

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CMS IMPROPERLY PAID  
MILLIONS OF DOLLARS FOR  
SKILLED NURSING FACILITY  
SERVICES WHEN THE  
MEDICARE 3-DAY INPATIENT  
HOSPITAL STAY REQUIREMENT  
WAS NOT MET**

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# ***Office of Inspector General***

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## INTRODUCTION

### WHY WE DID THIS REVIEW

According to section 1861(i) of the Social Security Act (the Act), to be eligible for coverage of posthospital extended care services a Medicare beneficiary must be an inpatient in a hospital for not less than 3 consecutive calendar days (3-day rule) before being discharged from the hospital. Skilled nursing facilities (SNFs) are specially qualified facilities that provide extended care services, such as skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions.

Prior Office of Inspector General (OIG) reviews estimated that the Centers for Medicare & Medicaid Services (CMS) paid \$169 million for SNF services in calendar years (CYs) 1996 through 2001 when the 3-day rule was not met.<sup>1</sup> Though the Medicare contractors generally agreed with our findings, CMS told them not to recover improper payments because CMS could not determine whether SNFs were “at fault” in not meeting the 3-day rule, which meant that the Medicare beneficiaries would have become responsible for the payment.<sup>2</sup> Rather than pursuing recoupment, CMS issued instructions to providers regarding the importance of complying with the applicable requirements.

### OBJECTIVE

Our objective was to determine whether CMS paid SNF claims with dates of service during CYs 2013 through 2015 (the most recent available data at the start of our audit) when the 3-day rule was not met.

### BACKGROUND

#### **The Medicare Program**

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. CMS administers the Medicare program.

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<sup>1</sup> Appendix B contains a list of related OIG reports on SNFs’ compliance with the 3-day rule.

<sup>2</sup> CMS issued a Memorandum, JSM-17, 11-20-03, dated November 26, 2003, to all Medicare contractors. Available online as Appendix B of the report located at <https://oig.hhs.gov/oas/reports/region5/50400061.pdf>. Accessed on November 14, 2017.

## **Medicare Coverage Requirements for Skilled Nursing Facility Services**

Posthospital extended care services are an extension of care for a condition for which an individual received inpatient hospital services.<sup>3</sup> A mandatory hospital discharge planning evaluation for beneficiaries identified as likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning must include an evaluation of the patient's likely need for appropriate posthospital services, such as posthospital extended care services (the Act § 1861(ee)(2)(D)).

To qualify for posthospital extended care services, a beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days, not counting the date of discharge (42 CFR § 409.30(a)(1)). The 3-day rule may be met by inpatient stays totaling 3 consecutive days in one or more hospitals. Time spent in observation status or in the emergency room before (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day rule.<sup>4</sup> In addition, the beneficiary must be admitted to the SNF and receive the needed care within 30 calendar days (unless the posthospital SNF care would not be medically appropriate within 30 days) after the date of discharge from a hospital (42 CFR § 409.30(b)(1)).

SNF services must be ordered by a physician and provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals and be for a condition previously treated at a hospital (42 CFR § 409.31).

In CYs 2013 through 2015, CMS paid \$86 billion for more than 5 million Medicare beneficiaries to receive SNF services.

## **Medicare Outpatient Observation Notice and Important Message From Medicare**

The Medicare Outpatient Observation Notice (MOON) was mandated by the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), P.L. No. 114-42 (enacted Aug. 6, 2015). Hospitals and critical access hospitals must provide both the standardized written MOON and oral notification to all Medicare beneficiaries who receive observation services as outpatients for more than 24 hours. The notice must explain, among other requirements, the beneficiary's status as an outpatient, the reasons for the status, and how observation services affect subsequent eligibility for SNF care services.

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<sup>3</sup> CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.2.1.

<sup>4</sup> CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.1.

Also, hospitals are required to deliver the Important Message from Medicare (IM) to all Medicare beneficiaries who are hospital inpatients.<sup>5</sup> The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights.

### **Determination of Liability and Waiver of Recovery for Overpayments**

Section 1879 of the Act, also referred to as “the limitation on liability provision,” provides financial relief to beneficiaries and providers by permitting Medicare payment to be made for certain services and items for which Medicare payment would otherwise be denied. This provision applies to payments for custodial care and services that are not reasonable and necessary (42 CFR § 411.400). However, Medicare payment under this provision cannot be made when Medicare coverage is denied because a SNF stay was not preceded by a 3-day qualifying inpatient hospital stay.<sup>6</sup>

If a Medicare contractor concludes that an overpayment was made and payment cannot be made under the limitation on liability provision, it makes a determination under section 1870 of the Act on whether the provider or beneficiary was without fault with respect to the overpayment. If the provider was without fault, recovery of the overpayment from the provider is waived, and the overpayment is considered an overpayment to the beneficiary. If the beneficiary was without fault, recovery may be waived if it would cause financial hardship or would not be equitable and in good conscience.<sup>7</sup>

SNFs must issue a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to a beneficiary enrolled in the Medicare Part A program before the SNF provides an item or service that may not be paid for by Medicare because it is not medically reasonable and necessary or it is custodial care.<sup>8</sup> However, SNFs are not required to provide a SNFABN if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met.<sup>9</sup>

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<sup>5</sup> CMS, An Important Message From Medicare About Your Rights, CMS-R-193. Available online at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMSR-193-ENGLISH.pdf>. Accessed on June 21, 2018.

<sup>6</sup> CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 30, § 20.2.2.

