Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE OVERPAID INPATIENT REHABILITATION FACILITIES MILLIONS OF DOLLARS FOR CLAIMS WITH LATE PATIENT ASSESSMENT INSTRUMENTS FOR CALENDAR YEARS 2009 AND 2010

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Deputy Inspector General

September 2012
A-01-11-00534

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Under the prospective payment system for inpatient rehabilitation facilities (IRF), the Centers for Medicare & Medicaid Services (CMS) establishes a prospective payment rate for each of 92 distinct case-mix groups. Medicare Part A Medicare Administrative Contractors (MAC), under contract with CMS, use the Fiscal Intermediary Shared System (FISS) to process and pay claims submitted by IRFs.

To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument (PAI) for each IRF stay to the National Assessment Collection Database (the Database). Each IRF must report the date that it transmitted the PAI to the Database on the claim that it submits to the MAC. If an IRF transmits the PAI more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group incurs a 25-percent late-assessment penalty, pursuant to 42 CFR § 412.614(d) and CMS guidance in Transmittal A-01-131.

Our audit covered 2,414 claims totaling $41.6 million that were at high risk of having been overpaid because IRFs had transmitted PAIs to the Database after the 27-day deadline.

OBJECTIVE

Our objective was to determine whether IRFs received reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline.

SUMMARY OF FINDINGS

IRFs often did not receive reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline. Of the 108 claims that we sampled, which had dates of service in calendar years 2009 and 2010, 20 were either canceled or paid correctly. For the remaining 88 claims, IRFs did not receive reduced case-mix-group payments for PAIs that were transmitted to the Database after the 27-day deadline.

Overpayments occurred because IRF and Medicare payment controls were inadequate. Based on our sample results, we estimated that MACs made a total of $8.4 million in overpayments to IRFs.

RECOMMENDATIONS

We recommend that CMS:

- adjust the 88 sampled claims for overpayments of $696,371 to the extent allowed under the law;

- work with the Office of Inspector General to resolve the remaining 2,306 nonsampled claims with potential overpayments estimated at $7.7 million and recover overpayments to the extent allowed under the law;

- continue to provide specific education to IRFs on the importance of reporting the correct PAI transmission dates on their claims;

- complete the process that would allow the FISS to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect PAI transmission dates; and

- support the MACs' and Recovery Audit Contractors' efforts to conduct periodic postpayment reviews of IRF claims.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMMENTS

In written comments on our draft report, CMS concurred with our findings and recommendations and outlined steps for implementing our recommendations. CMS's comments, excluding three technical comments that we addressed as appropriate, are included as Appendix C.

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INTRODUCTION

BACKGROUND

The Prospective Payment System for Inpatient Rehabilitation Facilities

Inpatient rehabilitation facilities (IRF) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. 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. Under the system, CMS establishes a Federal prospective payment rate for each of 92 distinct case-mix groups. The assignment to a case-mix group is based on the beneficiary's clinical characteristics and expected resource needs.

During our audit period, calendar years (CY) 2009 and 2010, CMS contracted with Medicare Part A Medicare Administrative Contractors (MAC) to process and pay claims submitted by institutional providers, including IRFs.[1] MACs use the Fiscal Intermediary Shared System (FISS) for claim processing.

Patient Assessment Instruments

Section 1886(j)(2)(D) of the Act requires IRFs to transmit sufficient patient data to allow CMS to administer the IRF prospective payment system. These data are necessary to assign beneficiaries to the appropriate case-mix groups, to monitor the effects of the IRF prospective payment system on patient care and outcomes, and to determine whether adjustments to the case-mix groups are warranted.

To meet its data needs, CMS requires IRFs to electronically transmit a patient assessment instrument (PAI) for each IRF stay. Each IRF must report the date that it transmitted the PAI to CMS's National Assessment Collection Database (the Database) on the claim that it submits to the MAC. If an IRF transmits the PAI more than 27 calendar days from (and including) the beneficiary's discharge date (the 27-day deadline), the IRF's payment rate for the applicable case-mix group is reduced by a 25-percent late-assessment penalty, pursuant to 42 CFR § 412.614(d) and CMS guidance in Transmittal A-01-131.

Prior Office of Inspector General Report

In 2010, we issued a report entitled *Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007*

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[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that MACs replace fiscal intermediaries by October 2011.

