Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
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DEC 2 1 2006

CIN: A-01-06-00506

Ms. Shalini Kumari
Director, Medicare Operations
Associated Health Service
Anthem Health Plans of New Hampshire
1515 Hancock Street
Quincy, MA 02169

Dear Ms. Kumari:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Review of Associated Hospital Service Payments to Long Term Care Hospitals From January 1, 2003 Trough April 30, 2004."

Final determination as to actions taken on all matters will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should include any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General reports are made available to members of the public to the extent information contained therein is not subject to exemptions under the Act (See 45 CFR Part 5).

To facilitate identification, please refer to report number A-01-06-00506 in all correspondence.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Charlotte S. Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
U.S. Department of Health and Human Services
J.F.K Federal Building, Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Review of Associated Hospital Service Payments to Long-Term Care Hospitals in Massachusetts From January 1, 2003, Through April 30, 2004

Daniel R. Levinson
Inspector General

(December 2006)
A-01-06-00506

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare Payment Regulations

Before October 1, 2002, Medicare paid long-term care hospitals (LTCH) based on reasonable costs pursuant to Section 1886(d) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982. The Centers for Medicare & Medicaid Services (CMS) implemented a new discharge-based prospective payment system for LTCHs for cost reporting periods beginning on or after October 1, 2002.

Medicare provides each beneficiary 90 regular Part A covered benefit days for an episode of care. Each beneficiary also has 60 lifetime reserve days that may be used to cover additional days of an episode of care after the beneficiary has used the 90 regular benefit days. When using lifetime reserve days, beneficiaries pay a coinsurance amount equal to one half of the inpatient hospital deductible.

The LTCH prospective payment system uses long-term care diagnosis-related groups (DRGs) as a patient classification system. Each DRG has a predetermined average length of stay that is used to determine when a beneficiary's LTCH stay qualifies for a full DRG payment. Medicare pays LTCHs a full DRG payment for a stay that exceeds five-sixths of the average length of stay for the DRG. If a beneficiary uses all of his or her Medicare-covered days, including lifetime reserve days, before the stay qualifies for a full DRG payment, Medicare pays LTCHs only for the beneficiary's covered benefit days. This type of DRG payment is called a short-stay outlier payment. The beneficiary is responsible for the remaining days of the stay.

The Medicare program requires fiscal intermediaries to be responsible for making DRG payments, including short-stay outlier payments. The fiscal intermediary is also responsible for ensuring that LTCHs include the appropriate codes on claims that they file and for requesting that LTCHs resubmit their claims if they have not included the appropriate codes on the original claim.

Associated Hospital Service

Associated Hospital Service (the Intermediary) is the fiscal intermediary for LTCHs in Massachusetts. Until April 30, 2004, the Intermediary used the Arkansas Part A Standard System to process Medicare claims. Since May 1, 2004, the Intermediary has used the Fiscal Intermediary Shared System.

OBJECTIVE

The objective of our review was to determine whether the Intermediary paid the eight Massachusetts LTCHs' claims in accordance with Medicare requirements when beneficiaries had used all of their regular covered benefit days.

SUMMARY OF FINDINGS

The Intermediary did not always pay LTCH claims in accordance with Medicare requirements when the beneficiaries had used all of their regular covered benefit days. Specifically, the Intermediary made full DRG payments for (1) claims that should have been reduced to a short-stay outlier payment and (2) claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. As a result, the Intermediary made overpayments totaling $936,418 for 83 claims to 8 LTCHs for services provided from January 1, 2003, through April 30, 2004. Payment errors occurred because the Intermediary did not follow procedures to ensure that LTCHs' claims contained the appropriate coverage status codes when beneficiaries had used all of their covered benefit days before their length of stay qualified for a full DRG payment.

RECOMMENDATION

We recommend that the Intermediary recover the overpayments made to 8 LTCHs for the 83 claims totaling $936,418.