<sup>7</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 3, § 70.3.

<sup>8</sup> CMS, “FFS SNFABN.” Available online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html>. Accessed on February 28, 2018.

<sup>9</sup> CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 30, § 70.2.2.2.

## Medicare Claim Processing System Edits

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for hospital services. The contractors' responsibilities include determining reimbursement amounts, conducting audits, and safeguarding against fraud and abuse.

Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS but before payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. After the CWF has processed a claim, it electronically transmits information to the contractor regarding potential claim errors and to the Medicare National Claims History (NCH) file for monthly loading.

The FISS and CWF qualifying hospital stay edits are specifically designed to verify whether SNF claims meet the 3-day rule. SNFs must report occurrence span code "70" to provide the dates of a qualifying hospital stay of at least 3 consecutive days.<sup>10</sup> The FISS rejects SNF claims that report an inpatient hospital stay of less than 3 consecutive calendar days, not counting the date of discharge. In addition, the CWF rejects a SNF claim if at least one of the dates reported with occurrence span code "70" matches an incoming or previously posted inpatient hospital claim's dates of service found within 30 days of the SNF admission, and the hospital stay dates do not span 3 or more calendar days, not including the date of discharge. If none of the dates reported with occurrence span code "70" match the dates of service reported on the inpatient hospital claim, or the SNF or hospital claim meets the bypass criteria, the CWF allows the SNF claim to bypass the edit.<sup>11</sup>

Because of incorrect or incomplete SNF and hospital claim data, a lack of access to the U.S. Department of Veterans Affairs (VA)<sup>12</sup> or private-pay hospital claims that should be considered while calculating the length of a qualifying hospital stay, and timing differences between the submission of hospital claims and SNF claims, the CWF qualifying hospital stay edit is not always effective and can result in incorrect rejections or payments of SNF claims. During our audit

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<sup>10</sup> CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 6, § 30.

<sup>11</sup> Some claim indicators on SNF and hospital claims—including but not limited to (i) claims submitted by providers participating in the Bundled Payments for Care Improvement Initiative Models 2 and 3, (ii) claims reporting that a beneficiary disenrolled from a Medicare Advantage plan while receiving SNF care services, and (iii) claims associated with disaster relief—allow SNF claims without a qualifying inpatient hospital stay to bypass the CWF edit.

<sup>12</sup> According to section 1128J(a) of the Act, the CMS data warehouse Integrated Data Repository (IDR) ultimately is to include, among other data, appropriate claims and payment data from the health-related programs administered by the Secretary of the Department of Veterans Affairs. As of the end of our fieldwork, the IDR contained Medicare claims, beneficiary and provider data sources, and ancillary data including, but not limited to, contact information and risk.

period, CMS allowed SNF claims to bypass the CWF qualifying stay edit because of incorrect SNF claim rejections.<sup>13</sup>

## HOW WE CONDUCTED THIS REVIEW

Our review covered \$134,860,811 in Medicare payments for 22,052 SNF claims for services provided from January 1, 2013, through December 31, 2015 (audit period), to beneficiaries who, according to the NCH file, had preceding acute-care inpatient hospital stays of less than 3 consecutive calendar days, not counting the date of discharge.<sup>14</sup>

In developing our sampling frame, we used the NCH file to extract SNF and associated inpatient hospital claims:

- At first, we extracted all SNF claims with payments greater than or equal to \$200 each and with service dates within our audit period. If several SNF claims for the same beneficiary were within 30 days of each other, we considered them to be for the same SNF stay.<sup>15</sup>
- We also extracted claims for acute-care hospital stays that were within 30 days of a respective SNF stay. We noted that the NCH file did not contain VA or private-pay hospital stay data, which should be considered when calculating the length of a qualifying inpatient hospital stay. SNF claims that did not have the associated qualifying hospital stay claims in the NCH file were likely for beneficiaries having either a VA or private-pay inpatient hospital stay. Therefore, we did not include in our sampling frame the SNF claims without any associated hospital claims in the NCH file.<sup>16</sup>
- Then we excluded (1) all SNF claims comprising SNF stays that were preceded by one or more hospital inpatient stays totaling more than 2 consecutive calendar days, not counting the date of discharge; (2) claims submitted on behalf of beneficiaries for whom the 3-day rule or 30-day transfer requirement was waived by CMS; (3) claims of SNFs under investigation by CMS's Zone Program Integrity Contractor (ZPIC); and (4) claims for

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<sup>13</sup> CMS, “Update to the CWF Qualifying Stay Edit C7123 for Inpatient SNF and SB Claims.” Available online at [https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-08-21-eNews.html#\\_Toc396290045](https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-08-21-eNews.html#_Toc396290045). Accessed on March 12, 2018.

<sup>14</sup> Our sampling frame did not include any swing-bed claims, which are for services equivalent to those performed at a SNF.

<sup>15</sup> If a break in SNF care lasts more than 30 days, a new 3-day qualifying inpatient hospital stay is required for Medicare to cover subsequent SNF care (CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.2.1).

<sup>16</sup> We are currently researching SNF claims without any associated hospital claims in the NCH file under a separate project.

which service dates billed on a SNF claim overlapped with the service dates billed on the associated hospital claim.

We selected for review a stratified random sample of 100 SNF claims with payments totaling \$779,419. We did not review one sampled claim totaling \$11,886 because it was part of an open OIG investigation. For each of the remaining 99 sampled claims, we reviewed CWF records and medical records obtained from the SNFs and associated hospitals.