(A-01-09-00507). That report disclosed that IRFs did not always receive reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline. Overpayments occurred because IRF and Medicare payment controls were inadequate. Specifically, IRFs did not have adequate controls to ensure that the PAI transmission dates reported on claims matched the actual dates on which the IRFs transmitted the PAI to the Database. Further, (1) FISS edits were not designed to identify PAIs that were transmitted to the Database 1 day late, (2) Medicare prepayment controls were not designed to compare PAI transmission dates on claims paid by the FISS with the actual dates on which IRFs transmitted the PAI to the Database, and (3) MACs did not conduct postpayment reviews to identify late or missing PAIs. Based on our sample results, we estimated that MACs made a total of $20.2 million in overpayments to IRFs. We recommended that CMS recover any overpayments and establish specific corrective actions to prevent and detect subsequent overpayments.

Corrective Actions

Based on the recommendations from our previous report, CMS implemented a system change[2] that revised the FISS edit to count the discharge date as day 1 in the 27-day period for transmitting the PAI and for avoiding the 25-percent payment penalty. In addition, CMS is developing an interface between the FISS system and the Database that could begin affecting claims submitted as early as October 2012. Furthermore, CMS stated that the MACs and the Recovery Audit Contractors (RAC) started a postpayment review process to identify and collect on IRF claims that are subject to the 25-percent penalty.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether IRFs received reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline.

Scope

Nationwide, IRFs submitted a total of 509,957 claims valued at $8.6 billion with dates of service in CYs 2009 and 2010. Our audit covered 2,414 claims totaling $41.6 million that were at high risk of having been overpaid because, according to the transmission date in the Database, the IRF had transmitted the PAI to the Database after the 27-day deadline.

Our objective did not require an understanding or assessment of the complete internal control structures of IRFs, CMS, or MACs. Therefore, we limited our review at IRFs to the controls related to reporting PAI transmission dates on Medicare claims. We limited our review at CMS and selected MACs to the controls related to preventing or detecting Medicare overpayments to IRFs for claims with PAIs that were transmitted to the Database after the 27-day deadline.

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[2] CMS implemented the system change on October 5, 2009, which was after completion of our fieldwork and prior to issuance of the draft report.

Our fieldwork consisted of contacting IRFs nationwide, visiting two IRFs in Connecticut and New York, and contacting two MACs. We conducted our fieldwork during January and February 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- interviewed officials from CMS and two MACs to gain an understanding of edits in the FISS and other controls intended to prevent or detect Medicare overpayments to IRFs;

- extracted IRF paid claim data from CMS's National Claims History file for CYs 2009 and 2010;

- obtained from CMS a Database of all the original submissions of PAIs for claims with dates of service in CYs 2009 and 2010;

- developed a computer match between the National Claims History file and the Database that identified 2,414 claims that, according to the Database, had PAI transmission dates that were more than 27 days after (and including) the beneficiaries' discharge dates on the claims;

- selected a stratified random sample of 108 claims from the 2,414 claims (Appendix A);

- reviewed data from CMS's Common Working File for the 108 sampled claims to (1) validate claim information extracted from the National Claims History file, (2) verify that the late-assessment penalty had not been applied, and (3) determine whether any of the selected claims had been canceled;

- contacted representatives from the 49 IRFs that submitted the 108 sampled claims to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for our sampled claims by reducing the prospective payment rate for the applicable case-mix group by 25 percent;

- estimated the total value of overpayments based on our sample results (Appendix B); and

- discussed the results of our review with CMS.

We assessed the reliability of IRF data by (1) performing electronic testing of required data elements, (2) reviewing existing information about the data and the system that produced them, and (3) interviewing agency officials knowledgeable about the data. In addition, we traced a random sample of data to source documents. We determined that the data were reliable for the purpose of this audit.

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 objective.

FINDINGS AND RECOMMENDATIONS

IRFs often did not receive reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline. Of the 108 claims that we sampled, which had dates of service in CYs 2009 and 2010, 20 were either canceled or paid correctly.[3] For the remaining 88 claims, IRFs did not receive reduced case-mix-group payments for the PAIs that were transmitted to the Database after the 27-day deadline.

Overpayments occurred because IRF and Medicare payment controls were inadequate. Based on our sample results, we estimated that MACs made a total of $8.4 million in overpayments to IRFs.

PROGRAM REQUIREMENTS

Pursuant to 42 CFR § 412.614, IRFs must electronically transmit to CMS timely, complete, and accurate encoded data from the PAI for each Medicare Part A beneficiary.

CMS guidance in Transmittal A-01-131, dated November 1, 2001, elaborates on the requirement for timely transmission of the PAI set forth in 42 CFR § 412.614(c) and (d). The guidance states that an IRF must transmit PAI data to the Database by the 17th calendar day from the date of the beneficiary's discharge. If the actual transmission date is more than 10 calendar days from the mandated transmission date, CMS considers the PAI late, and, pursuant to 42 CFR § 412.614(d), the IRF's payment rate for the applicable case-mix group is reduced by a 25-percent late-assessment penalty. Therefore, if the IRF transmits the PAI more than 27 calendar days from the discharge date (with the discharge date itself starting the counting sequence), the 25-percent penalty should be applied.