Because the Intermediary no longer uses the Arkansas Part A Standard System to process claims, we have no procedural recommendations. The current claims processing system does not allow the LTCHs to enter inappropriate codes to incorrectly process claims for beneficiaries who have used all of their regular covered benefit days before their length of stay qualifies for a full DRG payment.

INTERMEDIARY'S COMMENTS

In its comments to our draft report, AHS generally agreed to implement our recommendation. However, the Intermediary noted that the overpayment related to only 83 of the 106 LTCH claims processed incorrectly. The Intermediary also stated that an unidentified system error caused the problem. We have included the Intermediary's comments in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We have amended our report to reflect that the overpayments related to only 83 of the 106 claims that the Intermediary processed incorrectly. However, although we agree that the Arkansas Part A Standard System rejected claims that LTCHs had properly submitted, we maintain that it was the Intermediary's responsibility to ensure that its instructions to the LTCHs would result in the appropriate payments.

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INTRODUCTION

BACKGROUND

Medicare Payment Regulations

Before October 1, 2002, Medicare paid long-term care hospitals (LTCH) based on reasonable costs pursuant to Section 1886(d) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982. To control escalating costs, the Balanced Budget Refinement Act of 1999 mandated a new discharge-based prospective payment system for LTCHs. The Centers for Medicare & Medicaid Services (CMS) implemented this system for cost reporting periods beginning on or after October 1, 2002.

Medicare provides each beneficiary 90 regular Part A covered benefit days for an episode of care under the inpatient hospital benefit. LTCH patients often begin an episode of care in an acute care hospital and thus may have used part or all of their covered benefit days before they are admitted to the LTCH. However, each beneficiary also has 60 lifetime reserve days. These lifetime reserve days may be used to cover additional days of an episode of care after the beneficiary has used the 90 regular benefit days. When using lifetime reserve days, beneficiaries pay a coinsurance amount equal to one half of the inpatient hospital deductible.

The LTCH prospective payment system uses long-term care diagnosis-related groups (DRGs) as a patient classification system. Each beneficiary's stay in an LTCH is assigned to a specific DRG based on the beneficiary's diagnosis, procedures, age, gender, and discharge status. Each DRG has a predetermined average length of stay that is used to determine when a beneficiary's LTCH stay qualifies for a full DRG payment.

Medicare pays LTCHs a full DRG payment for a stay that exceeds five-sixths of the average length of stay for the DRG. When the beneficiary's length of stay in the LTCH is not long enough to qualify for a full DRG payment, the beneficiary must use available covered benefit days to continue Medicare coverage until the stay reaches the threshold for a full DRG payment. If a beneficiary does not have enough regular covered days to reach the threshold, the beneficiary must use his or her available lifetime reserve days to continue Medicare coverage. If a beneficiary uses all of his or her Medicare-covered days, including lifetime reserve days, before the stay qualifies for a full DRG payment, Medicare pays LTCHs only for the beneficiary's covered benefit days. This type of DRG payment is called a short-stay outlier payment. The beneficiary is responsible for the remaining days of the stay.

Hospital Billing and Fiscal Intermediary Payment

CMS's "Medicare Claims Processing Manual" requires LTCHs to submit claims data for both Medicare covered and noncovered days to fiscal intermediaries on Form CMS-1450. The LTCHs are responsible for correctly coding their claims on this form to reflect the beneficiaries' coverage status.

The Medicare program requires fiscal intermediaries to be responsible for making DRG payments, including short-stay outlier payments. The fiscal intermediary is also responsible for ensuring that

LTCHs include the appropriate codes on the claims when these codes are needed and for requesting that LTCHs resubmit their claims if they have not included the appropriate codes on the original claim.

Associated Hospital Service

Associated Hospital Service (the Intermediary) is the fiscal intermediary for LTCHs in Massachusetts. Until April 30, 2004, the Intermediary used the Arkansas Part A Standard System to process Medicare claims. Since May 1, 2004, the Intermediary has used the Fiscal Intermediary Shared System.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the Intermediary paid the eight Massachusetts LTCH's claims in accordance with Medicare requirements when beneficiaries had used all of their regular covered benefit days.

