DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
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CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

April 4, 2003

CIN: A-05-03-00015

Ms. Ann Keown
Vice President – Government Programs
Riverbend Government Benefits Administrator (GBA)
730 Chestnut Street
Chattanooga, Tennessee 37402

Dear Ms. Keown,

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 Riverbend GBA." 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-05-03-00015 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:

Rose Crum-Johnson – CMS Regional Administrator
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Atlanta Federal Center
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Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF RIVERBEND GBA

JANET REHNQUIST
Inspector General

April 2003
A-05-03-00015

Notices

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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. 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 Riverbend Government Benefits Administrator (GBA).

FINDINGS

We estimate that the Medicare program improperly paid $11.6 million to SNF providers that should be recovered by Riverbend GBA. Based on a sample of 200 SNF stays, we estimate that 89 percent of the Riverbend GBA 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 Riverbend GBA'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 Riverbend GBA 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 $11.6 million were paid without being detected.

RECOMMENDATIONS

We recommend that Riverbend GBA:

- Initiate recovery actions estimated to be $11.6 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 a written response to our draft report, Riverbend GBA expressed its concern as to the difficulty assessing the unallowability of the SNF payments and its inability to reopen earlier periods for review. They did, however, indicate that they would perform a review to recoup any possible improper payments and will continue their provider education efforts. Although Riverbend GBA contends that our estimated error rate, including claims from two years beyond the regulatory period for recoupment, may be inaccurate, it does not consider that our statistically valid sample was only taken to validate the unallowability of our developed universe of potential overpayments. Our sample estimated that only 11 percent of our universe had a qualifying admission per CWF documentation. Therefore, 89 percent of our universe or $11.6 million is believed to represent inappropriate SNF payments. Regulations do allow Riverbend GBA to

take recovery action on claims at anytime, if their review indicates just cause that fraud or similar fault may be involved. The significance of the estimated overpayment warrants consideration and action by the fiscal intermediary. A summary of Riverbend GBA's response and our comments begin on page 5 of the report. The full text of Riverbend GBA's response is included as Appendix B to this report.

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Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CWF	Common Working File
FI	Fiscal Intermediary
GBA	Government Benefits Administrator
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 potentially 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 Riverbend GBA is responsible for 2,071 potentially ineligible SNF stays, consisting of 3,798 SNF claims and reimbursed by Medicare in the amount of $12.8 million.

OBJECTIVE, SCOPE AND METHODOLOGY

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

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 Riverbend GBA. Our database identified 2,071 potentially ineligible SNF stays, which included 3,798 SNF claims reimbursed in the amount of $12.8 million under Riverbend GBA's responsibility.

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

Our fieldwork was performed in the Chicago Regional Office during November and December 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 Riverbend GBA database (reimbursed at $1,209,324) 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 Riverbend GBA's responsibility amounted to $11.6 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 $11.6 million that Riverbend GBA should recover. Eighty-nine percent of the 2,071 SNF stays in the Riverbend GBA 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 Riverbend GBA'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 Riverbend GBA 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 Riverbend GBA 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 Riverbend GBA database is not directly attributable to any inappropriate action or inaction by Riverbend GBA, we believe that our review has identified the need for Riverbend GBA to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $12.8 million, we estimate that improper Medicare SNF payments under Riverbend GBA's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $11.6 million. From the Riverbend GBA database, we confirmed that 178 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 22 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 22 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 89 percent of the 2,071 SNF stays and $11.6 million of the payments in the Riverbend GBA 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 Riverbend GBA officials.

RECOMMENDATIONS

We recommend that Riverbend GBA:

- Initiate recovery actions estimated to be $11.6 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.

RIVERBEND GBA'S RESPONSE

Riverbend GBA expressed reservations about the effort required to establish the unallowability of the SNF payments and noted that our database includes claims from 1997 and 1998 that may not be available for review. Officials contend that, without an identified fraud situation, they are precluded from reopening payment cases beyond the four-year regulatory time limit. In addition, they believe the cited 89% error rate, which includes claims not available for recoupment, may be inaccurate.

Riverbend GBA will perform a review to recoup any improper payments and continue with their provider education efforts.

OAS COMMENTS

Although the statistically developed error rate is accurate, we must emphasize that it was presented only to reflect the portion of our identified universe which may not represent a payment error. The 89% of the identified universe ($11.6 million) was substantial and warrants action by the fiscal intermediary. As our report states, our data analysis objective was to create 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. The sample identified 11% having a qualifying stay per CWF documentation. The balance of the potential overpayments in our sample still are without a qualifying inpatient stay. Whether a claim is beyond the regulatory time period for recoupment does not change the impropriety of the payment. In addition, we believe that as the database claims are reviewed, Riverbend GBA may find potential fraud or similar fault in claims from 1997 and 1998 that would allow them to reopen those claims even beyond the regulatory period.

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 $12,830,716.

