Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING HOME ENFORCEMENT: PROCESSING DENIALS OF MEDICARE PAYMENT

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) and its fiscal intermediaries (FI) appropriately process denials of Medicare payment remedies for skilled nursing facilities that have been found noncompliant with Federal program participation standards.

BACKGROUND

Denial of payment is an enforcement remedy that CMS may use to address noncompliance with Federal quality of care standards in skilled nursing facilities. CMS is responsible for imposing denial of payment remedies but relies on its FIs to actually identify and reject the relevant Medicare claims. Once CMS instructs an FI to put a remedy into effect, the FI creates an edit, also known as a Medicare Medical Policy Parameter, to identify and suspend claims meeting certain parameters. Those claims are reviewed and then paid, rejected, or returned to the facility as appropriate.

We reviewed information and supporting documentation from CMS and FIs for a random sample of cases in which CMS imposed denials of payment for new admissions (DPNA) remedies during fiscal year (FY) 2004. Based on this analysis and follow-up conversations with CMS and FI staff, we identified cases in which denials of payment were processed incorrectly by FIs and the resulting overpayments.

FINDINGS

During FY 2004, 74 percent of denial of payment remedies were processed incorrectly, resulting in overpayments exceeding $5 million. In 40 percent of cases, errors resulted in one or more inappropriate payments to skilled nursing facilities. These overpayments exceeded $5 million. In the other 34 percent of cases, processing errors occurred but did not result in claims paid in error, either because the facilities did not have new admissions during the remedy periods or because the facilities were aware of the remedies and did not submit claims for new admissions during the remedy periods. Errors were attributable primarily to late processing and problems with CMS's provision of denial of payment instructions to the appropriate FI.

Approximately half of claims involving readmissions lacked codes indicating the readmission status, which made these claims appear to be new admissions that should be denied. Although readmission claims are suitable for reimbursement during a DPNA remedy, the absence of appropriate codes causes these claims to appear to be new admissions that should be denied. This creates additional work for the FIs and limits CMS's ability to verify that claims for new admissions are appropriately denied under a DPNA remedy.

RECOMMENDATIONS

We recognize that recent changes have the potential to improve processing of DPNAs. First, as part of Medicare contracting reform, work currently conducted by FIs is gradually being assumed by Medicare Administrative Contractors (MAC) and providers will be required to submit claims to a designated MAC. Providers will no longer be permitted to routinely change contractors, which may make it less likely that CMS will send instructions about DPNAs to the wrong MACs. Second, new features of the Automated Service Processing Environment Enforcement Management system may better enable CMS to provide timely notice of DPNAs to the contractors.

Although these changes may result in improved processing of DPNAs, they may not fully address all of the types of errors identified in this report. Therefore, we recommend that CMS:

Manage DPNA cases to ensure that all DPNA instructions are sent timely and ensure that FIs and MACs retrospectively review cases that are processed late to correct any payment errors.

Address communication breakdowns by implementing a standard format to notify FIs or MACs that a DPNA remedy will be in effect and require confirmation that instructions are received and understood.

Update guidance on coding readmissions and verifying readmission status for DPNA claims.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with our recommendations and outlined specific actions that it will take to address each recommendation. These actions include developing new internal procedures to help ensure that CMS effectively

communicates DPNA instructions to FIs and MACs, creating a protocol between CMS and contractors to ensure follow-up notification to CMS that a DPNA was implemented as requested, and updating manual instructions to clarify coding and verification requirements for DPNA readmissions. CMS's response is included in its entirety as Appendix B.

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INTRODUCTION

OBJECTIVE

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) and its fiscal intermediaries (FI) appropriately process denials of Medicare payment remedies for skilled nursing facilities that have been found noncompliant with Federal program participation standards.