Scope

Our review covered payments that the Intermediary made to LTCHs from January 1, 2003, to April 30, 2004.

Our objective did not require an understanding or assessment of the complete internal control structure at the Intermediary. Therefore, we limited our review to obtaining an understanding of the Intermediary's controls related to processing and paying LTCH claims.

We performed our review from April through August 2006. Our fieldwork included contacting the eight Massachusetts LTCHs by phone and visiting three of these LTCHs. We also performed fieldwork at the Intermediary's office in Quincy, Massachusetts.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and Medicare program guidance;
- extracted data from CMS's National Claims History on LTCH claims that the Intermediary paid for beneficiaries who had used all of their regular covered benefit days to compare the number of Medicare-covered days in a beneficiary's stay with the number of days in the DRG threshold;
- verified LTCH payment data for selected claims with the highest payment amounts with payment data from CMS's Common Working File and analyzed claims details;

- assessed the risk of overpayment by calculating DRG payments for the selected claims using CMS LTCH PRICER software;

- requested data on all claims that the Intermediary paid during our audit period for beneficiaries who had used all of their regular covered benefit days to determine the total amount of overpayments to LTCHs;

- verified claims detail and discussed billing practices with the eight LTCHs that received all of the overpayments that we identified; and

- discussed the results of our review with officials at the Intermediary.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The Intermediary did not always pay LTCH claims in accordance with Medicare requirements when the beneficiaries had used all of their regular covered benefit days. Specifically, the Intermediary made full DRG payments for (1) claims that should have been reduced to a short-stay outlier payment and (2) claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. As a result, the Intermediary made overpayments totaling $936,418 for 83 claims to 8 LTCHs for services provided from January 1, 2003, through April 30, 2004. Payment errors occurred because the Intermediary did not follow procedures to ensure that LTCHs' claims contained the appropriate coverage status codes when beneficiaries had used all of their covered benefit days before their length of stay qualified for a full DRG payment.

PROGRAM REQUIREMENTS

Pursuant to 42 CFR § 412.529, a short-stay outlier is a length of stay between one day and up to and including five-sixths of the average length of stay for the DRG with which the episode of care is grouped. Under the prospective payment system, Medicare pays LTCHs only for covered benefit days until the length of stay exceeds five-sixths of the average length of stay, which results in a full DRG payment.

The Medicare Benefit Policy Manual (the Manual), chapter 5, section 10, states that each Medicare beneficiary who has used 90 days of services in a benefit period for hospital inpatient care is entitled to draw upon a lifetime reserve of 60 days of inpatient hospital services covered under Medicare Part A. A benefit period is a period of consecutive days during which medical benefits for covered services are available to the beneficiary. Section 30.6 of the Manual states that when a beneficiary has run out of regular benefit days before reaching the short-stay outlier threshold, the remaining days of the stay will be counted against the beneficiary's available lifetime reserve days (unless the beneficiary chooses not to use them).

