DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

March 26, 2003

CIN: A-05-02-00086

Mr. Michael McCarron
President and COO
AdminaStar Federal, Inc.
8115 Knue Road
Indianapolis, Indiana 46250

Dear Mr. McCarron:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of AdminaStar Federal." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported 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 present 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), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-02-00086 in all correspondence relating to this report.

Sincerely,

Paul Swanson
Regional Inspector General
    for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

David Dupre – CMS Acting Regional Administrator
Centers for Medicare & Medicaid Services – Region V
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ADMINASTAR FEDERAL

JANET REHNQUIST
Inspector General

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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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, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part5.)

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

OBJECTIVE

The audit objective was to determine the extent of ineligible Medicare Skilled Nursing Facilities (SNF) payments contained in our database of payments made under the administrative responsibility of AdminaStar Federal (AdminaStar).

FINDINGS

We estimate that the Medicare program improperly paid $25.3 million to SNF providers that should be recovered by AdminaStar. Based on a sample of 200 SNF stays, we estimate that 86.5 percent of the AdminaStar database is not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of SNF admission.

The absence of automated cross-checking, within the Centers for Medicare and Medicaid Services' (CMS) Common Working File (CWF) and AdminaStar's claims processing systems, allowed ineligible SNF claims to be paid. Because a comparison of the actual dates of the inpatient stay on the hospital claim to the inpatient hospital dates on the SNF claim did not occur, a qualifying three-day hospital stay preceding the SNF admission was not verified. Neither the CWF nor AdminaStar have an automated means to match an inpatient stay to a SNF admission and to generate a prepayment alert that a SNF claim does not qualify for Medicare reimbursement. As a result, unallowable SNF claims amounting to $25.3 million were paid without being detected.

RECOMMENDATIONS

We recommend that AdminaStar:

- Initiate recovery actions estimated to be $25.3 million or support the eligibility of the individual stays included in the database.

- Initiate SNF provider education to emphasize Medicare interpretations which establish an eligible three-day inpatient hospital stay and qualify a SNF admission for Medicare reimbursement.

In their written response to our draft report, AdminaStar agreed with the findings and recommendations presented in the report. The full text of AdminaStar's response is included as Appendix B to this report.

TABLE OF CONTENTS

Glossary of Abbreviations and Acronyms

AdminaStar   AdminaStar Federal

CFR   Code of Federal Regulations

CMS   Centers for Medicare and Medicaid Services

CWF   Common Working File

FI   Fiscal Intermediary

HIC   Health Insurance Claim

INPL   Inpatient Listing

SNF   Skilled Nursing Facility

INTRODUCTION

BACKGROUND

Skilled Nursing Facilities

A SNF is an institution primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care and the rehabilitation for the injured, disabled, and sick. To qualify for Medicare reimbursement, a SNF stay must be preceded by an inpatient hospital stay of at least three consecutive days, not counting the date of discharge, which is within 30 days of the SNF admission.

Regulations

The legislative authority for coverage of SNF claims is contained in Section 1861 of the Social Security Act; governing regulations are found in Title 42 of the Code of Federal Regulations (CFR); and CMS coverage guidelines are found in both the Intermediary and Skilled Nursing Facility Manuals.

Data Analysis of Ineligible SNF Stays Nationwide

In a previous, self-initiated review of SNF compliance with the three-day inpatient hospital stay requirement in the State of Illinois, we identified improper Medicare payments for calendar year 1996 of approximately $1 million (CIN A-05-99-00018). Because of the significance of the improper payments in one state, we expanded our review to calendar years 1997 through 2001 and to SNF stays nationwide. In order to quantify the extent of improper SNF payments nationwide, we created a database of SNF claims that were paid even though CMS's automated systems did not support the existence of a preceding three-day inpatient hospital stay. Using the claim data from the CMS National Claims History Standard Analytical File, we matched SNF and inpatient hospital claims and identified 60,047 potentially ineligible SNF claims with improper reimbursements of $200.8 million.

In developing our nationwide database, all SNF claims, with service dates between January 1, 1997 and December 31, 2001, were extracted from the CMS National Claims History Standard Analytical File. We excluded all SNF claims with a zero dollar payment or identification with a Health Maintenance Organization. We also extracted inpatient hospital claims, with dates of service between January 1, 1996 and December 31, 2001, which were associated with the beneficiary Health Insurance Claim (HIC) numbers on the extracted SNF claims.