BACKGROUND

The Social Security Act (the Act), as amended by the Omnibus Budget Reconciliation Act of 1987, established a survey and certification process to ensure that nursing homes meet Federal standards for participation in the Medicare and Medicaid programs.[1] [2] The Secretary of the Department of Health and Human Services is responsible for ensuring that these requirements and their enforcement "are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys."[3] To accomplish this, CMS contracts with State agencies to conduct surveys assessing nursing facilities' compliance with the requirements. If, during a survey, the State agency finds that a nursing home is not in substantial compliance with Federal requirements, CMS may initiate a variety of enforcement actions. Collectively, these actions are known as remedies, the purpose of which is "to ensure prompt compliance with program requirements."[4]

Denial of Payment Remedies

CMS has two denial of payment remedies for nursing home enforcement. The more severe remedy is to deny payment for services provided to all Medicare and Medicaid beneficiaries, including those who are already receiving care in the nursing home. This remedy would likely cause existing nursing home residents to be relocated. As such, this remedy is rarely used and CMS's internal guidance documents emphasize that "it is a severe sanction" and should be considered for use only when other remedies have failed to achieve compliance.[5] The less

[1] Social Security Act, sections 1819(f)(1) and 1919(f)(1).

[2] Omnibus Budget Reconciliation Act, P.L. No.100-203 § 4202 (1987).

[3] Social Security Act, sections 1819(f)(1) and 1919(f)(1).

[4] 42 CFR § 488.402 (2004) and 59 FR 56116 (November 10, 1994).

[5] Centers for Medicare and Medicaid Services (CMS), "State Operations Manual," § 7508.

severe remedy is to deny payment only for services provided to beneficiaries who are newly admitted to the nursing home.[6]

CMS has discretion to impose either type of denial of payment remedy in enforcement cases, but is required to impose at least a denial of payment for new admissions (DPNA) under two circumstances: (1) extended noncompliance, i.e., when facilities remain out of compliance with Federal standards longer than 3 months; and (2) repeated instances of substandard quality of care, i.e., three consecutive surveys with findings of substandard quality of care.[7] [8] In effect, this remedy is used for a wide variety of noncompliance offenses. For example, DPNAs may similarly be used for facilities that are cited with a string of unrelated, low-level deficiencies that create a potential for harm to beneficiaries as well as for the most severe instances of immediate jeopardy, which pose serious injury, harm, impairment, or death to beneficiaries.

Processing Denial of Payment Remedies

CMS is responsible for imposing denial of payment remedies, but relies on FIs to identify and deny the relevant Medicare claims. CMS regional offices initiate the process by providing written instructions to the appropriate FI.[9] In order for the FI to process the remedy before claims are received, CMS must provide initiating instructions to the FI prior to the designated effective date of the remedy. CMS must also provide instructions to end the remedy once the facility has achieved compliance. A similar process is used to notify State agencies of the need to deny the relevant Medicaid claims; however, that process is outside the scope of this study.

FIs process a remedy by creating a Medicare Medical Policy Parameter, also known as an edit. The edit is part of an electronic screening system that will suspend claims that meet certain parameters. When a denial of payment is put into effect, an edit is created to identify claims for particular providers that are subject to a denial of payment remedy. The edit can be designed to flag only claims with admission dates

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[6] 42 CFR § 488.406(a)(2) (2004).

[7] Social Security Act, sections 1819(h)(2)(D) and (E).

[8] 42 CFR §§ 483.13, 483.15, and 483.25 (2004). Substandard quality of care is defined as any deficiency that constitutes immediate jeopardy to a resident's health or safety; a pattern of widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

[9] CMS, "State Operations Manual," § 7506(D).

during the remedy period. As claims are submitted by skilled nursing facilities, this screening mechanism will suspend claims pending further review by FI staff. Staff verify whether each claim is subject to the denial of payment remedy and pay, reject, or return the claim to the facility as appropriate. If a claim is not suspended by an edit, the claim will be processed through an automated system without further review by FI staff.

New Admissions

In its 2001 Program Memorandum, "Fiscal Intermediary (FI) Instructions on Applying Payment Bans on Skilled Nursing Facility (SNF) Admissions," CMS provided detailed instructions to FIs for processing denial of payment remedies, including specific criteria to use in determining which residents fall under the definition of a new admission.[10] This guidance has also been incorporated into the "Medicare Claims Processing Manual" and the "Medicare Benefit Policy Manual." [11] [12] For the purpose of denial of payment remedies, a new admission is "a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date."[13] This definition provides several important distinctions about which residents are subject to the remedy. For example, claims for residents on temporary leave or returning to a facility after treatment at an inpatient hospital are not subject to the remedy. This type of admission is termed a readmission. Additionally, some patients residing in a facility may newly qualify for Medicare or for a new Medicare benefit period during the DPNA remedy period. Because such residents already reside in the facility, they are also classified as readmissions and are exempt from the DPNA restrictions. However, without proper coding on the claim, FI staff may be unable to distinguish between a new admission and a readmission.