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
2,071	200	$1,209,324	22	$80,504

VARIABLE PROJECTION

Point Estimate $833,622

90% Confidence Interval

Lower Limit	$432,695
Upper Limit	$1,234,549

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

Database Value		$12,830,716	Database Value		$12,830,716
Upper limit	(-)	$1,234,549	Lower limit	(-)	$432,695
Lower Limit As Reported		**$11,596,167**	**Upper Limit**		**$12,398,021**

www.cms.gov

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Medicare

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January 31, 2003

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

Dear Mr. Slamar,

Riverbend Government Benefits Administrator (Riverbend), would like to thank you for the information you and your staff provided in the report titled "Ineligible Medicare Payments To Skilled Nursing Facilities Under the Administration Responsibility Of Riverbend GBA". Any information made available by external reviewers in an effort to ensure proper payments are made to providers is always welcomed. Riverbend strongly believes that a commitment to ensuring proper payments are made to providers is necessary to be a strong and effective fiscal intermediary in the Medicare program. Based upon the information included in the report, there were a total of 3,798 claims potentially incorrectly paid, and for the same time period, Riverbend processed a total of 790,563 SNF claims for a potential error rate of .48%. Although Riverbend works to try and obtain a 0% error rate, we do feel that less than half a percent for a five year period is respectable.

Since the beginning of Riverbend's participation in the Medicare program, we have strived to be a leader in our efforts of awareness for possible program vulnerabilities, such as the situation described within your report. During the first quarter of calendar year 2002, Riverbend's Benefit Integrity Department reported to CMS the program vulnerability of skilled nursing facilities and the need for a three day qualifying stay. Once this report was filed with CMS, a national report was published by CMS noting this situation as a program vulnerability. Since this time, Riverbend's Benefit Integrity Department has begun work to conduct proactive reviews within the department for three day qualifying stays. The unfortunate situation is that with the Benefit Integrity function being consolidated within PSCs, Riverbend will be precluded from concluding this review.

Included in your report, a request was made to specifically address your recommendations. There were two recommendations made:

* Initiate recovery actions estimated to be $11.6 million or support the eligibility of the individual stays included in the database.

  In an effort to review the detail that allowed you to reach your conclusion that a potential $11.6 million recoupement should take place, a request was made for the documentation. Riverbend was greatly disappointed to be denied the opportunity to review the information. Therefore, this 89% error rate has not been validated by Riverbend.

During the review of the report, Riverbend noted the period of time selected for which the review was conducted. Congress has passed specific regulations that do not allow the reopening of a claim beyond four years unless, "such initial, revised, or reconsidered determination or such decision or revised decision is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting clerical error or error on the face of the evidence on which such determination or decision was based; or such initial, revised, or reconsidered determination or such decision or revised decision was procured by fraud or similar fault of the beneficiary or some other person." The exception to this rule allows intermediaries to re-open claims for an infinite period if fraud has been established. We do not feel that RGBA has adequate information to support reopening claims beyond this four year window. Therefore, the only claims available for recoupment, if it is established that an incorrect payment was made, are the claims with paid dates within four years from the date of determination. Per review of the database provided, the paid date cannot be determined without reviewing each claim, but based upon claims with thru dates ending in 1997 and 1998, the total amount for potential exclusion due to the four year window equals $4,903,368.11.

Additionally, Riverbend feels that with the information described in the preceding paragraph, the potential error percentage, 89%, as documented in the report is potentially inaccurate due to the inclusion of claims not available for recoupment. Claims for the period 1997 through 1998 represent approximately 38% of the total population dollar amount, as well as the total population of stays.

Riverbend does believe that the recommendation outlined in the report could be beneficial in an effort to help ensure proper payments have been made to providers, but an additional concern is our inability to validate the stats that have been documented in your report. Riverbend has already established that a portion of the timeframe being reviewed is potentially unable to be recouped, and without the ability to review the sample selection you describe in the report, we are unable to agree at this time to the amount of potential overpayment.

Riverbend would also need to evaluate funding and/or request additional funding to ensure that we meet current CMS expectations before initiating additional projects. There are several steps involved in performing a post-pay review of this type to ensure that provider rights are not violated and to ensure providers have every opportunity to support that a valid three day stay was executed before admission to the skilled nursing facility. For example, staff hours would need to be dedicated to the review of CWF for 2,071 SNF stays. For the inpatient stays that could not be located on CWF providers must be contacted to provide them the opportunity to support the stay with additional documentation.

* 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.

Riverbend also strongly believes that education is a vital part of protecting the Medicare Trust Fund. Education efforts have been the focus of Riverbend, and

included in our educational efforts has been specific subject material such as three day qualifying stays. Riverbend is the fiscal intermediary for the states of Tennessee and New Jersey, as well as a single intermediary for two large SNF chain placing us in approximately 30 states, and the subject of three day qualifying stays has specifically been covered during calendar year 2002.

Included with provider education funding for the current year, Riverbend will continue education efforts to provide education to emphasize Medicare interpretations in accordance with guidance provided by CMS.

Again, Riverbend would like to stress our commitment to ensuring that proper payments are made to providers. Evaluation of the information provided will continue and additional funding will be requested if needed to perform this review to recoup any possible improper payments.

Sincerely,

Ann Keown
Government Programs

ak/jl

Cc: David Jackson, Director, MIP & Reimbursement
Dana Reid, Medicare CFO
Jason Lloyd, Senior Compliance Auditor

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.