We did not review the overall internal control structure of CMS, SNFs, or hospitals. Rather, we limited our review of internal controls to those applicable to ensuring compliance with the 3-day rule.

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.

Appendix A contains the details of our audit scope and methodology, Appendix C contains the details of our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal requirements for posthospital extended care services.

## FINDINGS

CMS improperly paid 65 of the 99 SNF claims we sampled when the 3-day rule was not met.<sup>17</sup> Improper payments associated with these 65 claims totaled \$481,034. On the basis of our sample results, we estimated that CMS improperly paid \$84,202,593 for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

We attribute the improper payments to the absence of a coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure compliance with the 3-day rule. We noted that hospitals did not always provide correct inpatient stay information to SNFs, and SNFs knowingly or unknowingly reported erroneous hospital stay information on their Medicare claims to meet the 3-day rule. We determined that the SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met.<sup>18</sup> Because CMS allowed SNF claims to bypass the CWF qualifying stay edit during our audit period, these SNF claims were not matched with the associated hospital claims that reported inpatient stays of less than 3 days.

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<sup>17</sup> We did not review one sample claim because it was part of an open OIG investigation.

<sup>18</sup> Non-inpatient hospital days included observation, outpatient, and emergency room days, as well as other days that could not be traced to any qualifying hospital stay.

Without a coordinated notification mechanism, CMS does not have sufficient documentary evidence to prevent SNFs from submitting erroneous claims that result in improper payments and to determine whether SNFs were at fault for the improper payments. The “at fault” consideration affects the determination of whether the SNF or beneficiary would be financially liable for the overpayment.

## **CMS IMPROPERLY PAID SKILLED NURSING FACILITY CLAIMS WHEN THE 3-DAY RULE WAS NOT MET**

### **Federal Requirements**

To qualify for posthospital extended care such as SNF services, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days, not counting the date of discharge (42 CFR § 409.30(a)(1)). The requirement of 3 consecutive calendar days can be met by stays totaling 3 consecutive days in one or more hospitals and may not include observation, emergency room, or discharge days.<sup>19</sup> In addition, the beneficiary must be admitted to the SNF and receive the needed care within 30 calendar days (unless the posthospital SNF care would not be medically appropriate within 30 days) after the date of discharge from a hospital (42 CFR § 409.30(b)).

Section 1870 of the Act states that waiving recovery of an overpayment is appropriate when the provider is without fault with respect to causing the overpayment. Medicare contractors consider a provider to be without fault if the provider exercises reasonable care in billing for, and accepting, payment. Reasonable care means that the provider makes full disclosure of all material facts and, on the basis of the available information, including, but not limited to, Medicare instructions and regulations, it has a reasonable basis for assuming that the payment is correct.<sup>20</sup> Conversely, examples of situations in which a provider is liable include (1) when a beneficiary is not entitled to Part A benefits and the provider has reason to believe that the beneficiary is not entitled to such benefits, and (2) situations in which the provider bills for services that the provider should know are not covered.<sup>21</sup> If the provider is without fault, recovery of the overpayment from the provider is waived, and the overpayment becomes an overpayment to the beneficiary (§§ 1870(a) and (b) of the Act).

### **Improperly Paid Skilled Nursing Facility Claims**

CMS improperly paid 65 of the 99 SNF claims we sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled \$481,034. On the basis of our

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<sup>19</sup> CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.1.

<sup>20</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 3, § 90.

<sup>21</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 3, §§ 90.1(G) and (H).

sample results, we estimated that CMS improperly paid \$84,202,593 for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

Through our review of the CWF records and the medical records that we obtained from the SNFs and hospitals relative to the 65 noncompliant SNF claims, we determined that the SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met. Figure 1 provides an example of a SNF's reporting of inpatient and non-inpatient hospital stay days on its claim.

**Figure 1: Example of Skilled Nursing Facility Claim Reporting  
Inpatient and Non-Inpatient Hospital Stay Days**

A beneficiary was treated in the hospital emergency room on January 21. The beneficiary was admitted as an inpatient on January 22 and discharged on January 24. The hospital claim reported the inpatient dates as January 22 through 24. However, the inpatient hospital stay was only 2 days because the date of discharge did not count. The associated SNF claim reported the qualifying inpatient hospital dates as January 21 through 24, claiming the inpatient hospital stay as 3 days, not counting the date of discharge. CMS paid for the SNF services that did not meet the 3-day rule.

CMS properly paid for the SNF services that met the 3-day rule for the remaining 34 SNF claims we sampled. These claims were appropriate despite appearing to be noncompliant in the NCH file mainly because the associated hospitals either underreported inpatient stay days on their Medicare claims or submitted their claims to VA or private insurance in addition to Medicare. The medical records submitted by the hospitals showed that the actual length of the inpatient hospital stay(s) associated with each of the 34 SNF claims was 3 or more calendar days, not counting the date of discharge.

**CMS Made Payments for Claims That Did Not Meet the 3-Day Rule Because a Common Working File Edit Was Not Enabled**

All of the 65 noncompliant SNF claims reported that qualifying inpatient hospital stays were 3 or more calendar days, not counting the date of discharge, which allowed them to pass through the FISS. If the CWF qualifying hospital stay edit was enabled, these SNF claims would have been matched with the associated hospital claims that reported inpatient stays of less than 3 days and would have been rejected as noncompliant with the 3-day rule.