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[10] CMS, Program Memorandum, Intermediaries/Carriers, "Fiscal Intermediary (FI) Instructions on Applying Payment Bans on Skilled Nursing Facility (SNF) Admissions," Transmittal AB-01-131, September 21, 2001.

[11] CMS, "Medicare Claims Processing Manual," Chapter 6, § 50 (Rev. 1151, January 11, 2007).

[12] CMS, "Medicare Benefit Policy Manual," Chapter 8, § 20.3 (Rev. 58, November 9, 2006).

[13] 42 CFR § 488.401.

METHODOLOGY

Scope

This report focuses on the processing of DPNAs by CMS and its FIs. Although the DPNA remedy spans both the Medicare and Medicaid programs, we did not evaluate the performance of State agencies in denying Medicaid claims subject to the remedy. In 2004, the Office of Inspector General (OIG) released audits of seven State agencies' performance in processing denials of payment during fiscal year (FY) 2001.[14] Additionally, this report focuses specifically on the DPNA remedy and does not address the denial of payment remedy for all Medicare and Medicaid beneficiaries.[15]

Sample Selection

To assess the performance of CMS and its fiscal intermediaries, we randomly selected 200 denial of payment cases for review. Cases were chosen from a population of 726 skilled nursing facilities identified as having denials of payment that went into effect during FY 2004, i.e., October 2003 through September 2004, the most current data available at the time we began the review.[16] Of the 200 cases selected, 8 were determined to be ineligible for review. Specifically, three denials of payment were imposed against Medicaid-only facilities and five denials of payment did not go into effect.[17] These ineligible cases reduced our sample size to 192 cases and our projected number of denials of payment from 726 to 697.

Data Collection and Analysis

For each sampled case, we requested information and supporting documentation from both the CMS regional office and the FI responsible for the case. From CMS we requested copies of the instructions sent to the FI, directing it to process the DPNA. From the FI we requested

[14] See, for example, OIG, "Nursing Homes and Denial of Payment Remedies in the State of Florida," A-04-03-06007 (February 2004). Other States reviewed include Illinois, Indiana, Massachusetts, Michigan, Ohio, and Pennsylvania.

[15] Only one denial of payment for all Medicare and Medicaid beneficiaries remedy was identified in our sampling frame.

[16] Some facilities were represented more than once in the sampling frame because multiple denials of payment went into effect during the specified timeframe.

[17] In the five sample cases for which denials of payment did not go into effect, documentation was inadequate to determine prior to sample selection that either: (1) the cases were not in effect, or (2) a settlement agreement revised the compliance and/or effective dates, which effectively nullified the remedy.

documentation that the denial of payment was processed and information about the associated dollar amounts. We reviewed documentation for each case to determine whether the DPNA was processed correctly and to identify causes of errors. In addition, we independently identified claims in the National Claims History that appeared to have been paid in error—i.e., claims that appeared to have been paid for new admissions while the DPNA was in effect. All identified errors were verified by the appropriate FI and recoupment actions were requested when appropriate.

Our discussion of procedural breakdowns is the result of our original documentation requests, responses to the error verification, and follow-up conversations with both CMS and FI staff.