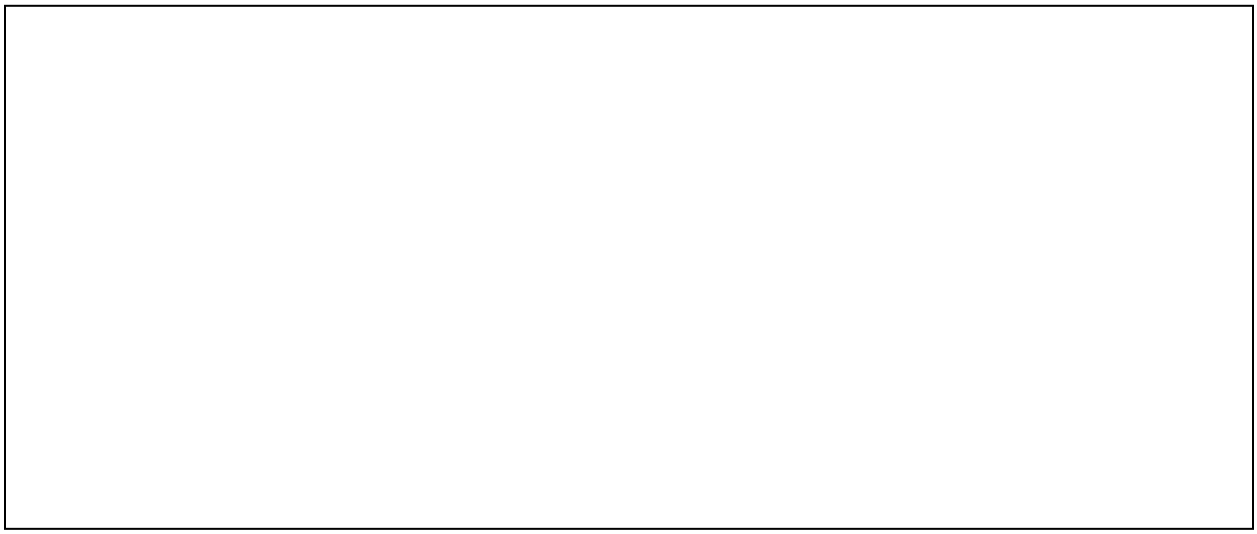
Section 1813 of the Social Security Act provides for an inpatient hospital deductible and certain coinsurance amounts to be subtracted from the amount that Medicare pays for inpatient hospital services furnished to a beneficiary. The daily coinsurance for lifetime reserve days is one-half of the inpatient hospital deductible.

OVERPAYMENTS FOR LONG-TERM CARE HOSPITAL CLAIMS

The Intermediary made overpayments for 83 out of 106 claims to eight LTCHs for services provided from January 1, 2003, through April 30, 2004. Specifically, the Intermediary made full DRG payments for 28 claims that should have been reduced to a short-stay outlier payment and 55 claims that should have been reduced by the beneficiaries' coinsurance amounts for lifetime reserve days. The remaining 23 claims processed incorrectly did not result in overpayments.

Claims Not Reduced to Short-Stay Outlier Payment

The Intermediary made full DRG payments for 28 claims that qualified only for short-stay outlier payments. In other words, the Intermediary should have paid LTCHs only for the beneficiaries' covered benefit days. In each of these cases, the beneficiary had used all covered benefit days, including available lifetime reserve days, before the LTCH stay reached the threshold for qualifying for a full DRG payment.