**Skilled Nursing Facilities Claimed Services That Did Not Meet the 3-Day Rule Because There Had Been No Coordinated Notification Mechanism**

Although we determined that the SNFs entered erroneous inpatient hospital stay information on 65 noncompliant sampled Medicare claims, we could not always determine whether the SNFs did so knowingly or unknowingly. Therefore, we could not ascertain that the SNFs were at fault. For 18 of the 65 noncompliant SNF claims, we noted that the hospitals provided incomplete,

misleading, or erroneous discharge information to the SNFs, thereby affecting the SNFs' ability to determine whether their services met the 3-day rule. Figure 2 provides an example of erroneous hospital information provided to a SNF.

**Figure 2: Example of Erroneous Hospital Information Provided to a Skilled Nursing Facility**

A beneficiary was treated as an outpatient at a hospital on April 17 and 18 and, per the hospital's records, was admitted as an inpatient from April 19 through 21. Because the date of discharge is not included within the count of inpatient days, the beneficiary had only 2 documented inpatient days of care, thereby disqualifying subsequent SNF care from Medicare reimbursement. However, the discharge information that the hospital provided to a SNF erroneously showed that the beneficiary was admitted as an inpatient on April 17, which incorrectly indicated that the beneficiary had 3 days of inpatient care that would qualify the subsequent SNF care for Medicare reimbursement. The hospital could not explain why it had provided erroneous hospital stay information to the SNF.

To allow beneficiaries and SNFs to make informed decisions as to whether a SNF service would be eligible for Medicare reimbursement, it is important that hospitals provide both beneficiaries and SNFs accurate and verifiable information about the number of inpatient hospital stay days. However, there was no coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure that SNFs were billing Medicare only for services that met the 3-day rule. Specifically, Medicare regulations did not:

- require hospitals to provide beneficiaries and SNFs with any written notification explicitly stating the dates of the inpatient hospital stay,
- specify the information SNFs must use and retain to verify that their Medicare claims are for services that meet the 3-day rule, or
- require SNFs to provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met.

Without a coordinated notification mechanism, CMS does not have sufficient documentary evidence to hold SNFs accountable for submitting erroneous claims that result in improper payments and to determine whether SNFs were at fault for the improper payments. The "at fault" consideration affects the determination of whether the SNF or beneficiary is financially liable for the overpayment.

In accordance with section 1870 of the Act, if the provider is without fault, recovery of the overpayment from the provider is waived, and the overpayment is considered an overpayment to the beneficiary. Without the requirement for hospitals to notify beneficiaries about the number of inpatient days, beneficiaries do not have an effective means to determine whether their hospital stay qualifies their subsequent SNF care for Medicare reimbursement. Therefore,

they cannot give informed consent regarding SNF services, and they might not know about their potential financial liability for SNF services they may agree to receive.

## **CONCLUSION**

Without a coordinated notification mechanism among hospitals, beneficiaries, and SNFs, CMS will continue to improperly pay millions of dollars annually for SNF care when the 3-day rule is not met. There is no effective deterrent or financial risk to SNFs submitting claims with erroneous qualifying inpatient hospital stay information. Although the edits in CMS's claim processing system may detect that a SNF claim reported erroneous information, CMS has little or no basis to determine whether SNFs were at fault for submitting noncompliant claims. Therefore, in accordance with section 1870 of the Act, if CMS cannot determine the SNFs to be at fault, the improper payment might become an overpayment to beneficiaries. In addition, if beneficiaries were determined to be without fault, recovery may be waived, and CMS would bear the cost of noncompliant SNF care.

## **RECOMMENDATIONS**

We make the following recommendations to CMS, which could have saved an estimated \$84,202,593 during our audit period:

- Ensure that when SNF claims are being processed for payment, the CWF qualifying inpatient hospital stay edit for SNF claims is enabled and operating properly to identify SNF claims ineligible for Medicare reimbursement.
- Require hospitals to provide a written notification to beneficiaries whose discharge plans include posthospital SNF care, clearly stating how many inpatient days of care the hospital provided and whether the 3-day rule for Medicare coverage of SNF stays has been met. If necessary, CMS should seek statutory authority to do so.
- Require SNFs to obtain from the hospital or beneficiary, at the time of admission, a copy of the hospital's written notification to the beneficiary and retain it in the beneficiary's medical record. (See our second recommendation.) If necessary, CMS should seek statutory authority to do so.
- Require SNFs to provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met. If necessary, CMS should seek statutory authority to do so.
- Educate hospitals about the importance of explicitly communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent SNF care for Medicare reimbursement so that beneficiaries understand their potential financial liability related to SNF care.

- Educate SNFs about their responsibility to submit accurate and valid claims for payment that are supported with documentation that clearly shows that the SNF services qualify for reimbursement.

## **CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **CMS COMMENTS**

In written comments on our draft report, CMS concurred with our first, fifth, and sixth recommendations. Regarding our first recommendation, CMS said that it enabled the CWF qualifying inpatient hospital stay edit for SNF claims effective April 2018. Regarding our fifth and sixth recommendations, CMS agreed to (1) educate hospitals about the importance of communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent SNF care for Medicare reimbursement and (2) educate SNFs about their responsibility to submit accurate and valid claims that are supported with documentation that clearly shows that the SNF services qualify for reimbursement.