Confidence intervals for key statistics are presented in the appendix and use a 95-percent level of confidence. They were calculated using standard statistical formulas, including an adjustment, i.e., finite population correction factor, to account for the fact that our original sample of 200 cases was a significant proportion of the population.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

During FY 2004, 74 percent of denial of payment remedies were processed incorrectly, resulting in overpayments exceeding $5 million

We estimate that of 697 DPNAs that were in effect during FY 2004, 74 percent (516 cases) had processing and/or payment errors (see Table 1). In 40 percent of DPNA cases, errors resulted in one or more inappropriate payments to skilled nursing facilities. This means that noncompliant skilled nursing facilities admitted new Medicare beneficiaries and received payment. For this group, we estimate that 3,133 Medicare claims were paid to 276 facilities for services rendered during DPNAs. Resulting overpayments total more than $5 million for the 1-year period. In 34 percent of cases, processing errors occurred but did not result in claims paid in error, either because the facilities did not have new Medicare admissions during the remedy periods or because the facilities admitted new beneficiaries but did not submit claims for them during the remedy periods.

Table 1: CMS and FI Processing of Medicare DPNA Cases in FY 2004

	Estimated Number of Cases	Estimated Percentage of Cases	Estimated Paid in Error
Processed Correctly	182	26%	N/A
Processed Incorrectly	516	74%	$5,042,181
Resulting in Payment Errors	276	40%	$5,042,181
Processing Errors Only	240	34%	N/A
Total	697	100%	$5,042,181

Source: Office of Inspector General analysis of 192 DPNA cases. Estimated number of cases does not total 697 because of rounding. Confidence intervals are displayed in the appendix.

Errors were attributable primarily to late processing and problems with the provision of instructions

Processing a DPNA requires that the FI receive appropriate instructions from CMS and create the necessary screening system, or edit, to suspend claims for additional review. Until the edit is created, the FI will have no mechanism to identify claims subject to DPNA remedies. Late processing of the edit was the single largest cause of processing errors, accounting for almost half of the errors identified (see Table 2 on the next page). The other leading causes of error involved communication breakdowns between CMS and the FIs and CMS sending the processing instructions to the wrong FIs. Less common

sources of error included inappropriate deletion of the edits and human error.

Table 2: Types of Errors Identified in DPNA Cases in FY 2004

	Estimated Number of Error Cases	Estimated Percentage of Error Cases
Late Processing	254	49%
Communication Breakdown	87	17%
Sent to Wrong FI	73	14%
Deleted Edit	62	12%
Human or Other Error	40	8%
Total	516	100%

Source: Office of Inspector General analysis of 192 DPNA cases. Confidence intervals are displayed in the appendix.

Late processing of the DPNA. Forty-nine percent of errors resulted from edits that were put into place after the beginning of the remedy periods. If the edit is not in place when the remedy begins, there is a window of time during which claims that should be denied may be processed and incorrectly paid. Cases involving late processing of the DPNA included both circumstances in which CMS did not provide the FI with instructions until after the start date of the DPNA remedy, and circumstances in which we were able to document that the FI had indeed received instructions timely.

When a DPNA remedy is processed late, the FI is required to recover payments for claims erroneously paid.[18] To accomplish this, FIs should retrospectively review claims to identify those inappropriately paid prior to the creation of the edit and make necessary adjustments. However, staff in several FIs told us that they do not consistently (and in some cases, never) review previously paid claims when a DPNA remedy is put into effect late.

Communication breakdowns between CMS and FIs. In 17 percent of error cases, the FIs reported that they never received instructions to initiate DPNA remedies. In these cases, it was often difficult to determine

[18]CMS, "Medicare Claims Processing Manual," Chapter 6, § 50.6 (Rev. 1151, January 11, 2007).

whether the instructions were misdirected, never sent by CMS, or mishandled by the FIs. Of the 24 sample cases in this group, we were able to document that CMS failed to send instructions for 7 DPNA remedies. For the remaining 17 cases, we were unable to identify the breakdown. In 16 of these 17 cases, CMS provided us some, although frequently very limited, documentation that instructions were sent to the FI, but the FI reported that instructions were never received. In the other case, the FI reported that a breakdown occurred internally. Documentation provided by CMS was often limited to a copy of the imposition letter addressed to the facility administrator with a "cc" notation to indicate that a copy was sent to the FI. In these cases, it is difficult to ascertain whether instructions were actually sent and to whom they were sent. However, our review demonstrates that a "cc" copy of the imposition letter without specific instructions to the FI is not always sufficient to alert the FI that it needs to process an edit.

