DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

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

February 24, 2011

Report Number: A-01-10-00518

Ms. Jared A. Adair
Senior Vice President, Medicare Division
Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway P.O. Box 8190
Madison, WI 53708

Dear Ms. Adair:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Jurisdiction 5 Payments for Inpatient Rehabilitation Facility Claims Billed With Patient Status Code 05 for Calendar Year 2007.* 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-10-00518 in all correspondence.

Sincerely,

/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 & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF JURISDICTION 5 PAYMENTS FOR INPATIENT REHABILITATION FACILITY CLAIMS BILLED WITH PATIENT STATUS CODE 05 FOR CALENDAR YEAR 2007

Daniel R. Levinson
Inspector General

February 2011
A-01-10-00518

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

Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities (IRF). The system provides for a predetermined, per-discharge payment. IRFs use information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource use. Medicare makes a full case-mix-group payment to an IRF that discharges a beneficiary to home or to another institution that is not covered by Medicare's transfer regulations. For a transfer case, however, Medicare pays a lesser amount, based on a per diem rate and the number of days that the beneficiary spent in the IRF, pursuant to 42 CFR §412.624(f). Federal regulations define a transfer case as one in which:

- the beneficiary's IRF stay is shorter than the average stay for the non-transfer cases in the case-mix group and

- the beneficiary is transferred to another IRF, a long-term-care hospital, an acute-care inpatient hospital, or a nursing home that accepts Medicare or Medicaid payments.

IRFs use patient status codes to designate that a transfer is subject to the transfer regulation. Patient status codes also indicate the type of institution, e.g., inpatient hospital or skilled nursing facility, to which a beneficiary is transferred. Medicare makes per-diem transfer payments for claims submitted with these codes. IRFs use patient status code 05 to indicate that the beneficiary was "discharged/transferred to another type of institution not defined elsewhere." Medicare makes a full case-mix-group payment for claims submitted with this code.

During our audit period, calendar year (CY) 2007, CMS awarded Wisconsin Physicians Service (WPS) the Part A and Part B Medicare Administrative Contractor (MAC) contract for Jurisdiction 5, which included responsibility for states formerly held under contract with Blue Cross and Blue Shield (BCBS) of Kansas and BCBS of Nebraska. Additionally, WPS assumed the Part A workload formerly processed by Mutual of Omaha.

Our review covered 53 Medicare Part A claims totaling $1,061,827 that were submitted by 27 IRFs during CY 2007.

OBJECTIVE

Our objective was to determine whether IRFs correctly coded claims paid by WPS, Mutual of Omaha, BCBS of Kansas, and BCBS of Nebraska.

SUMMARY OF FINDING

IRFs incorrectly coded 24 of the 53 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes on these claims, WPS, Mutual of Omaha, BCBS of Kansas, and BCBS of Nebraska made $245,090 in overpayments for miscoded transfers to 11 IRFs in CY 2007.

The overpayments occurred because IRFs did not have adequate controls to ensure the correct use of patient status 05. In addition, Medicare payment controls in the Common Working File were not adequate to prevent or detect these overpayments until CMS established the necessary edit in April 2007.

RECOMMENDATIONS

We recommend that WPS:

- recover the $245,090 in outstanding overpayments for 24 claims and

- alert IRFs to the importance of reporting the correct patient status code on their claims.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In comments to our draft report, WPS concurred with our recommendations and described the corrective actions it has taken or plans to take. WPS stated that it had adjusted 22 of 24 OIG identified claims with overpayments, to date, and recovered $239,904. The two remaining claims are now the responsibility of TrailBlazer Health Enterprises, LLC. WPS also stated that it has forwarded these two claims through CMS's Kansas City Regional Office for recovery. WPS'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 hospital-level care to patients that need a relatively intense rehabilitation program. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, implemented the prospective payment system for cost-reporting periods beginning on or after January 1, 2002. The system provides for a predetermined, per-discharge payment. IRFs use information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource use.

Transfer Payments

Under the IRF prospective payment system, Medicare makes a full case-mix-group payment to an IRF that discharges a beneficiary to home or to another institution that is not covered by Medicare's transfer regulations. For a transfer case, however, Medicare pays a lesser amount, based on a per diem rate and the number of days that the beneficiary spent in the IRF, pursuant to 42 CFR §412.624(f). Federal regulations define a transfer case as one in which:

- the beneficiary's IRF stay is shorter than the average stay for the non-transfer cases in the case-mix group and

- the beneficiary is transferred to another IRF, a long-term-care hospital, an acute-care inpatient hospital, or a nursing home that accepts Medicare or Medicaid payments.