However, CMS did not concur with the remaining recommendations related to a coordinated notification mechanism among hospitals, beneficiaries, and SNFs that includes a written notification to beneficiaries stating how many inpatient days of care the hospital provided and whether the 3-day rule for Medicare coverage of SNF stays has been met. Specifically, CMS indicated that hospitals already provide a written notification and an oral explanation to beneficiaries who receive observation services as outpatients for more than 24 hours, informing them, among other things, how their status may affect eligibility for Medicare coverage of SNF services.<sup>22</sup> In addition, CMS stated that discharge planning requirements are set out in the hospital Conditions of Participation, which generally do not differentiate between patients based on source of payment. Accordingly, CMS said that it did not believe it would be appropriate to include a requirement referencing Medicare coverage criteria for SNF care as part of the hospital discharge planning requirements. CMS also did not concur with our recommended notification requirements for SNFs, stating that hospitals already provide written notification to beneficiaries who receive observation services and that CMS encourages SNFs to provide SNFABNs to beneficiaries when the 3-day rule is not met.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix F.

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<sup>22</sup> In a December 2016 report entitled *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* (OEI-02-15-00020), OIG recommended that CMS analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our findings and recommendations are valid. In its comments, CMS referred to the MOON, which informs Medicare beneficiaries that they are outpatients receiving observation services rather than inpatients of the hospital or critical access hospital (CAH). The MOON does not address the cause of the findings in our report. The beneficiaries in our sample were hospital inpatients; however, not all of them had inpatient hospital stays of 3 or more days (not counting the day of discharge) needed to qualify their subsequent SNF care for Medicare reimbursement.

Further, while CMS disagreed with our recommendation to require hospitals to provide written notification to beneficiaries regarding whether the 3-day rule has been met, we note that our recommendation did not envision modifying the Conditions of Participation. Rather, a requirement similar to the MOON could be established to implement this recommendation, or, if necessary, CMS could seek legislative authority to revise the MOON to implement this recommendation. Without a requirement that hospitals provide a written notification clearly stating the number of inpatient days, Medicare-insured beneficiaries have no guarantee of receiving the information they need to make an informed decision about their SNF care and the potential financial liability related to that care. Without a requirement that SNFs obtain this information from the hospital, the information SNFs use to justify a qualifying hospital stay will continue to be incomplete, misleading, or erroneous and will continue to lead to improper Medicare billing and reimbursement. These problems will not be corrected until CMS requires a consistent documentation standard for SNFs that provides verifiable evidence of a qualifying hospital stay, which CMS can use to either certify allowable SNF reimbursements or detect and recover improper SNF reimbursements. Finally, we do not believe that encouraging SNFs to provide ABNs is sufficient to ensure that beneficiaries have adequate information regarding eligibility for SNF services, and we continue to recommend that the provision of SNFABN be made mandatory.

Since 2000, OIG has issued 27 reports related to improper payments made because of noncompliance with the 3-day rule. As evidenced by the continued improper payments noted in this report, CMS has not taken effective action since the issuance of the previous reports to correct the problems causing noncompliance with the 3-day rule. The actions CMS is agreeing to take based on the recommendations in this report are inadequate to prevent future improper payments when the 3-day rule is not met. Without a coordinated notification mechanism among hospitals, beneficiaries, and SNFs, the Medicare Trust Fund will continue to make expenditures for services that do not meet program requirements.

Therefore, we maintain that CMS should require that (1) hospitals provide beneficiaries a notification stating how many inpatient days of care the hospital provided, (2) SNFs obtain and maintain such written notification as a condition of SNF billing and reimbursements, and (3) SNFs provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered \$134,860,811 in Medicare payments for SNF claims for services provided from January 1, 2013, through December 31, 2015 (the most recent available data at the start of our audit), to beneficiaries who, according to the NCH file, had preceding acute-care inpatient hospital stays of less than 3 consecutive calendar days.

In developing our sampling frame, we used the NCH file to extract SNF and associated inpatient hospital claims:

- At first, we extracted all SNF claims with payments greater than or equal to \$200 each and with service dates within our audit period. If several SNF claims for the same beneficiary were within 30 days of each other, we considered them to be for the same SNF stay.
- We also extracted claims for acute-care hospital stays that were within 30 days of a respective SNF stay. We noted that the NCH file did not contain VA or private-pay hospital stay data, which should be considered when calculating the length of a qualifying inpatient hospital stay. SNF claims that did not have the associated qualifying hospital stay claims in the NCH file were likely for beneficiaries having either a VA or private-pay inpatient hospital stay. Therefore, we did not include in our sampling frame the SNF claims without any associated hospital claims in the NCH file. (Please refer to footnote 16 on page 5.)
- Then we excluded (1) all SNF claims comprising SNF stays that were preceded by one or more hospital inpatient stays totaling more than 2 consecutive calendar days, not counting the date of discharge; (2) claims submitted on behalf of beneficiaries for whom the 3-day rule or 30-day transfer requirement was waived by CMS; (3) claims of SNFs under investigation by CMS's ZPIC; and (4) claims for which service dates billed on a SNF claim overlapped with the service dates billed on the associated hospital claim.

We established reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the overall completeness of the file.

We selected for our review a stratified random sample of 100 SNF claims with payments totaling \$779,419. We did not review one sampled claim totaling \$11,886 because it was part of an open OIG investigation. For each of the remaining 99 sampled claims, we reviewed CWF records and medical records submitted by the SNFs and associated hospitals.

We did not review the overall internal control structure of CMS, SNFs, or hospitals. Rather, we limited our review of internal controls to those applicable to ensuring compliance with the 3-day rule.