Instructions sent to the wrong FI. Instructions for approximately 14 percent of error cases were sent to the wrong FIs. This was evidenced by CMS's responses to our case-specific questions and copies of the instructions actually provided to the FIs.

At the time of our data collection, nursing facilities were able to choose from two or more FIs to process their claims and could change their selection periodically.[19] [20] CMS had to keep FI information current for each nursing facility to ensure that DPNA instructions were directed to the proper FI. According to CMS staff, CMS used two different databases to identify which FI a facility had chosen. These two sources were not always updated at the same time, so the FI information was not always consistent or correct.

When a second quality check was skipped by the FI, payments were made in error. Although it is not currently a requirement, some FIs reported that they routinely check to verify that they have responsibility for the nursing facility indicated in the instructions and notify CMS and/or the appropriate FI when they discover an error. In

[19] 42 CFR 421.104(a) (2004) allowed providers to nominate an organization or agency to serve as their FI. All nursing home providers had the option to select their regional FI, the regional FI that served a corporate headquarters, or an FI that served providers across the Nation.

[20] The nursing home's right to nominate its FI was repealed by section 911(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 911(b). See also 71 FR 68183 (November 24, 2006).

the 14 percent of cases identified by our review, the FIs either did not recognize CMS's error and incorrectly entered edits into their own systems (in effect creating null edits), or the FIs realized that the information was misdirected but did not notify CMS staff.

Deleted edits. In 12 percent of error cases, FI staff misinterpreted CMS's instruction to end the remedies as an instruction to rescind the remedies. Consequently, the FIs repaid monies that had been appropriately withheld from the facility. We reviewed the language in CMS's instructions to the FIs and found that the wording that most frequently caused confusion was "we are now canceling the remedy." Although the letter containing this phrase went on to state the dates that the DPNA was in effect, the FIs that made this mistake apparently identified the operative word as "cancel." Two FIs made this mistake frequently, with related errors in over half of the sample cases we reviewed for those FIs. However, one of them reported that it corrected its procedures prior to our data request. Other FIs also made this mistake, but did so only in isolated cases.

Other causes. Other problems, including human error, accounted for 8 percent of errors. In these cases, edits were in place timely but still resulted in claims paid in error. The most frequently identified issue was a manual bypass of the edit. In these cases, the edits properly suspended the claims, but claims-processing personnel manually processed the claims as payable. Although there are legitimate reasons for a manual bypass, the FIs in these cases provided no rationale supporting payment of these claims. Some of these claims were paid after multiple submissions by a facility had been denied or rejected. These errors may have resulted because a claims processor was improperly trained or because the resubmission occurred after the edit's effective period had lapsed. Additionally, processing errors occurred when data elements, such as dates or facility identifiers, were incorrectly entered into the edit. These data entry errors can make the edit ineffective at identifying claims subject to the DPNA remedy.

Another problem we identified related to a system known as SuperOp.[21] Some claims that were processed through SuperOp bypassed the edit, causing the DPNA status for the nursing facility to be overlooked.

Approximately half of claims involving readmissions lacked codes indicating the readmission status, which made these claims appear to be new admissions that should be denied

We estimate that during our sample year, 1,898 claims were processed and paid for residents exempted from the DPNA remedy because they were identified as readmissions. Of these, less than half (46 percent) were properly coded.[22] According to CMS's program memorandum, "Fiscal Intermediary (FI) Instructions on Applying Payment Bans on Skilled Nursing Facility (SNF) Admissions," claims for readmissions should be identified by including specific codes.[23] Although readmission claims are suitable for reimbursement during a DPNA remedy, the absence of these codes causes these claims to appear as if they are new admissions that should be denied. This creates additional work for the FIs that will initially reject or deny the claims and must reprocess the claims once additional information is supplied by the facilities. Additionally, this problem limits CMS's ability to verify that claims for new admissions are appropriately denied under a DPNA remedy.

FIs reported different processes for verifying the prior stay and ensuring that the claim qualifies for readmission status. Several told us that they have no verification processes at all and rely on statements by the facilities. Others described ad hoc processes utilizing whatever information is at hand. For example, one FI reported that it looks for a prior admission and, if there is a discharge code, rejects the claim. This procedure would help identify individuals who were previous residents at the nursing home but do not qualify as readmissions because the

[21] SuperOp is an automated program used by all FIs to identify and resolve claims meeting certain predefined criteria. Processing logic within SuperOp allows identified claims to be automatically modified without claims-processing personnel reviewing the claims.

