulations for providers to submit claims might result in a high incidence of inappropriately suspended SNF claims. Although generally SNFs submit claims more promptly than hospitals, it is not uncommon for a SNF to submit several claims for a prolonged beneficiary stay, before the hospital submits the claim for the qualifying hospital stay. Consequently, it is foreseeable that hospital inpatient claims data would not be available on the automated system for a prepayment matching, at the time a SNF claim is submitted for processing.

Although the cause of the improper SNF payments in the Arkansas BCBS database is not directly attributable to any inappropriate action or inaction by Arkansas BCBS, we believe that our review has identified the need for Arkansas BCBS to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $1.2 million, we estimate that improper Medicare SNF payments under Arkansas BCBS's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $1.1 million. From the Arkansas BCBS database, we confirmed that 174 of the 200 SNF stays sampled were not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of the SNF admission.

We determined that 26 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 26 stays, we found inpatient claims which were listed on the CWF host sites. For some unknown reason, these admissions were not transmitted to the CMS National Claims History File, used to create our database. If these claims had been included in our cross match procedure, the SNF stay would have been eligible and excluded from the database. Based on the results of our sample, we estimate that 87 percent of the 304 SNF

stays and $1.1 million of the payments in the Arkansas BCBS database were not in compliance with Medicare reimbursement regulations.

To assist in the identification and recovery of the unallowable SNF payments, we will make the necessary arrangements for the secure transfer of the database to the designated Arkansas BCBS officials.

RECOMMENDATIONS

We recommend that Arkansas BCBS:

- Initiate recovery actions estimated to be $1.1 million or support the eligibility of the individual stays included in the database.

- Initiate SNF provider education to emphasize Medicare interpretations which establish an eligible three-day inpatient hospital stay and qualify a SNF admission for Medicare reimbursement.

ARKANSAS BCBS'S RESPONSE

Based on Arkansas BCBS's self-initiated comparative analysis of inpatient hospital and SNF claims data, they believe that only two percent of our database was improperly paid. Their test analysis was limited to all inpatient SNF claims finalized by Arkansas BCBS in two months, August 2001 and August 2002, and all the related inpatient hospital claims. The full text of Arkansas BCBS's response is presented in Appendix B.

OAS COMMENTS

The intermediary is misrepresenting the two percent ratio resulting from their analysis by contending that it is an estimate of improperly paid claims due to an unqualified hospital stay. Their two percent calculation is not a comparable measure to our 87 percent error rate because they used a significantly different methodology from what we used in creating our database. The intermediary analyzed all SNF claims finalized in their two month test period rather than limiting their analysis to a universe of potentially unqualified hospital stays, as we did. Consequently, Arkansas BCBS simply calculated a rate of estimated improper payments for all payments that the intermediary has made to SNF providers. The low error rate cited by the intermediary is misleading and has no relationship to the error rate expected to be identified from a review of our universe of potentially unallowable reimbursements.

APPENDICES

APPENDIX A

SAMPLING METHODOLOGY

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Unrestricted Variable Appraisal Program, we projected the amount of SNF payments eligible for Medicare reimbursement. Since our substantial data analysis identified a database of potentially ineligible Medicare reimbursements, we used the "difference estimator" estimation method to measure the effect of the projected amount of eligible payments in the database and, thus, estimate the extent of ineligible Medicare SNF payments contained in our database. We calculated the upper and lower limits of our adjusted estimate of ineligible SNF payments, at the 90 percent confidence level, by subtracting the upper and lower limits of our projected eligible payments from the original database value of $1,226,056.

SAMPLE RESULTS

The results of our review are as follows:

Number of SNF Stays	Sample Size	Value of Sample	Number of SNF Stays Eligible for Payment	Value of SNF Stays Eligible for Payment
304	200	$813,123	26	$71,273

VARIABLE PROJECTION

Point Estimate	$108,335
90% Confidence Interval	
Lower Limit	$83,645
Upper Limit	$133,025

Calculation of estimated ineligible SNF payments at the lower and upper limit of the 90% confidence interval:

Database Value		$1,226,056	Database Value		$1,226,056
Upper limit	(-)	$133,025	Lower limit	(-)	$83,645
Lower Limit As Reported		**$1,093,031**	**Upper Limit**		**$1,142,411**

MEDICARE

Part A Intermediary
Part B Carrier

Dennis Robertson
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August 25, 2003

Mr. Stephen Slamar
DHHS- OIG Office of Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Report Number- A- 05-03-00086

Dear Mr. Slamar:

In response to your letter to Robert Shoptaw, dated July 29th, Arkansas Blue Cross and Blue Shield has reviewed all pertinent information related to the above-mentioned report. It was noted in your Executive Summary that the absence of automated cross-checking with the Centers of Medicare and Medicaid Services (CMS) Common Working File (CWF) and Arkansas BCBS's claim processing system, allowed ineligible SNF claims to be paid.

We would like to point out that these types of audit results should not be a reflection on the performance of Arkansas Blue Cross and Blue Shield, but rather an indication of the possible lack of certain audit features in the CWF (Common Working File) system and/or the Medicare Part A Standard System.

In response to your letter of July 29th, 2003, our Medical Statistical Analyst pulled the pertinent data on inpatient SNF claims finalized in August 2001 and August 2002 and compared the sample of those claims to the inpatient hospital claims for those beneficiaries in the HIMR file. In the sample that was reviewed, it was noted that Arkansas Blue Cross and Blue Shield incorrectly paid 2% of the claims, rather than 87% of the claims, as identified by the Office of Inspector General Report.

Upon issuance of the final report, Arkansas Blue Cross and Blue Shield will have the details as to which providers you believe have been overpaid. Our claims area and provider audit area will then be able to compare that information to our data to determine the exact amount of the overpayments.

We look forward to working with you and your staff to review and address any overpayment issues related to this review.

Please feel free to contact Theresa Milligan, Director, Medicare Administrative Services, at 501-378-2078 if you have any additional questions.

Sincerely,

//s//

/tb

cc: Regina Favors
Barbara McDanel
Theresa Milligan
Amanda Crosby
Forrest Wolfe

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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David Markulin, *Senior Auditor*

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.