Additional CMS guidance in Transmittal 291, dated August 27, 2004, states that for a discharge on or after October 1, 2004, the IRF must record the date of the PAI transmission in the "Service Date" field of the claim.[4]

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[3] We identified some claims that had a PAI transmission date that was earlier than the transmission date recorded in the Database. In these instances the IRF submitted a PAI that was accepted by the Database; however, the IRF at a later date canceled that PAI and retransmitted another one. The PAI transmission date recorded in the Database is the date that the PAI was retransmitted. We considered these claims to be paid correctly if the earlier transmission date was within the 27-day deadline.

[4] CMS Transmittal 2011, dated July 30, 2010, revised the billing instructions to require IRFs to use occurrence code 50 to record the date of the PAI transmission. The "Service Date" field is no longer used as of January 1, 2011.

LATE TRANSMISSION OF PATIENT ASSESSMENT INSTRUMENTS

Overpayments Made to Inpatient Rehabilitation Facilities

Contrary to Medicare regulations, IRFs did not receive reduced case-mix-group payments for 88 sampled claims with PAIs that were transmitted to the Database after the 27-day deadline. IRFs reported incorrect transmission dates on the 88 claims. IRFs transmitted the PAIs that related to these 88 claims to the database from 1 to 424 days after the 27-day deadline. On average, IRFs transmitted these PAIs 70 days after the deadline. The IRFs received overpayments totaling $696,371 for these 88 claims.

Causes of Overpayments

Inadequate Controls at Inpatient Rehabilitation Facilities

IRFs did not ensure that the PAI transmission dates reported on their claims matched the actual dates on which the IRFs transmitted the PAIs to the Database. IRF officials informed us that clinical staff who transmitted PAIs to the Database did not always effectively communicate PAI transmission dates to billing staff, who were responsible for recording the dates on the claims. When the clinical staff did not communicate the PAI transmission dates to the billing staff, the billing staff often recorded the beneficiaries' discharge dates as the PAI transmission dates. In other instances, IRFs' billing systems did not include correct transmission dates on the claims. Specifically, the claims included the date that IRF staff completed the PAI instead of the date the staff transmitted the PAI to the Database.

Inadequate Medicare Payment Controls

During the period of our review, CMS payment controls were not adequate to detect and prevent overpayments. Specifically, Medicare prepayment controls were not designed to compare the PAI transmission dates on claims paid by the FISS with the actual dates on which IRFs transmitted the PAI to the Database.[5] In addition, although CMS officials stated that the MACs and RACs had started a postpayment review process, no postpayment reviews had been performed as of the end of our fieldwork. Further, the FISS edit did not count the discharge date as day 1 in the 27-day sequence for the first 9 months of our review period. Lastly, until April 2010, CMS did not provide specific education to IRFs on the importance of submitting PAIs on time.

PAYMENT ESTIMATES

Based on our sample results, we estimated that for services provided in CYs 2009 and 2010, MACs made a total of $8.4 million in overpayments to IRFs for claims that should have been reduced by the 25-percent penalty because the associated PAIs were transmitted to the Database after the 27-day deadline.

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[5] During the course of our review, CMS began working on the interface between the FISS system and the Database.

RECOMMENDATIONS

We recommend that CMS:

- adjust the 88 sampled claims for overpayments of $696,371 to the extent allowed under the law;
- work with the Office of Inspector General to resolve the remaining 2,306 nonsampled claims with potential overpayments estimated at $7.7 million and recover overpayments to the extent allowed under the law;
- continue to provide specific education to IRFs on the importance of reporting the correct PAI transmission dates on their claims;
- complete the process that would allow the FISS to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect PAI transmission dates; and
- support the MACs' and RACs' efforts to conduct periodic postpayment reviews of IRF claims.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMMENTS

In written comments on our draft report, CMS concurred with our findings and recommendations and outlined steps for implementing our recommendations. CMS's comments, excluding three technical comments that we addressed as appropriate, are included as Appendix C.

APPENDIXES

APPENDIX A: SAMPLING DESIGN AND METHODOLOGY

POPULATION

The population consisted of nationwide Medicare inpatient rehabilitation facility (IRF) claims for calendar years (CY) 2009 and 2010.