We conducted fieldwork from May 2016 through January 2018.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS guidance;
- gained an understanding of CMS's, SNFs', and hospitals' internal controls over compliance with the 3-day rule;
- extracted from the NCH file 22,052 SNF claims with Medicare payments greater than or equal to \$200 each for services provided from January 1, 2013, through December 31, 2015, and with preceding acute-care inpatient hospital stays of less than 3 consecutive calendar days, not counting the date of discharge;
- selected a stratified random sample of 100 SNF claims totaling \$779,419 in Medicare payments (Appendix C);
- reviewed available data from the CWF for the sampled claims to determine whether the claims had been canceled or adjusted;
- identified and removed from our review 1 sampled claim totaling \$11,886 that was part of an open OIG investigation;
- requested and reviewed SNF and hospital medical record documentation to determine whether it supported the remaining 99 sampled claims;
- used the sample results to estimate the value of improper Medicare payments to SNFs<sup>23</sup> (Appendix D); 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.

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<sup>23</sup> The estimates in the report apply only to providers that are not part of an open OIG investigation.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Cooperativa de Seguros de Vida de Puerto Rico</u></a>	A-05-04-00062	1/19/05
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Nebraska</u></a>	A-05-04-00061	12/02/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Wyoming</u></a>	A-05-04-00059	11/16/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Rhode Island Medicare Services</u></a>	A-05-04-00034	11/15/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Montana, Inc.</u></a>	A-05-04-00060	9/3/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Premera Blue Cross</u></a>	A-05-04-00032	8/16/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Anthem Health Plans of New Hampshire, Inc.</u></a>	A-05-04-00058	7/15/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Chisholm Administrative Services</u></a>	A-05-04-00057	6/28/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Kansas, Inc.</u></a>	A-05-04-00033	6/28/04
<a href="#"><u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Anthem Health Plans of Maine, Inc.</u></a>	A-05-03-00071	10/27/03

Report Title	Report Number	Date Issued
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Medicare Northwest</u>	A-05-03-00063	10/27/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Georgia, Inc.</u>	A-05-03-00087	10/21/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Arkansas Blue Cross and Blue Shield</u>	A-05-03-00086	10/21/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Arizona, Inc.</u>	A-05-03-00072	09/30/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of TriSpan Health Services</u>	A-05-03-00050	09/19/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Cahaba Government Benefit Administrators</u>	A-05-03-00051	7/16/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Veritus Medicare Services</u>	A-05-03-00035	7/16/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Noridian Mutual Insurance Company</u>	A-05-03-00062	6/19/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Empire HealthChoice, Inc.</u>	A-05-03-00022	5/8/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of First Coast Services Options, Inc.</u>	A-05-03-00036	4/9/03

Report Title	Report Number	Date Issued
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Riverbend GBA</u>	A-05-03-00015	4/4/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of CareFirst of Maryland, Inc.</u>	A-05-03-00026	3/31/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Palmetto GBA</u>	A-05-02-00088	3/31/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of United Government Services</u>	A-05-02-00087	3/26/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of AdminaStar Federal</u>	A-05-02-00086	3/26/03
<u>Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Mutual of Omaha</u>	A-05-02-00083	3/14/03
<u>Illinois Skilled Nursing Facility Claims Lacking a Preceding 3-Day Inpatient Hospital Stay</u>	A-05-99-00018	9/15/00

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

The population consisted of nation-wide Medicare SNF claims for services provided from January 1, 2013, through December 31, 2015, with payments greater than or equal to \$200 per claim and with a preceding acute-care inpatient stay totaling less than 3 consecutive calendar days in one or more hospitals.

### SAMPLING FRAME

The sampling frame consisted of 22,052 SNF claims totaling \$134,860,811 that we obtained from the NCH file.

The sampling frame excluded (1) all SNF claims for SNF stays that were preceded by one or more hospital inpatient stays with a total of 2 or more consecutive calendar days, not counting the date of discharge; (2) claims submitted on behalf of beneficiaries for whom the 3-day rule or 30-day transfer requirement was waived; (3) claims of SNFs under investigation by CMS's ZPIC; and (4) claims on which service dates billed on a SNF claim overlapped with the service dates billed on the associated hospital claim.

### SAMPLE UNIT

The sample unit was a paid Medicare SNF claim.

### SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into two strata, as shown in Table 1:

**Table 1: Stratum Description**

Stratum	Description of Stratum
1	13,695 SNF claims for services with payments ranging from \$200 to \$7,069 per claim (totaling \$44,799,306).
2	8,357 SNF claims for services with payments ranging from \$7,070 to \$42,068 per claim (totaling \$90,061,505).

## **SAMPLE SIZE**

We selected a sample of 100 SNF claims, as shown in Table 2:

**Table 2: Sample Stratum Size and Value**

<b>Stratum</b>	<b>Sample Size</b>	<b>Sample Value</b>
1	40	\$116,431
2	60	662,988
<b>Total</b>	<b>100</b>	<b>\$779,419</b>

## **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within each stratum. After generating the random numbers, we selected the corresponding claims in each stratum.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the dollar amount of improper Medicare payments for SNF claims for services provided during our audit period. We also used the software to calculate the corresponding lower and upper limits of the two-sided 90-percent confidence interval. The estimates in the report apply only to providers that are not part of an open OIG investigation. We accounted for the full sample design when we calculated our statistical estimate.