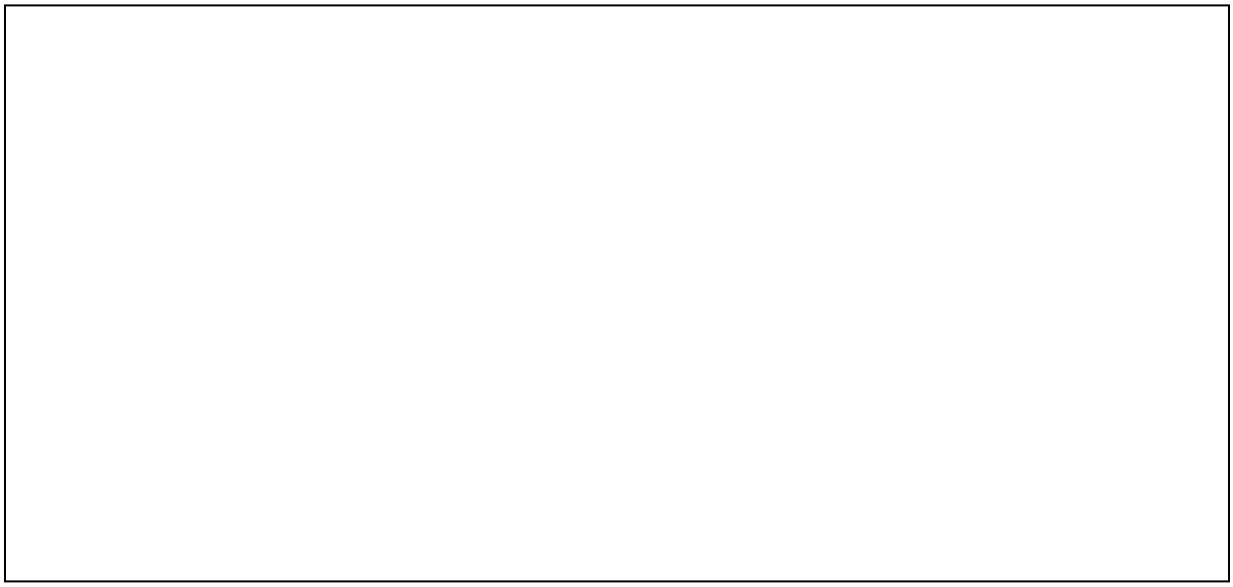


When billing these 28 claims, the LTCHs properly used a combination of coverage status codes that the Arkansas Part A Standard System incorrectly identified as improperly billed and flagged for the Intermediary to review. However, instead of recognizing that the submitted coding was correct, the Intermediary mistakenly instructed the LTCH to adjust the submitted coding on the claims. As a result of these incorrect codes, the Arkansas Part A Standard System then misread the availability of the beneficiary's lifetime reserve days, used the 60 used lifetime reserve days as available, and made a full DRG payment.

Claims Not Reduced by Beneficiaries' Coinsurance Amounts

The Intermediary made full DRG payments for 55 claims that it should have reduced by the coinsurance amounts that beneficiaries pay for each lifetime reserve day that they use. For these claims, the beneficiaries had used all of their regular covered benefit days but had enough remaining lifetime reserve days to qualify for a full DRG payment. Thus, the Intermediary should have

instructed the LTCHs to use the beneficiaries' lifetime reserve days and reduced the LTCHs' payments by the beneficiaries' coinsurance amounts, as Medicare requires.



When processing these 55 claims, the Intermediary misunderstood the requirements and used the wrong code for the dates of service after the beneficiaries' regular covered days had been exhausted. The Intermediary then overrode the payment system edits to generate full DRG payments without using the beneficiaries' available lifetime reserve days.

CAUSES OF PAYMENT ERRORS

Payment errors occurred because the Intermediary did not follow procedures to ensure that LTCHs used the appropriate coverage status codes, as specified by the Medicare Claims Processing Manual, when billing claims for beneficiaries who had used all of their covered benefit days before their length of stay qualified for a full DRG payment. The Arkansas Part A Standard System identified exhausted benefits and unused lifetime reserve days on the claims that the LTCHs submitted to the Intermediary. However, the Intermediary misinterpreted the system's instructions and requested that the LTCHs enter inappropriate codes.

MEDICARE OVERPAYMENTS

The Intermediary made overpayments totaling $936,418 for 83 claims to eight LTCHs for services provided from January 1, 2003, through April 30, 2004. Specifically, the Intermediary overpaid LTCHs (1) $517,782 for 28 claims that it paid as full DRGs rather than as short-stay outlier adjusted payments and (2) $418,626 for 55 claims that it should have reduced by beneficiaries' coinsurance amounts for available lifetime reserve days.

RECOMMENDATION

We recommend that the Intermediary recover the overpayments made to 8 LTCHs for 83 claims totaling $936,418.

Because the Intermediary no longer uses the Arkansas Part A Standard System to process claims, we have no procedural recommendations. The current claims processing system does not allow the LTCHs to enter inappropriate codes to incorrectly process claims for beneficiaries who have used all of their regular covered benefit days before their length of stay qualifies for a full DRG payment.