SAMPLING FRAME

We obtained a Microsoft Access table of 509,957 nationwide Medicare IRF claims that had a total claim paid amount of $8,587,067,452.33 through dates of service in CYs 2009 and 2010 from the National Claims History file. Each claim paid amount was greater than zero dollars and was not related to claims for Medicare Managed Care. Each table record (row) corresponded to one IRF claim. The audit team then removed 4,344 claims that contained services with revenue center dates that were greater than 27 days from their associated claim through dates (usually the patient's discharge date). We also removed 13 duplicate claims. This resulted in an Access table containing 505,600 IRF claims with a total claim paid amount of $8,529,071,038.14.

We obtained a second Access table from the Centers for Medicare & Medicaid Services that consisted of 887,630 rows for original IRF patient assessment instrument (PAI) submissions for CYs 2009 and 2010. Each row corresponded to a single IRF-PAI. We used Access to match and combine data from the IRF claim and PAI tables. We removed all non-Medicare fee-for-service PAI submissions and Medicare PAI submissions transmitted within the 27-day deadline. The resulting Access table of matched data was exported to an Excel spreadsheet that contained 2,428 rows for IRF claims with their matching PAI data. We then removed rows for claims with claim payment amounts less than or equal to $1,000.

The resulting Excel spreadsheet contained a sampling frame of 2,414 IRF claims with a total claim paid amount of $41,612,184.90.

SAMPLE UNIT

The sample unit was an IRF claim.

SAMPLE DESIGN

Our sample design was a stratified random sample with the following four strata:

Stratum	Claim Paid Amount Range	Number of IRF Claims	Dollar Value of IRF Claims
1	$1,084.80 to $13,690.99	1,022	$9,451,000
2	$13,691 to $24,004.99	956	17,255,293
3	$24,005 to $58,390.98	418	13,479,648
4 (100% Review)	Greater than $58,390.98	18	1,426,244
Total		**2,414**	**$41,612,185**

SAMPLE SIZE

We randomly selected 30 claims from stratum 1, 30 claims from stratum 2, and 30 claims from stratum 3. We also reviewed the 18 claims in stratum 4. Therefore, our total sample size was 108 claims. We considered the results of prior audits when we selected our sample size.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLED UNITS

We consecutively numbered the sample units in the frame from 1 to 1,022 for stratum 1, from 1 to 956 for stratum 2, and 1 to 418 for stratum 3. After generating 30 random numbers for stratum 1, 30 random numbers for stratum 2, and 30 random numbers for stratum 3, we then selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the dollar value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	IRF Claims in Error	Value of Overpayments
1	1,022	$9,451,000	30	$258,006	23	$50,441
2	956	17,255,293	30	532,674	26	115,576
3	418	13,479,648	30	998,939	22	189,855
4 (100% Review)	18	1,426,244	18	1,426,244	17	340,499
Total	**2,414**	**$41,612,185**	**108**	**$3,215,863**	**88**	**$696,371**

Estimated Overpayments
(*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$8,387,204
Lower limit	7,594,480
Upper limit	9,179,928

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs

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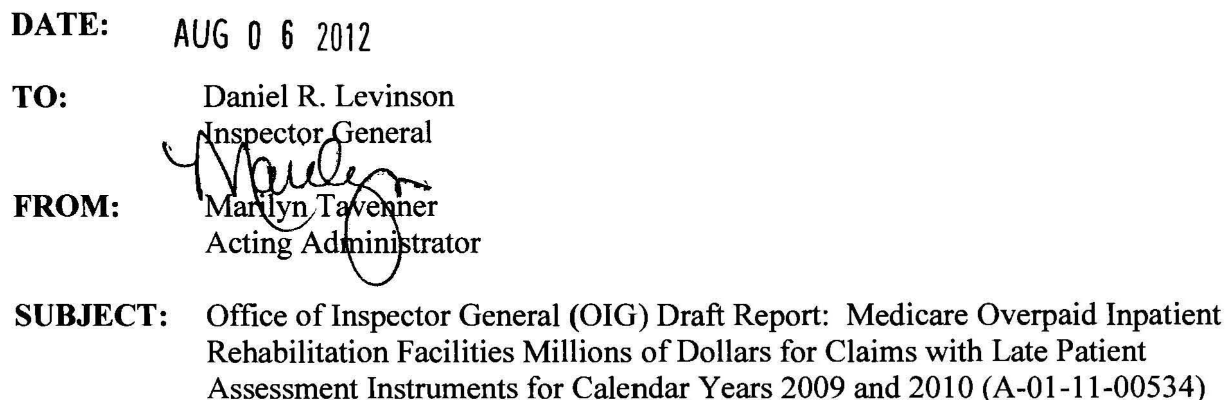

DATE: AUG 0 6 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims with Late Patient Assessment Instruments for Calendar Years 2009 and 2010 (A-01-11-00534)