Whether Medicare makes a full case-mix-group payment or a transfer payment depends on the patient status code on an IRF's claim. IRFs use several different patient status codes to designate transfer to a specific type of institution that is subject to the transfer regulation: 02 – short-term inpatient hospital; 03 – skilled nursing facility; 61 – hospital-based, Medicare-approved swing bed within the IRF; 62 – another IRF; 63 – long-term-care hospital; and 64 – a Medicaid-only nursing facility. Medicare makes per-diem transfer payments for claims submitted with any of these codes.

IRFs use patient status code 05 to indicate that the beneficiary was "discharged/transferred to another type of institution not defined elsewhere." Medicare makes a full case-mix-group payment for claims submitted with this code.

Prior Office of Inspector General Reviews

Two prior Office of Inspector General reviews of improperly coded IRF transfers found that IRFs did not always code claims in compliance with Medicare's transfer regulation.[1] Together, these two reviews identified $14.3 million in potential overpayments for miscoded claims. Both reports recommended that CMS implement an edit to its Common Working File to prevent future overpayments for transfer cases. CMS agreed with the findings and recommendations.

In response to these reviews, CMS implemented an edit in its Common Working File in April 2007. The edit matches beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims. Claims identified as transfers are cancelled and returned to the IRF for correction.

Contracts for Processing Medicare Part A Claims

In September 2007, CMS awarded Wisconsin Physicians Service (WPS) the Part A and Part B Medicare Administrative Contractor (MAC) contract for Jurisdiction 5, which included responsibility for the states of Kansas and Nebraska, formerly held under contract with Blue Cross and Blue Shield (BCBS) of Kansas and BCBS of Nebraska. Additionally, in November 2007, WPS assumed the Part A workload formerly processed by Mutual of Omaha.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether IRFs correctly coded claims paid by WPS, Mutual of Omaha, BCBS of Kansas, and BCBS of Nebraska.

Scope

Our review covered 53 Medicare Part A claims totaling $1,061,827 during CY 2007 with patient status code of 05 that were submitted by 27 IRFs in Colorado, Georgia, Illinois, Kansas, Louisiana, Massachusetts, Missouri, Nebraska, Oklahoma, Pennsylvania, Texas, and the District of Columbia. We limited our review to claims for shorter than average stays.

Our objective did not require an understanding or assessment of the complete internal control structure of IRFs or the Medicare contractors that paid the claims. Therefore, we limited our review to (1) obtaining an understanding of IRFs' procedures for coding claims with patient status code 05 and (2) WPS's policies and procedures for reviewing claims identified by CMS's edit in the Common Working File.

Our fieldwork consisted of contacting WPS and 27 IRFs that submitted the 53 claims in our review. We conducted our fieldwork from June through September 2010.

[1] *Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation* (A-04-04-00008, September 11, 2006) and *Nationwide Review of Inpatient Rehabilitation Facility Claims Coded as "Discharged to Home with Home Health Agency Services"* (A-04-04-00013, November 2, 2006).

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS manuals regarding IRF transfers;
- extracted IRF paid claims data from CMS's National Claims History File for CY 2007;
- identified 53 IRF claims paid by WPS, Mutual of Omaha, BCBS of Kansas, and BCBS of Nebraska with a patient status code of 05 by removing claims for beneficiaries whose lengths of stay were equal to or greater than the average length of stay per case-mix group;
- reviewed CMS's Common Working File claims history for the 53 claims to determine whether the claims were correctly coded as "05" and to verify that the selected claims had not been canceled;
- contacted representatives of the 27 IRFs that submitted the selected claims to verify whether the claims were correctly coded and to determine the causes of miscoding;
- contacted seven institutions that admitted beneficiaries after IRF transfer but did not submit Medicare claims for those stays to determine whether they accepted Medicare or Medicaid;
- used CMS's PRICER program to assist in determining payment error amounts; and
- discussed the results of our review with officials of the IRFs and WPS.

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 finding and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

IRFs incorrectly coded 24 of the 53 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes on these claims, Medicare contractors made $245,090 in overpayments for miscoded transfers to 11 IRFs in CY 2007.

The overpayments occurred because IRFs did not have adequate controls to ensure the correct use of patient status 05. In addition, Medicare payment controls in the Common Working File were not adequate to prevent or detect these overpayments until CMS established the necessary edit in April 2007.