We created a file of inpatient hospital stays using the hospital admission and discharge dates for the extracted inpatient claims and created a SNF file by combining all the extracted SNF claims indicating an admission date within 30 days of a previous discharge. The files of inpatient hospital and the SNF stays were then sorted by HIC number and compared to determine whether an inpatient hospital stay actually occurred within 30 days of SNF admission. We extracted all SNF stays with an inpatient stay within 30 days of SNF admission, but less than three days in

length. Based on our previous review in Illinois, we excluded all SNF stays with no inpatient hospital stay prior to admission. These situations likely pertained to the beneficiary having either a Veterans Administration or private-pay qualifying inpatient hospital stay which made the SNF stay eligible for Medicare reimbursement.

By arraying the database by the Fiscal Intermediary (FI) responsible for the SNF payments, we determined that AdminaStar is responsible for 5,676 potentially ineligible SNF stays, consisting of 9,906 SNF claims and reimbursed by Medicare in the amount of $32 million.

OBJECTIVE, SCOPE AND METHODOLOGY

The audit objective was to determine the extent of ineligible Medicare SNF payments made under the administrative responsibility of AdminaStar.

We performed our audit in accordance with generally accepted government auditing standards. This audit is part of a nationwide review of ineligible SNF payments. Accordingly, this report is part of a series of reports to be issued to the FIs identified in our national database. In addition, a roll-up report will be issued to CMS, combining the results of the FI audits. Our review was limited to testing the extent of ineligible Medicare SNF payments associated with the financial and administrative responsibility of AdminaStar. Our database identified 5,676 potentially ineligible SNF stays, which included 9,906 SNF claims reimbursed in the amount of $32 million under AdminaStar's responsibility.

Because of the limited scope of our review, we did not review the overall internal control structure of AdminaStar. Our internal control testing was limited to a questionnaire relating to the claim processing system edits in place at AdminaStar for SNF claim payments.

Our fieldwork was performed in the Chicago Regional Office during September and October 2002.

Methodology. Since our substantial data analysis established a database of SNF claims that were paid even though CMS's National Claim History File did not support the existence of a preceding three-day inpatient hospital stay, our audit testing was limited to determining whether any other sources supported the required inpatient stay. In essence, our validation process consisted of determining whether any eligible SNF stays were inadvertently included in the database. We selected a statistical sample of 200 SNF stays from the AdminaStar database (reimbursed at $1,266,870) and compared the SNF admission to inpatient information on the CWF system. For each of the 200 SNF stays selected in our sample, we reviewed the Inpatient Listing (INPL) claims screen from the various CWF host sites to identify any inpatient stays omitted from our database which would make the SNF stay eligible for Medicare reimbursement.

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Unrestricted Variable Appraisal Program, we projected the amount of SNF payments eligible for Medicare reimbursement. Since our database was intended to quantify only ineligible Medicare reimbursements, we used the "difference estimator" estimation

method to measure the amount of eligible Medicare reimbursements that were inadvertently included in the database. Using the difference estimator, we adjusted the database of ineligible SNF payments and calculated the upper and lower limits at the 90 percent confidence level. We estimate that the lower limit of the 90th percentile of ineligible SNF payments under AdminaStar's responsibility amounted to $25.3 million during the period January 1, 1997 to December 31, 2001. Details of our sample methodology and estimation are presented in the Appendix.

FINDINGS AND RECOMMENDATIONS

We estimate that the Medicare program improperly paid SNF providers $25.3 million that AdminaStar should recover. Eighty-six and one half percent of the 5,676 SNF stays in the AdminaStar database were not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of the SNF admission. In accordance with 42 CFR, section 409.30, a SNF claim generally qualifies for Medicare reimbursement only if the SNF admission was preceded by an inpatient hospital stay of at least three consecutive calendar days, not counting the date of discharge, and was within 30 calendar days after the date of discharge from a hospital. The majority of the potentially ineligible SNF payments within our database did not have the required inpatient stay and should be recovered.

No Automated Matching

We attribute the significant amount of improper Medicare SNF payments to the lack of automated procedures within the CWF and AdminaStar's claims processing systems. SNF claims are not matched against a history file of hospital inpatient claims to verify that a qualifying hospital stay preceded the SNF admission. Consequently, neither the CWF nor AdminaStar have an automated means of assuring that the SNF claims are in compliance with the three consecutive day inpatient hospital stay regulations and eligible for Medicare reimbursement.