## APPENDIX D: SAMPLE RESULTS AND ESTIMATES

**Table 3: Sample Results**

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Non-Compliant SNF Claims	Value of Non-Compliant SNF Claims
1	13,695	\$44,799,306	40	\$116,431	29	\$84,703
2	8,357	90,061,505	59 <sup>24</sup>	651,102	36	396,331
<b>Total</b>	<b>22,052</b>	<b>\$134,860,811</b>	<b>99</b>	<b>\$767,533</b>	<b>65</b>	<b>\$481,034</b>

**Table 4: Estimated Value of Improper Medicare Payments**  
*(Limits Calculated for a 90-percent Confidence Interval)*

Point estimate	\$84,202,593
Lower limit	71,267,935
Upper limit	97,137,250

<sup>24</sup> We did not review one sample SNF claim with a payment of \$11,886 because it was part of an open OIG investigation.

## APPENDIX E: FEDERAL REQUIREMENTS FOR POSTHOSPITAL EXTENDED CARE SERVICES

### DEFINITION OF POSTHOSPITAL EXTENDED CARE SERVICES

Section 1861(i) of the Act defines the term “post-hospital extended care services” to mean:

extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

Section 1819(a) further defines skilled nursing facility to mean an institution which

- (1) is primarily engaged in providing to residents—
  - (A) skilled nursing care and related services for residents who require medical or nursing care, or
  - (B) rehabilitation services for rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases;
- (2) has in effect a transfer agreement . . . with one or more hospitals. . . .

Post-hospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services (CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.2.1).

Skilled nursing and skilled rehabilitation services are defined in 42 CFR §§ 409.31(a) and (b) to mean services that

- (1) are ordered by a physician;
- (2) require the skills of technical or professional personnel . . . ; and

- (3) are furnished directly by, or under the supervision of, such personnel.

The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis. Those services must be furnished for a condition

- (1) for which the beneficiary received inpatient hospital or inpatient CAH services, or
- (2) which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he received inpatient hospital or inpatient CAH services.

### **3-DAY QUALIFYING INPATIENT HOSPITAL STAY**

The beneficiary must have been hospitalized in a participating or qualified hospital or participating CAH for medically necessary inpatient hospital or inpatient CAH care for at least 3 consecutive calendar days, not counting the date of discharge (42 CFR § 409.30(a)(1)).

The requirement to stay for at least 3 consecutive calendar days may be met by stays totaling 3 consecutive days in one or more hospitals. Time spent in observation status or in the emergency room before (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay. Inpatient status commences with the calendar day of hospital admission (CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.1).

### **30-DAY TRANSFER REQUIREMENT**

Federal regulations specify that the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH. A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital or CAH may be admitted at the time it would be medically appropriate to begin an active course of treatment (42 CFR § 409.30(b)).

If a beneficiary whose SNF stay was covered on admission is thereafter determined not to require a SNF level of care for a period of more than 30 days, Medicare would not cover any subsequent SNF services until the occurrence of a new qualifying hospital stay (CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.2.1).

## Report in Brief

Date: February 2019  
Report No. A-05-16-00043

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



### Why OIG Did This Review

According to section 1861(i) of the Social Security Act, to be eligible for coverage of posthospital extended care services, a Medicare beneficiary must be an inpatient in a hospital for not less than 3 consecutive calendar days (3-day rule) before being discharged from the hospital. Prior OIG reviews estimated that \$169 million in Medicare payments for skilled nursing facility (SNF) services did not meet the 3-day rule in calendar years (CYs) 1996 through 2001. Though the Medicare contractors generally agreed with our findings, the Centers for Medicare & Medicaid Services (CMS) told the SNFs not to recover improper payments because CMS could not determine whether SNFs were "at fault" in not meeting the 3-day rule.

Our objective in this followup review was to determine whether CMS paid SNF claims with dates of service during CYs 2013 through 2015 when the 3-day rule was not met.

### How OIG Did This Review

Our review covered \$134.9 million in Medicare payments for more than 22,000 SNF claims for beneficiaries who had preceding acute-care inpatient hospital stays of less than 3 consecutive calendar days. We selected a random sample of 100 SNF claims with payments totaling \$779,419. We reviewed Common Working File (CWF) records and medical records submitted by the SNFs and associated hospitals for the sampled claims.

## CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met

### What OIG Found

CMS improperly paid 65 of the 99 SNF claims we sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled \$481,034. On the basis of our sample results, we estimated that CMS improperly paid \$84 million for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

We attribute the improper payments to the absence of a coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure compliance with the 3-day rule. We noted that hospitals did not always provide correct inpatient stay information to SNFs, and SNFs knowingly or unknowingly reported erroneous hospital stay information on their Medicare claims to meet the 3-day rule. We determined that the SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met. In addition, because CMS allowed SNF claims to bypass the CWF qualifying stay edit during our audit period, these SNF claims were not matched with the associated hospital claims that reported inpatient stays of less than 3 days.

### What OIG Recommends and CMS Comments

CMS should ensure that the CWF qualifying inpatient hospital stay edit for SNF claims is enabled when SNF claims are processed for payment. In addition, CMS should require hospitals to provide beneficiaries a written notification of the number of inpatient days of care provided during the hospital stay and whether the hospital stay qualifies subsequent SNF care for Medicare reimbursement so that beneficiaries are aware of their potential financial responsibility before consenting to receive SNF services. CMS should require SNFs to obtain a written notification from the hospital and retain it as a condition of payment for their claims. Further, CMS should educate both hospitals and SNFs about verifying and documenting the 3-day inpatient hospital stay relative to supporting a Medicare claim for SNF reimbursement.