[22] The percentage of readmissions properly coded is projected to be 46 percent, with a confidence interval of 34 to 59 percent.

[23] Readmission claims are distinguished by the inclusion of condition code 57 and occurrence span code 78. CMS, Program Memorandum, Intermediaries/Carriers, "Fiscal Intermediary (FI) Instructions on Applying Payment Bans on Skilled Nursing Facility (SNF) Admissions," Transmittal AB-01-131, September 21, 2001.

admissions represented new and unrelated spells of illness. However, this practice would not identify first-time admissions that were incorrectly coded as readmissions.

RECOMMENDATIONS

Our evaluation revealed that DPNAs were frequently mishandled in FY 2004, with processing errors in almost three-quarters of remedy cases. Although not all errors resulted in inappropriate payments to facilities, we estimate that in FY 2004 approximately $5 million in overpayments were made that should have been denied as a result of DPNAs. These errors and overpayments limit the effectiveness of the DPNA remedy, which is one of the strongest enforcement tools available to CMS for managing nursing facility compliance with Federal standards.

We recognize that recent changes related to Medicare contracting reform and enhancements to CMS's electronic tracking system for nursing home enforcement cases, known as the Automated Service Processing Environment (ASPEN) Enforcement Management system, have the potential to improve processing of DPNAs. First, as part of Medicare contracting reform pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, work currently conducted by FIs is gradually being assumed by Medicare Administrative Contractors (MAC). As these new contractors begin to administer claims within a geographic area, providers will be required to submit claims to a designated MAC and will not be permitted to routinely change contractors.[24] This reform may make it less likely that CMS will send instructions about DPNAs to the wrong MACs. Second, in its comments regarding two recent OIG reports, CMS reported that new features of the ASPEN Enforcement Management system enable the system to provide CMS regional offices with early notification of impending DPNAs.[25] If these features are utilized appropriately, this enhancement may better enable CMS to provide timely notice of DPNAs to FIs or MACs.

Although these changes may result in improved processing of DPNAs, they may not fully address all of the types of errors identified in this report. Therefore, we recommend that CMS:

Manage DPNA Cases To Ensure That All DPNA Instructions Are Sent Timely and That FIs and MACs Retrospectively Review Cases That Are Processed Late To Correct Any Payment Errors

Late processing of DPNAs accounted for nearly half of the error cases

[24] 71 FR 68228, 68229 (November 24, 2006).

[25] OIG, "State Referral of Nursing Home Enforcement Cases," OEI-06-03-00400; and "Nursing Home Enforcement: Application of Mandatory Remedies," OEI-06-03-00410.

we identified, and FIs self-reported that they do not consistently attempt to retrospectively recoup payments that should have been denied. Recently added features of the ASPEN Enforcement Management system have improved CMS's ability to monitor upcoming DPNA dates (for 3-month DPNAs). CMS should utilize the ASPEN Enforcement Management System to monitor these cases and ensure that instructions are sent well in advance of those dates. Additionally, reviewing any payments made prior to edit creation will enable FIs and MACs to identify and recoup inappropriate payments.

Address Communication Breakdowns by Implementing a Standard Format To Notify FIs or MACs That a DPNA Remedy Will Be in Effect and Require Confirmation That Instructions Are Received and Understood

Communication breakdowns and instructions sent to the wrong FIs accounted for 31 percent of errors. Standard formats will help ensure that instructions are recognized as such. Further, including standardized language that is clear and comprehensible will help prevent confusion, which caused inappropriate deletion of edits in 12 percent of errors. Additionally, a common procedure for confirming receipt of instructions will help ensure that instructions are received and understood by FIs and MACs. For instances in which the FI or MAC does not confirm receipt, CMS should follow up to ensure that the appropriate staff received the instruction.