Instead of an automated match of inpatient and SNF claims data, SNFs are on an honor system. The automated edits, in place in the CWF and AdminaStar claims processing systems, merely ensure that the dates of a hospital stay have been entered on the SNF claim form. As the SNF claim is processed, edits ensure that the hospital dates on the SNF claim indicate a stay of at least three consecutive days. If the SNF mistakenly enters inaccurate hospital dates reflecting a three consecutive day hospital stay, the edits are unable to detect the errant data that renders the claim ineligible for Medicare reimbursement. Consequently, the ineligible SNF claim is processed for payment.

Relative to the improper SNF payments that we identified in our database, some SNFs may not understand that a particular day in a beneficiary's hospital stay may not be considered an inpatient day under Medicare regulations. We determined that occasionally a beneficiary's hospital stay of three consecutive days will include a day of outpatient services, such as emergency room or observation care preceding the actual inpatient services. When this situation occurs, the Medicare Hospital Manual, section 400D, states that the outpatient services, rendered during the hospital

3

visit, are treated as inpatient services for billing purposes only. The first day of inpatient hospital services is the day that the patient is formally admitted as an inpatient, which is subsequent to the patient's release from the emergency room or from observational care. A SNF's misunderstanding of these Medicare regulations will result in an incorrect claim of a three consecutive day hospital stay. The hospital's related inpatient claim will appropriately reflect two days of inpatient care. Since SNF claims are not matched against a history file of hospital inpatient claims, the disparity in the hospital days listed on the SNF and the hospital claims are not detected.

Although we have detected a weakness in the claims processing systems that enables a significant dollar amount of ineligible SNF claims to be paid, the processing of the SNF and inpatient claims by different contractors and delayed claims submission practices by Medicare providers may preclude an effective prepayment matching routine for SNF claims. Hospital providers may have their claims processed by FIs different than those processing the related SNF claims, and Medicare providers have up to 27 months, after the date of service, to submit a claim. Under these circumstances, the FI processing the SNF claims would not have the inpatient claim data necessary for an effective and efficient prepayment matching with SNF claims. While the CWF system would have all the inpatient hospital claim data and SNF claim data necessary for a matching procedure, the time allowed by Medicare regulations for providers to submit claims might result in a high incidence of inappropriately suspended SNF claims. Although generally SNFs submit claims more promptly than hospitals, it is not uncommon for a SNF to submit several claims for a prolonged beneficiary stay, before the hospital submits the claim for the qualifying hospital stay. Consequently, it is foreseeable that hospital inpatient claims data would not be available on the automated system for a prepayment matching, at the time a SNF claim is submitted for processing.

Although the cause of the improper SNF payments in the AdminaStar database is not directly attributable to any inappropriate action or inaction by AdminaStar, we believe that our review has identified the need for AdminaStar to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $32 million, we estimate that improper Medicare SNF payments under AdminaStar's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $25.3 million. From the AdminaStar database, we confirmed that 173 of the 200 SNF stays sampled were not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of the SNF admission.

We determined that 27 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 27 stays, we found inpatient claims which were listed on the CWF host sites. For some unknown reason, these admissions were not transmitted to the CMS National Claims History File, used to create our database. If these claims had been included in our cross match procedure, the SNF stay would have been eligible and excluded from the database. Based on the results of our sample, we estimate that 86.5 percent of the 5,676 SNF

stays and $25.3 million of the payments in the AdminaStar database were not in compliance with Medicare reimbursement regulations.

To assist in the identification and recovery of the unallowable SNF payments, we will make the necessary arrangements for the secure transfer of the database to the designated AdminaStar officials.

RECOMMENDATIONS

We recommend that AdminaStar:

- Initiate recovery actions estimated to be $25.3 million or support the eligibility of the individual stays included in the database.

- Initiate SNF provider education to emphasize Medicare interpretations which establish an eligible three-day inpatient hospital stay and qualify a SNF admission for Medicare reimbursement.

ADMINASTAR'S RESPONSE

In a letter dated December 18, 2002, AdminaStar concurred with the findings and recommendations presented in the report. The full text of AdminaStar's response is included as Appendix B to this report.