INTERMEDIARY'S COMMENTS

In its comments to our draft report, AHS generally agreed to implement our recommendation. However, the Intermediary noted that the overpayment related to only 83 of the 106 LTCH claims processed incorrectly. The Intermediary also stated that an unidentified system error caused the problem. We have included the Intermediary's comments in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We have amended our report to reflect that the overpayments related to only 83 of the 106 claims that the Intermediary processed incorrectly. However, although we agree that the Arkansas Part A Standard System rejected claims that LTCHs had properly submitted, we maintain that it was the Intermediary's responsibility to ensure that its instructions to the LTCHs would result in the appropriate payments.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
Part A Intermediary
Maine, Massachusetts,
New Hampshire,
Vermont and
Regional Home Health
Intermediary

December 18, 2006

Report Number: A-01-06-00506

Mr. Michael Armstrong
Regional Inspector General for Audit Services
Office of Inspector General, U.S. Department of Health and Human Services
Office of Audit Services
JFK Federal Building, Suite 2425
Boston, MA 02203

Dear Mr. Armstrong:

This is our response to your draft report entitled "Review of Associated Hospital Service Payments to Long-Term care Hospitals From January 1, 2003 through April 30, 2004." Associated Hospital Services agrees with your recommendations. We discussed the following at our meeting on Monday with David Lamir and Eric Cohen, please consider revising the following:

Page i, paragraph "Associated Hospital Service." Associated Hospital Service (the Intermediary) is the fiscal intermediary for LTCHs in Massachusetts, New Hampshire, Vermont, and Maine.

Page ii, paragraph "RECOMMENDATION." The actual overpayments were made to 83 claims totaling $936,418.20.

Page 4, paragraph "Claims not reduced to Short Stay Outlier Payment." The full DRG payments were for 28 claims not for 49 claims.

Page 4, paragraph "Claims not reduced to Short Stay Outlier Payment." To clarify, the APASS system would not allow benefit exhaust code A3 to be used in conjunction with occurrence code 76 due to a problem within the APASS system at that time. The intermediary decided in error that the benefit exhaust code A3 should have been used only in the remarks section and instructed the providers in error. The intermediary did not key LTR days on the claim. The system somehow showed 60 LTR days on the Pricing page (pg14). The information on page 14 is what is sent to PRICER. PRICER calculated the payment based on the days found in the LTR DYS USED field. The field was populated with the incorrect information by the system in what looks like an undetected system problem. Each one of the claims that were identified had erroneous LTR days posted to the Pricing page. This is a field that is not updatable by our clerks.

Associated Hospital Service
Anthem Health Plans of NH, Inc.
Serving the Medicare community from several offices including:
Portland, ME Quincy, MA Lynnfield, MA Manchester, NH

P O Box 919

Page 4; paragraph "Claims Not Reduced by Beneficiaries' Coinsurance Amounts." Were for 55 claims not 57.

It is also important to note the following potential issues when recovering the overpayment amounts.

First, in the situation where life days should have been used, the LTR days may no longer be available to use once the adjustment is initiated. The LTR days could be used by the beneficiary on a later bill. The adjustment can be entered, however, the actual reimbursement amount and the lifetime reserve coinsurance amounts may be subject to change if the LTR days available change

Second, for three of the impacted LTCHs, a "Claims Accounts Receivable" may result when Claim Adjustments are eventually processed (once official approval is received from the OIG).

Third, it is also important to note the impact that this may have on the beneficiary if the provider bills them the difference in co-insurance. There is also the change the beneficiary may be deceased.

Based on your recommendations and direction from CMS, Associated Hospital Services will continue to work with our Claims, Audit and Reimbursements and Business Analysis Areas to resolve the overpayments identified in your findings.

Sincerely,

Shalini Kumari

Shalini Kumari, MHA
Associated Hospital Service
Anthem Health Plans of New Hampshire, Inc.

CC: David Lamir, Audit Manager
Eric Cohen, Auditor