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

May 8, 2003

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-03-00022

Mr. William Foley
Vice President – Government Programs, Medicare Services
Empire HealthChoice, Inc.
2651 Strang Boulevard
Yorktown Heights, New York 10598

Dear Mr. Foley,

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 Empire HealthChoice, Inc." 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 Report Number A-05-03-00022 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:

Gilbert Kunken – CMS Acting Regional Administrator
Centers for Medicare & Medicaid Services – Region II
26 Federal Plaza, 38th Floor
New York, NY 10278

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF EMPIRE HEALTHCHOICE, INC.

JANET REHNQUIST
Inspector General

May 2003
A-05-03-00022

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. 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 Empire HealthChoice, Inc. (Empire).

FINDINGS

We estimate that the Medicare program improperly paid $9.7 million to SNF providers that should be recovered by Empire. Based on a sample of 200 SNF stays, we estimate that 79.5 percent of the Empire 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 Empire'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 Empire 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 $9.7 million were paid without being detected.

RECOMMENDATIONS

We recommend that Empire:

- Initiate recovery actions estimated to be $9.7 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 report, Empire stated that, based on previous instructions from CMS's New York Regional Office, collection efforts on our database would hold the beneficiaries liable, thereby creating financial hardships for them. We disagree. Empire also indicated that a United States District Court of Connecticut decision, a CMS granted waiver due to the September 11, 2001 disaster, and a CMS determination relative to beneficiary disenrollments from Medicare+Choice HMOs may result in SNF claims being included in our database inaccurately. While we agree that SNF claims affected by either the court decision or waiver may be included in our database and, as such, Empire will be precluded from collection action on the applicable claims, we disagree that our database includes any SNF claims related to beneficiaries who disenrolled from Medicare+Choice HMOs. Empire agreed that provider education is necessary.

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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
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 Empire is responsible for 1,728 potentially ineligible SNF stays, consisting of 3,513 SNF claims and reimbursed by Medicare in the amount of $12.7 million.

OBJECTIVE, SCOPE AND METHODOLOGY

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

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 Empire. Our database identified 1,728 potentially ineligible SNF stays, which included 3,513 SNF claims reimbursed in the amount of $12.7 million under Empire's responsibility.

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

Our fieldwork was performed in the Chicago Regional Office during 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 Empire database (reimbursed at $1,572,458) 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 Empire's responsibility amounted to $9.7 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 $9.7 million that Empire should recover. Seventy-nine and one half percent of the 1,728 SNF stays in the Empire 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 Empire'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 Empire 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 Empire 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 Empire database is not directly attributable to any inappropriate action or inaction by Empire, we believe that our review has identified the need for Empire to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $12.7 million, we estimate that improper Medicare SNF payments under Empire's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $9.7 million. From the Empire database, we confirmed that 159 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 41 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 41 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 79.5 percent of the 1,728 SNF stays and $9.7 million of the payments in the Empire 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 Empire officials.

RECOMMENDATIONS

We recommend that Empire:

- Initiate recovery actions estimated to be $9.7 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.

EMPIRE'S RESPONSE

Empire noted that for the past two years they have been working on the recovery of improper SNF payment's caused by the same reported condition. As part of their review, they were instructed by CMS's New York Regional Office to make the beneficiaries liable for repayment. Consequently, since our database includes improper payments, for which the beneficiaries would have been held liable for payments made, in some cases, six years ago; they believe that their recovery action on our database would create financial hardship for those beneficiaries.

Empire cited three situations which could result in SNF claims being included in our database inaccurately. A United States District Court of Connecticut decision ruled that, in Connecticut, emergency room services preceding a hospital admission are considered impatient care. Secondly, CMS waived the three–day hospital stay requirement for beneficiaries in areas affected by the September 11, 2001 disaster. Lastly, CMS deemed that beneficiaries, who had disenrolled from a Medicare+Choice HMO and were in a SNF at the end of 1999, had met the three-day hospitalization requirement.

Empire agreed that provider education is necessary and stated that in addition to conducting outreach sessions with the SNFs to explain the three-day qualifying stay requirement, they have published numerous informational bulletins on the requirement.

OAS COMMENTS

We disagree that the recoveries should be the financial responsibility of the beneficiaries. Title XVIII of the Social Security Act (Act), Section 1870, states that there will be no recovery of an incorrect payment from an individual who is without fault. Section 403.5 of the SNF Manual, which addresses admission procedures to the SNF, specifies that the SNFs, when admitting a beneficiary, should ask the transferring hospital if the beneficiary had a three day qualifying stay. For the majority of the improperly paid SNF claims in our database, we believe that the

beneficiaries did not know, at the time of their SNF admission, that their hospital stay did not meet the three-day inpatient requirement. Accordingly, the beneficiaries were not at fault. Conversely, it is reasonable to expect that the SNF's should have known that the hospital information, submitted on behalf of the beneficiaries was invalid or incomplete. Therefore, as Empire performs the recommended review of our database, we believe that they will determine that the SNF's, rather than the beneficiaries, were at fault and are financially liable to repay the Medicare program.

