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-05-02-00087

Ms. Sandy Coston
President
United Government Services
401 West Michigan Street
Milwaukee, Wisconsin 53203-2804

Dear Ms. Coston,

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 United Government Services." 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-05-02-00087 in all correspondence relating to this report.

Sincerely,

Paul Swanson

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 UNITED GOVERNMENT SERVICES

JANET REHNQUIST
Inspector General

March 2003
A-05-02-00087

Notices

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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 information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

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. Final determination on these matters will be made by authorized officials of the HHS divisions.

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 United Government Services (UGS).

FINDINGS

We estimate that the Medicare program improperly paid $23.3 million to SNF providers that should be recovered by UGS. Based on a sample of 200 SNF stays, we estimate that 84.5 percent of the UGS 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 UGS'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 UGS 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 $23.3 million were paid without being detected.

RECOMMENDATIONS

We recommend that UGS:

- Initiate recovery actions estimated to be $23.3 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, UGS agreed with the findings and recommendations presented in the report. The full text of UGS's response is included as Appendix B to this report.

TABLE OF CONTENTS

Glossary of Abbreviations and Acronyms

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
UGS	United Government Services

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 UGS is responsible for 4,433 potentially ineligible SNF stays, consisting of 8,307 SNF claims and reimbursed by Medicare in the amount of $27.6 million.

OBJECTIVE, SCOPE AND METHODOLOGY

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

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 UGS. Our database identified 4,433 potentially ineligible SNF stays, which included 8,307 SNF claims reimbursed in the amount of $27.6 million under UGS's responsibility.

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

Our fieldwork was performed in the Chicago Regional Office during October and November 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 UGS database (reimbursed at $1,279,565) 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 UGS's responsibility amounted to $23.3 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 $23.3 million that UGS should recover. Eighty-four and one half percent of the 4,433 SNF stays in the UGS 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 UGS'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 UGS 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 UGS 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 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 UGS database is not directly attributable to any inappropriate action or inaction by UGS, we believe that our review has identified the need for UGS to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $27.6 million, we estimate that improper Medicare SNF payments under UGS's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $23.3 million. From the UGS database, we confirmed that 169 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 31 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 31 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 84.5 percent of the 4,433 SNF stays and $23.3 million of the payments in the UGS 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 UGS officials.

RECOMMENDATIONS

We recommend that UGS:

- Initiate recovery actions estimated to be $23.3 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.

UGS'S RESPONSE

In a letter dated December 19, 2002, UGS concurred with the findings and recommendations presented in the report. The full text of UGS's response is included as Appendix B to this report.

APPENDICES

APPENDIX A

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 $27,622,504.

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
4,433	200	$1,279,565	31	$137,268

VARIABLE PROJECTION

Point Estimate $3,042,546

90% Confidence Interval

Lower Limit	$1,786,556
Upper Limit	$4,298,536

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

Database Value		$27,622,504	Database Value		$27,622,504
Upper limit	(-)	$4,298,536	Lower limit	(-)	$1,786,556
Lower Limit As Reported		**$23,323,968**	**Upper Limit**		**$25,835,948**

December 19, 2002

Mr. Stephen Slamar, Audit Manager
DHHS-OIG Office of Audit Services
233 N. Michigan Avenue, Suite 1360
Chicago, IL 60601

RE: Common Identification Number A-05-02-00087

Dear Mr. Slamar:

We have reviewed the draft document referenced above detailing the study of ineligible Medicare payments to skilled nursing facilities under the administrative responsibility of United Government Services, LLC. The following reflects our position with respect to the findings and recommendations.

Although the statement of findings indicates that "the improper SNF payments are not directly attributable to any inappropriate action or inaction by UGS" we would like to emphasize that point and highlight the finding that the weakness exists in the claims processing systems themselves. We are the fiscal intermediary for two very large SNF chains. As such, we process the SNF claim but are not necessarily the fiscal intermediary for the matching inpatient facility.

In addition, the Medical Review (MR) area only selects claims for review per the mandated Progressive Corrective Action (PCA) process or from a referral source (e.g. the Program Safeguard Contractor, Provider Audit, CMS, etc.) The PCA process requires MR to conduct data analysis on processed claims and those that have abberancies and/or outliers are selected for medical review. Additionally, at the beginning of a fiscal year MR is required to submit to CMS the volume of claims it expects to review on a pre and post payment basis. Adjustments are allowed if workload situations change throughout the year. Currently, we have been directed by CMS to focus MR efforts on education unlike previous years where the focus was claim review.

Specifically, on a SNF Inpatient bill, the provider must use an occurrence code span field of 70, and document the 3-day inpatient hospital stay. The OIG is correct when they indicate that the SNFs are on an honor system, as the Common Working File (CWF) and UGS' claims processing systems merely ensure that the dates of a hospital stay have been entered on the SNF claim. There are no edits that match the occurrence code span field against the CWF to validate. It would be very difficult for UGS to develop such an edit for many reasons. First, the hospitals do not need to submit their bill prior to the SNF billing. There is no way to confirm when the hospital will actually bill. Secondly, UGS is not the contractor for all applicable hospitals. Therefore, we are unable to implement effective edits within our control to identify and prevent the inappropriate payments. To identify these situations, CMS would need to put a post payment alert in CWF. We would then receive the alerts and process adjustments to recover SNF payments without a 3-day qualifying hospital stay.

We agree with the recommendation to initiate additional SNF provider education as indicated. We are currently updating our training materials to include specific examples related to the 3-day qualifying hospital stay. The following are the dates and locations for our fiscal year 2003 SNF training:

- January 9th - Richmond, Virginia
- January 13th - Burbank, California
- January 15th - San Diego, California
- January 23rd - Oakland, California
- April 22nd - Appleton, Wisconsin
- May 6th - Charleston, West Virginia
- May 13th - Honolulu, Hawaii
- May 13th - Lansing, Michigan
- July 22nd - Southfield Michigan

We will also discuss this during the PET Advisory meetings that SNF providers participate in. The dates and locations for these meetings are as follows:

- February 4th - Lansing, Michigan
- February 25th - San Francisco, California
- February 18th - West Virginia
- March 25th - Milwaukee, Wisconsin

In addition to the above training, we also intend to utilize meetings with the Peer Review Organizations (PROs) to raise this issue and concern so that they can supplement our educational efforts. We will also be including an article on this subject in our January 2003 Medicare Memo.

We also agree with the recommendation to initiate recovery actions for the inappropriate payments. Following the receipt of the database, we will sample the material to determine the most appropriate and efficient method for recovery. We will also work closely with CMS on the recovery process. We are aware of at least one situation where a provider has a global settlement agreement with CMS/DOJ that may prevent us from being able to recover certain payments from that provider.

Thank you for the opportunity to respond to the draft report. If you have any questions regarding our response, please feel free to contact me at 414-226-5588 or Cheryl Leissring at 414-226-5884.

Sincerely,

Copy: Daly Vargas, CMS
Ron Bryan, CMS
Rosalie Teran, CMS
Sean Johnson, CMS
Sally Wood, UGS
Steve Holubowicz, UGS
Barb Hensley, UGS
Pat Coleman, UGS
Cheryl Leissring, UGS

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.