PROGRAM REQUIREMENTS

Section 1886(j)(1)(E) of the Social Security Act authorized the Secretary of the Department of Health and Human Services to adjust prospective payments to account for the early transfer of a beneficiary from an IRF to another site of care. Pursuant to implementing regulations (42 CFR §§412.602 and 412.624(f)(1)), IRFs receive an adjusted prospective payment if (1) the beneficiary's stay in the IRF is shorter than the average stay for the given case-mix group and (2) the beneficiary is transferred from an IRF to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts Medicare or Medicaid payments.

Pursuant to 42 CFR §412.624(f)(2), Medicare pays for transfer cases on a per diem basis. CMS calculates the per diem payment rate by dividing the full case-mix-group payment rate by the average length of stay for the case-mix group. CMS then multiplies the per diem rate by the number of days that the beneficiary stayed in the IRF before being transferred. Medicare makes an additional half-day payment for the first day.

The Medicare Claims Processing Manual (the Manual), chapter 3, section 140.3, and chapter 25, section 75.2, lists the patient status codes that identify a transfer case, the code definitions, and examples of appropriate use. When an IRF uses these transfer codes, the claims processing system generates a per diem transfer payment to the IRF rather than a full case-mix-group payment.

PAYMENTS BASED ON INCORRECT PATIENT STATUS CODE

IRFs incorrectly coded 24 of the 53 claims that we reviewed with patient status code 05. These beneficiaries were transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes, Medicare contractors made $245,090 in overpayments for miscoded transfers to 11 IRFs in CY 2007.

CAUSES OF OVERPAYMENTS

The overpayments occurred because of clerical errors and computer programming errors at the IRFs. In addition, until April 2007, CMS's Common Working File did not contain the necessary edit to compare the date on which a beneficiary was discharged from an IRF with the date on which the beneficiary was admitted to another institution.

RECOMMENDATIONS

We recommend that WPS:

- recover the $245,090 in outstanding overpayments for 24 claims and

- alert IRFs to the importance of reporting the correct patient status code on their claims.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In comments to our draft report, WPS concurred with our recommendations and described the corrective actions it has taken or plans to take. WPS stated that it had adjusted 22 of 24 OIG identified claims with overpayments, to date, and recovered $239,904. The two remaining claims are now the responsibility of TrailBlazer Health Enterprises, LLC. WPS also stated that it has forwarded these two claims through CMS's Kansas City Regional Office for recovery. WPS's comments are included in their entirety as the Appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

February 4, 2011

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

RE: Office of Inspector General (OIG) Draft Report – A-01-10-00518

Dear Mr. Armstrong,

This letter is in response to the OIG draft report titled *Review of Jurisdiction 5 Payments For Inpatient Rehabilitation Facility Claims Billed With Patient Status Code 05 For Calendar Year 2007.*

OIG selected for review 53 Medicare Part A Inpatient Rehabilitation Facilities (IRFs) claims processed by Wisconsin Physicians Service (WPS), Mutual of Omaha, Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Nebraska. The IRFs incorrectly coded 24 of the 53 claims reviewed with the patient status code of 05. The beneficiaries on these claims were actually transferred to facilities subject to the Medicare transfer regulations creating an overpayment of $245,090.

As noted in the OIG report *the overpayments occurred because the IRFs did not have adequate controls to ensure the correct use of patient status 05. In addition, Medicare payment controls in the Common Working File were not adequate to prevent or detect these overpayments until CMS established the necessary edit in April 2007.*

OIG Recommendations to WPS:

- *recover the $245,090 in outstanding overpayments for the 24 claims and*
- *alert IRFs to the importance of reporting the correct patient status code on their claims*

WPS's Response to the OIG Recommendations:

- WPS has adjusted 22 of 24 OIG identified claims for an overpayment of $253,606.84 and recovered to date $239,903.85 (includes $1,990.60 in interest). The remaining two identified overpayment claims transitioned to TrailBlazer Health Enterprises, LLC on October 18, 2010, and are no longer recoverable by WPS. These claims have been referred to the Kansas City Regional Office for their referral to TrailBlazer Health Enterprises, LLC for recovery.
- Currently, WPS's Part A Provider Outreach & Education staff educates providers on the correct reporting of patient status information in our materials for Inpatient Rehabilitation Facility, Inpatient Acute Hospital and Inpatient Psychiatric Facility. We communicate the critical billing elements that must be reported correctly in order for the claim to process and pay accurately.

If you have any questions or need additional information, please contact me at 402-351-6915.

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: John Phelps, CMS
Lisa Goschen, CMS
Kimberly Rapoza, OIG