CMS concurred with our recommendations concerning the CWF qualifying inpatient hospital stay edit and educating hospitals and SNFs but did not concur with the remaining recommendations related to a coordinated notification mechanism among hospitals, beneficiaries, and SNFs. After reviewing CMS's comments, we maintain that our findings and recommendations are valid. Without a coordinated notification mechanism, CMS will continue to make improper payments when the 3-day rule is not met.

## APPENDIX F: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** SEP 27 2018

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Seema Verma  
Administrator /Seema Verma/

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met (A-05-16-00043)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. CMS has also taken action to prevent improper Medicare payments by educating health care providers on proper billing. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

In addition, subsequent to the audit period, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (Public Law 114-42), which required hospitals and critical access hospitals to provide written notification and an oral explanation of such notification to individuals who receive observation services as outpatients for more than 24 hours at hospitals or critical access hospitals. CMS implemented this requirement by requiring hospitals and critical access hospitals to furnish a standardized notice to each individual entitled to Medicare benefits if the individual receives observation services as an outpatient for more than 24 hours. The Medicare Outpatient Observation Notice is the standardized notice CMS adopted, and it requires hospitals and critical access hospitals to include the reason(s) the individual is an outpatient receiving observation services and explain the implications of being an outpatient receiving observations services, such as implications for Medicare cost-sharing requirements and post-hospitalization subsequent eligibility for Medicare coverage of skilled nursing facility services, and other important information.

Furthermore, CMS is committed to limiting the burden caused by Medicare documentation requirements and the medical reviews that help protect the Medicare Trust Funds for future generations. Therefore, CMS has established an internal process to evaluate and streamline

regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience, which has included revising some of the documentation requirements for skilled nursing facilities.

The OIG's recommendations and CMS' responses are below.

**OIG Recommendation**

The OIG recommends that CMS ensure that when SNF claims are being processed for payment, the CWF qualifying inpatient hospital stay edit for SNF claims is enabled and operating properly to identify SNF claims ineligible for Medicare reimbursement.

**CMS Response**

CMS concurs with this recommendation. CMS enabled the Common Working File qualifying inpatient stay edit for skilled nursing facility claims effective April 2018.

**OIG Recommendation**

The OIG recommends that CMS require hospitals, as part of the discharge planning, to provide a written notification to beneficiaries whose discharge plans include posthospital SNF care, clearly stating how many inpatient days of care the hospitals provided and whether the 3-day rule for Medicare coverage of SNF stays has been met. If necessary, CMS should seek statutory authority to do so.

**CMS Response**

CMS does not concur with this recommendation. As stated above, hospitals are required to provide beneficiaries who receive more than 24 hours of observation services written notification of their status and an oral explanation of that notification that includes, among other things, how their status may affect eligibility for Medicare coverage of skilled nursing facility services. Discharge planning requirements are set out in the hospital Conditions of Participation, which generally do not differentiate between patients based on source of payment. Therefore, CMS does not believe that it would be appropriate to include a requirement referencing Medicare coverage criteria for skilled nursing facility care as part of the hospital discharge planning requirements.

**OIG Recommendation**

The OIG recommends that CMS require SNFs, as a condition of Medicare payment, to obtain from the hospital or beneficiary, at the time of admission, a copy of the hospital's written notification to the beneficiary and retain it in the beneficiary's medical record. If necessary, CMS should seek statutory authority to do so.

**CMS Response**

CMS does not concur with this recommendation. As stated above, hospitals already provide written notification and an oral explanation of that notification to beneficiaries who receive observation services as outpatients for more than 24 hours to inform beneficiaries of, among other things, how their status may affect eligibility for Medicare coverage of skilled nursing facility services. In addition, CMS encourages skilled nursing facilities to provide written notification to beneficiaries prior to providing care that Medicare never covers, including when the 3-day rule was not met using the voluntary Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage.

**OIG Recommendation**

The OIG recommends that CMS require SNFs to provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule was not met. If necessary, CMS should seek statutory authority to do so.

**CMS Response**

CMS does not concur with this recommendation. CMS already requires skilled nursing facilities to provide written notification to beneficiaries prior to providing an item or service that may not be paid for by Medicare because it is not medically reasonable and necessary or it is custodial care, using the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage. In addition, CMS encourages skilled nursing facilities to provide written notice to beneficiaries prior to providing care that Medicare never covers, including when the 3-day rule was not met, using the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage.

CMS recently released a revised Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage along with newly developed, concise and separate instructions for form completion which included an example for use when the 3-day rule was not met and encouraged skilled nursing facilities to provide notice as a courtesy to the beneficiary and to forewarn them of impending financial obligation.

**OIG Recommendation**

The OIG recommends that CMS provide guidance to hospitals about the importance of explicitly communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent SNF care for Medicare reimbursement so that beneficiaries understand their potential financial liability related to SNF care.

**CMS Response**

CMS concurs with this recommendation. CMS will educate hospitals about the importance of communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent skilled nursing facility care for Medicare reimbursement so that beneficiaries understand their potential financial liability related to skilled nursing facility care.

**OIG Recommendation**

The OIG recommends that CMS provide guidance to SNFs about their responsibility to submit accurate and valid claims for payment that are supported with documentation that clearly shows that the SNF services qualify for reimbursement.

**CMS Response**

CMS concurs with this recommendation. CMS will continue to educate skilled nursing facilities about their responsibility to submit accurate and valid claims for payment that are supported with documentation that clearly shows that the skilled nursing facility services qualify for reimbursement.