Update and Clarify Guidance on Coding Readmissions and Verifying Readmission Status for DPNA Claims

Approximately half of claims involving readmissions lacked proper codes and FIs reported varied practices for handling readmission claims. Although this problem does not result in overpayments, it does create unnecessary work for the FIs and inhibits CMS's ability to monitor FI performance in implementing DPNAs. The guidance should include information on how to handle readmission claims that lack the proper codes and how to verify whether claims qualify as readmissions.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with our recommendations and outlined specific actions that it will take to address each recommendation. These actions include developing new internal procedures to help ensure that CMS effectively communicates DPNA instructions to FIs and MACs, creating a protocol

between CMS and contractors to ensure follow-up notification to CMS that a DPNA was implemented as requested, and updating manual instructions to clarify coding and verification requirements for DPNA readmissions. As noted in CMS's comments, FI activities are transitioning to MACs. Consequently, this transition provides an important opportunity for CMS to clarify the MAC's role in processing DPNAs. CMS's response is included in its entirety as Appendix B.

APPENDIX A

Estimates and 95-Percent Confidence Intervals			
Overview	**Estimate**	**Lower Bound**	**Upper Bound**
Processed Correctly	182	144	219
Processing Errors Only	240	199	280
Payment Errors	276	234	318
Total	697	680	714
Types of Error	**Percentage of Cases**	**Lower Bound**	**Upper Bound**
Late Processing	49%	42%	56%
Communication Breakdown	17%	12%	22%
Sent to Wrong FI	14%	9%	19%
Deleted Edit	12%	7%	17%
Human or Other Error	8%	4%	12%
Total Errors	74%	69%	79%
Impact of Errors	**Estimate**	**Lower Bound**	**Upper Bound**
Total Cases in Error	516	476	554
Total Claims in Error	3,133	2,238	4,027
Dollars Paid in Error	$5,042,181	$3,421,805	$6,662,556
Readmissions	**Percentage of Readmission Claims**	**Lower Bound**	**Upper Bound**
Improperly Coded Readmissions	54%	41%	66%
Properly Coded Readmissions	46%	34%	59%

Source: Office of Inspector General analysis of 192 denial of payment for new admission remedy cases.

APPENDIX B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 1 1 2008

FROM: Kerry Weems
Acting Administrator

TO: Daniel R. Levinson
Inspector General

SUBJECT: Office Of Inspector General (OIG) Draft Report: "Nursing Home Enforcement: Processing Denials of Medicare Payment" (OEI-06-03-00390)

Thank you for the opportunity to review and comment on this draft report, "Nursing Home Enforcement: Processing Denials of Medicare Payment". The Centers for Medicare & Medicaid Services (CMS) appreciates the effort OIG has invested in this report. The report examined the processing of a random sample of 'Denials of Payment cases' from initiation, throughout the fiscal intermediary/Medicare Administrative Contractor (FI/MAC) claim processing and recoupment of overpayment efforts.

CMS published the final rule in November 1994 to implement sections 1819(h) and 1919(h) of the Social Security Act. The rule provided an array of enforcement remedies, in addition to or in lieu of termination, to encourage nursing homes to achieve and maintain substantial compliance. Denial of Payment for New Admissions (DPNAs) is one example of an enforcement remedy or intermediate sanction that may be imposed on nursing homes for failure to comply with Conditions of Participation.

CMS must impose mandatory DPNA for substantial noncompliance that is not corrected by the nursing home at the end of the third month of an enforcement action. An enforcement action begins when substantial noncompliance is identified during a survey, either a standard or complaint survey. If the provider fails to demonstrate correction and substantial compliance with all regulatory requirements within 3 months of the original survey, mandatory DPNA is imposed. In addition, CMS may impose discretionary DPNA anytime prior to the third month for substantial noncompliance with either a 2-day or 15-day notice to the provider.

Although DPNA sanctions are not among the top three most frequently used enforcement remedies (CY 2007), they are one of the most effective enforcement remedies implemented by CMS when a nursing home is found to be in substantial noncompliance. CMS is committed to ensuring that DPNAs are effectuated timely and correctly, throughout each critical juncture of activity.