APPENDICES

SAMPLING METHODOLOGY

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Unrestricted Variable Appraisal Program, we projected the amount of SNF payments eligible for Medicare reimbursement. Since our substantial data analysis identified a database of potentially ineligible Medicare reimbursements, we used the "difference estimator" estimation method to measure the effect of the projected amount of eligible payments in the database and, thus, estimate the extent of ineligible Medicare SNF payments contained in our database. We calculated the upper and lower limits of our adjusted estimate of ineligible SNF payments, at the 90 percent confidence level, by subtracting the upper and lower limits of our projected eligible payments from the original database value of $31,975,308.

SAMPLE RESULTS

The results of our review are as follows:

Number of SNF Stays	Sample Size	Value of Sample	Number of SNF Stays Eligible for Payment	Value of SNF Stays Eligible for Payment
5,676	200	$1,266,870	27	$168,289

VARIABLE PROJECTION

Point Estimate $4,776,053

90% Confidence Interval

Lower Limit	$2,901,276
Upper Limit	$6,650,830

Calculation of estimated ineligible SNF payments at the lower and upper limit of the 90% confidence interval:

Database Value	$31,975,308	Database Value	$31,975,308
Upper limit	(-) $6,650,830	Lower limit	(-) $2,901,276
Lower Limit As Reported	**$25,324,478**	**Upper Limit**	**$29,074,032**

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
PART A INTERMEDIARY
Beneficiary (877) 602-2430
Provider (866)419-9457

December 18, 2002

Mr. Stephen Slamar
DHHS-OIG Office of Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: CIN A-05-02-00086

Dear Mr. Slamar:

AdminaStar Federal (ASF) has reviewed your report "Ineligible Medicare Payments to Skilled Nursing Facilities under the Administrative Responsibility of AdminaStar Federal" in which you have identified a potential overpayment by ASF in access of $25.3 million due to the lack of a three-day hospital qualifying stay. We appreciate the opportunity to comment on the draft report and offer the following comments.

The Medicare regulations states that for Skilled Nursing Facility (SNF) services may be reimbursed if the patient has been admitted within 30 days from an inpatient stay of three consecutive days. The Uniform Billing form (UB-92) requires Skilled Facilities to utilize an Occurrence Code and span dates, which defines specific events relating to the billing period. For example, occurrence code 70 indicates that a 3-day hospital stay was met.

The Fiscal Intermediary Shared System (FISS), which is used by AdminaStar Federal (ASF), has a validation process in place to edit for the occurrence code and the corresponding date relative to the hospital admission. Should the occurrence code and/or the corresponding dates be missing, the claim is returned to the provider for possible correction. The only time ASF would by-pass the three-day requirement is when an occurrence code is present denoting a Medicare Choices Plan has terminated.

As stated in your report, there are limitations to the current process. Since the bills submitted by hospitals and skilled nursing facilities could be processed by different contractors and there is not an automated cross-checking between the FISS and the Common Working File (CWF) Systems which compares the inpatient vs. skilled nursing facility bills to ascertain that the 3-day qualifying hospital stay was met, the potential exists for claims which do not meet the criteria to be processed erroneously.

In addition, as you note, while the systems could be enhanced to accommodate the reconciliation of claims, the issue surrounding the order of claims submitted by the provider, i.e. SNF claim submitted prior to the inpatient hospital bill, remains an issue. Should the SNF bill be submitted prior to the hospital bill and the fact providers have potentially up to 27 months to request payment, contractors would be unable to detect the problem until the inpatient claim was submitted.

To reduce the volume of claims submitted in error, ASF will continue to provide training related documents to the provider staff. In addition, a special segment of our Provider and Education Training (PET) meeting will be dedicated to providers scheduled for the first quarter of 2003.

Upon receipt of the claims file, ASF will review the claims you have identified that were erroneously paid. We will analyze the data and determine if the error existed due to the limitations within the system, clerical error, and/or the claim was paid correctly. ASF will adjust all claims paid incorrectly and pursue recovery of the dollars associated with the claims. ASF will provide monthly status reports and a final report will be provided to denote the actions taken on each claim identified by the OIG.

Should you have any addition questions, please contact Julie Daniel at 312-297-4799.

Sincerely,

Julie Daniel
Executive Director
Part A Program Management

Cc: Mike McCarron
    Karen Bryan
    Jeff Hannah
    Sarah Litteral

ACKNOWLEDGMENTS