Thank you for the opportunity to review and comment on the OIG draft report entitled, "Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims with Late Patient Assessment Instruments for Calendar Years 2009 and 2010" (A-01-11-00534). The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has utilized in reviewing this issue. The foundation for conducting the audit is based on the recommendations from a previous OIG report, "Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007" (A-01-09-00507). CMS implemented a system change that revised the Fiscal Intermediary Shared System (FISS) edit to count the discharge date as day 1 in the 27-day period for transmitting the patient assessment instruments (PAI) and for avoiding the 25 percent payment penalty. In addition, CMS is developing an interface between the FISS system and the Database that could begin affecting claims submitted as early as October 2012. Furthermore, CMS stated that the Medicare Administrative Contractors (MACs) and the Recovery Audit Contractors (RACs) started a postpayment review process to identify and collect on inpatient rehabilitation facility (IRF) claims that are subject to the 25 percent penalty.

The OIG's study reports IRFs did not always receive reduced case-mix-group payments for claims with PAIs that were transmitted to the Database after the 27-day deadline. Of the 108 claims that were sampled with dates of service in calendar years 2009 and 2010, 20 were either canceled or paid correctly. For the remaining 88 claims, IRFs did not receive reduced case-mix-group payments for PAIs that were transmitted to the Database after the 27-day deadline. Based on the OIG sample results, they estimated that MACs made a total of $8.4 million in overpayments to IRFs.

The CMS appreciates the effort that went into this report and looks forward to continuing to work with the OIG on safeguarding the Medicare program. We have reviewed the report and have provided technical comments in addition to responding to OIG recommendations.

OIG Recommendation 1

The OIG recommends that CMS adjust the 88 sampled claims for overpayments of $696,371 to the extent allowed under the law.

CMS Response

The CMS concurs. CMS has reviewed the sample claims from OIG and plans to recover the identified overpayments consistent with the agency's policies and procedures.

OIG Recommendation 2

The OIG recommends that CMS work with the Office of Inspector General to resolve the remaining 2,306 nonsampled claims with potential overpayments estimated at $7.7 million and recover overpayments to the extent allowed under the law.

CMS Response

The CMS concurs. Upon receipt of the files from OIG, CMS will provide the A/B MACs with their IRFs questionable claims as identified by OIG. CMS requests that OIG furnish the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, health insurance claim numbers, etc.). In addition, CMS requests that Medicare contractor-specific data be written to separate CD-ROMs or sent to a secure portal to better facilitate the transfer of information to the appropriate contractors. We will instruct the contractors to consider taking the appropriate actions on the suppliers identified in this report and the additional claim information when prioritizing their Medicare review strategies or other interventions.

The Recovery Auditors review Medicare Fee-For-Service claims on a post-payment basis and are tasked with identifying overpayments. While CMS does not mandate areas for review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

OIG Recommendation 3

The OIG recommends that CMS provide specific education to IRFs on the importance of reporting the correct PAI transmission dates on their claims.

CMS Response

The CMS concurs. Since April 2010, CMS's National Assessment Collection Database has been sending the following alert to IRFs when they transmit late patient assessment instruments: "This data record has been transmitted late. The transmission date must be reported on your Medicare claim, and may result in a late transmission penalty."

For assessments submitted on or after October 1, 2012, the alert will be updated to include more detail about the late transmission policy, including that the assessment must be submitted within 27 days of the date of discharge. Also, we are issuing instructions to the fiscal intermediaries and MACs to provide specific education to IRFs on the importance of recording the correct IRF-PAI transmission dates on their claims. We will continue to work with the associations that represent the IRF industry to reiterate the importance of reporting the correct patient assessment instrument transmission dates on the claims.

OIG Recommendation 4

The OIG recommends that CMS complete the process that would allow the FISS to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect PAI transmission dates.

CMS Response

The CMS concurs. CMS has completed the design process that would allow the FISS to interface with the PAI Database to identify IRF claims with incorrect PAI transmissions dates on a prepayment basis. An instruction (Change Request 7760) as part of CMS Quarterly System Release process was completed and published on April 27, 2012, for implementation with the October 2012 quarterly system release.

OIG Recommendation 5

The OIG recommends that CMS support the MACs' and Recovery Audit Contractors' efforts to conduct periodic postpayment reviews of IRF claims.

CMS Response

The CMS concurs. CMS will issue a Joint Signature Memorandum/Technical Direction Letter to the MACs and RACs with a link to the OIG report and specific claims information. CMS will inform them that these findings are informational and shall be considered a source of data as they prioritize their workload, along with all other data they consider.