We agree that the United States District Court of Connecticut decision and CMS granted waiver, cited by Empire, were unforeseen by us when we created our database and will preclude Empire from taking recovery action on the applicable claims in our database. However, the SNF claims for beneficiaries who disenrolled from a Medicare+Choice HMO were excluded from our database. The inpatient hospital care, if any, provided to these beneficiaries would have been the responsibility of the HMO and, as such, the related claim data would not be included in the CMS maintained files used in creating our database.

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 $12,738,780.

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
1,728	200	$1,572,458	41	$264,047

VARIABLE PROJECTION

Point Estimate $2,281,363

90% Confidence Interval

Lower Limit $1,484,861
Upper Limit $3,077,865

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

Database Value		$12,738,780	Database Value		$12,738,780
Upper limit	(-)	$3,077,865	Lower limit	(-)	$1,484,861
Lower Limit As Reported		**$9,660,915**	**Upper Limit**		**$11,253,919**

MEDICARE
Part A Intermediary
Part B Carrier

William E. Foley
Vice President
Empire Medicare Services
2651 Strang Boulevard
Yorktown Heights, NY 10598

Telephone: 914-248-2852
Facsimile: 914-248-2948
Internet: william.foley@empireblue.com

February 12, 2003

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

Ref.: Draft Report: Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Empire HealthChoice, Inc. (CIN A-05-03-00022)

Dear Mr. Slamar:

We are pleased to provide comments to the draft audit report that accompanied Paul Swanson's letter dated January 17, 2003.

This audit determined that Medicare skilled nursing facilities (SNFs) in our jurisdiction received a total of $9.7 million in improper payments during the period 1997 through 2001. As the report noted, these unallowable SNF claims were paid because neither the Common Working File (CWF) nor we have an automated means to match an impatient stay to a SNF admission and to generate a prepayment alert that a SNF claim does not qualify for Medicare reimbursement.

It is important to note that we, like all other fiscal intermediaries, use standard claims processing systems, as mandated by the Centers for Medicare and Medicaid Services (CMS). Accordingly, as stated on page 4 of the draft report, "The cause of the improper SNF payments ... is not directly attributable to any inappropriate action or inaction by Empire..."

Following are specific comments regarding these payments to SNFs:

1. Structural imperfections in the administration of the Medicare program that facilitate the generation of improper payments

   This report correctly states that there are a number of programmatic situations that render prepayment identification of improper SNF billing difficult. These include:

   a. Timely filing requirements - A hospital may take up to 27 months following a stay to submit a claim.

   b. Veterans Administration hospital stays are not tracked on the CWF.

   c. Hospital claims may not be filed in commercial payer or private pay situations.

   This study accurately accounted for these situations by excluding SNF stays with no inpatient stay. Some other situations that we have identified include:

   a. The United States District Court of Connecticut's decision in the case of Elizabeth Jenkel vs. Shala stated that emergency room services preceding admission constituted inpatient care.

   b. CMS deemed the three-day hospitalization requirement met for beneficiaries who disenrolled from a Medicare+Choice plan and were in a SNF at the end of 1999.

   c. CMS waived the three-day hospital stay requirement for beneficiaries in areas affected by the September 11, 2001, disaster who were required to be transferred to a SNF.

2. Recommendation 1 - Recovering Improper Payments

   We would like to call to your attention to the fact that our Benefit Integrity Unit had been working on the recovery of improper payments caused by this situation for the past two years and was in the process of recovering over $2 million. As of January 15, 2003, this function was transferred to EDS. We believe that this investigation and recovery will continue.

As part of this unit's investigation, the issue of liability was discussed with CMS's New York Regional Office. We were instructed to make the recouped claims beneficiary liable. However, retracting Medicare payments that had been made up to six years ago could create financial hardship for beneficiaries.

Further, a recovery of this type would be time consuming and costly. Multiple claims, benefit periods, and co-insurance amounts would require adjustment, and this would impact on our claims processing, provider inquiries, and appeals operations. The work could not be accomplished within our regular operating budget.

3. Recommendation 2 – The Need for Provider Education

We agree that provider education is necessary. We have conducted numerous outreach sessions with SNFs to explain the three-day qualifying stay requirement, and we have also published numerous articles with this information in provider publications.

The following is a list of recent provider bulletins that included information on the SNF qualifying stay requirement. These bulletins may be found on our website at www.empiremedicare.com.

Issue 2002-12	December 2002	Issue 2000-11	October 2000
Issue 2002-11	November 2002	Issue 2000-10	September 2000
Issue 2001-12	December 2001	Issue 2000-7	June 2000
Issue 2001-10	October 2001	Issue 2000-3	March 2000
Issue 2001-8	August 2001		

Thank you for the opportunity to provide these comments to this draft audit report.

Sincerely,

William E. Foley
Vice President

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:

Stephen Slamar, *Audit Manager*
David Markulin, *Senior Auditor*

Technical Assistance
Tammie Anderson, *Advanced Audit Techniques*

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