Medicare FIs and MACs effectuate denials of Medicare payment, upon imposition by CMS. The fiscal agent function performed by these entities is in transition at this time, with the implementation of the contracting reform authorities found in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Completion of the acquisition and implementation of the new contract entities is under way, and developing and clarifying operating processes for communicating DPNAs to both FIs and MACs is a critical component of the Agency's actions in response to this report.

OIG Recommendation

Manage DPNA cases to ensure that all DPNA instructions are sent timely and that FIs and MACs retrospectively review cases that are processed late to correct any payment errors.

> Late processing of DPNAs accounted for nearly half of the error cases we identified, and the FIs self-reported that they do not consistently attempt to retrospectively recoup payments that should have been denied.

CMS Response

CMS agrees that the management of DPNAs can be improved throughout the continuum of critical junctures. To do so, CMS will develop new internal procedures to ensure that the correct FI or MAC receives all communication on a more timely basis. CMS Regional Office (RO) staff will strive to be informed timely of new FI or MAC contact information, as reported by CMS Central Office. CMS will also examine a variety of administrative tools that may increase efficiencies in management of DPNAs. CMS RO Divisions will share any such administrative tools on DPNAs with the Division of Medicaid and Children's Health Operations, the Division of Financial Management, and the Center for Medicare Management's Medicare Contractor Management Group, which has direct oversight responsibility of the FIs and MACs, and their operations (such as the timely processing of DPNAs).

OIG Recommendation

Address communication breakdowns by implementing a standard format to notify FIs or MACs that a DPNA remedy will be in effect and require confirmation that instructions are received and understood.

> Communication breakdown and instructions sent to the wrong FIs accounted for 31 percent of the errors. Standard formats will help ensure that instructions are recognized as such. Further, including standardized language that is clear and comprehensible will help prevent confusion, which caused inappropriate deletion of edits in 12 percent of errors. Additionally, a common procedure for confirming receipt of instructions will help ensure that instructions are received and understood by FIs and MACs. For instances in which the FI or MAC does not

confirm receipt, CMS should follow up to ensure that the appropriate staff received the instruction.

CMS Response

In many of CMS' enforcement cases, the facility has achieved compliance before the effective date of the DPNA, yet the revisit has not been conducted to confirm compliance. Currently, CMS staff notifies the Medicare FI or MAC of enforcement remedies via the Internet. CMS will develop a communication protocol between CMS and Medicare contractors to ensure follow-up notification to CMS that DPNA was implemented as requested.

In addition, CMS ROs will develop standard language for inclusion in DPNA notices to the FI or MAC, and general program instructions related to DPNA administration will be incorporated into the CMS Internet-Only Manuals. A CMS Administrative Memorandum will be sent to all the ROs, requiring that they implement the revised language in all applicable notices to the FI.

The CMS will work to develop any needed conference calls and/or training sessions to address mutual roles and responsibilities across the continuum of CMS contractors. Increased communication and collaboration with the FI or MAC will ensure the DPNA remedy is imposed timely. CMS is committed to fostering improved communication and implementation of DPNA.

It has been difficult for CMS ROs to maintain a current and accurate listing of the Medicare claims processing contractors and an updated listing of chain providers. As the OIG report indicates, there are times when the CMS ROs may send a notice to the wrong FI or MAC, but are not notified of the error; and therefore, it is not corrected. Improved communication with FIs and MACs, as well as confirmation of the CMS notice, should eliminate or reduce errors. CMS will develop new internal procedures for issuing enforcement communications to its contractors that includes an acknowledgement of receipt by the receiving contractor.

OIG Recommendation

Update Guidance on Coding Readmissions and Verifying Readmission Status for DPNA Claims.

Approximately half of claims involving readmissions lacked proper codes and FIs reported varied practices for handling readmission claims. Although this problem does not result in overpayments, it does create unnecessary work for the FIs and inhabits CMS's ability to monitor FI performance in implementing DPNAs. The guidance should include information on how to handle readmission claims that lack the proper codes and how to verify whether claims qualify as readmissions.

CMS Response

The CMS will review the current manual instructions provided to the Medicare contractor/provider community and update the manual instructions to clarify the coding and verification requirements for DPNA readmissions.

The CMS thanks you for the opportunity to review and comment on this draft report.

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