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

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-03-00072 September 30, 2003

Ms. Susie Nash
Vice President of Federal Programs
Blue Cross and Blue Shield of Arizona, Inc.
2444 West Palmaritas Drive
Phoenix, Arizona 85021

Dear Ms. Nash,

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 Blue Cross and Blue Shield of Arizona, 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.

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To facilitate identification, please refer to Report Number A-05-03-00072 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:

H. Stephen Deering – Acting Regional Administrator
Centers for Medicare & Medicaid Services – Region IX
75 Hawthorne St., Suite 408
San Francisco, CA 94105

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.

September 2003
A-05-03-00072

Office of Inspector General

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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 awarding agency 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 Blue Cross and Blue Shield of Arizona, Inc. (BCBS of Arizona).

FINDINGS

We estimate that the Medicare program improperly paid $1.7 million to SNF providers that should be recovered by BCBS of Arizona. Based on a sample of 200 SNF stays, we estimate that *85.5* percent of the BCBS of Arizona 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 BCBS of Arizona'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 BCBS of Arizona 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 $1.7 million were paid without being detected.

RECOMMENDATIONS

We recommend that BCBS of Arizona:

- Initiate recovery actions estimated to be $1.7 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 draft report, BCBS of Arizona stated that their recovery efforts on our estimated $1.7 million of ineligible SNF payments would involve extensive and costly detailed work that needs to be coordinated through CMS. We believe that the *85.5* percent estimated error rate within our universe provides a cost effective return on recovery actions. BCBS of Arizona further stated that previous instructions from a CMS Regional Office indicated that collection efforts on our database would hold the beneficiaries liable. We do not agree. We believe that, through their recovery efforts, BCBS of Arizona will determine that the SNFs are at fault and liable for repayment. BCBS of Arizona agreed that provider education is necessary.

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Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare & 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 BCBS of Arizona is responsible for 322 potentially ineligible SNF stays, consisting of 535 SNF claims and reimbursed by Medicare in the amount of $2 million.

OBJECTIVE, SCOPE AND METHODOLOGY

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

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 BCBS of Arizona. Our database identified 322 potentially ineligible SNF stays, which included 535 SNF claims reimbursed in the amount of $2 million under BCBS of Arizona's responsibility.

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

Our fieldwork was performed in the Chicago Regional Office during May and June 2003.

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 BCBS of Arizona database (reimbursed at $1,282,587) 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 BCBS of Arizona's responsibility amounted to $1.7 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 $1.7 million that BCBS of Arizona should recover. Eighty-five and one half percent of the 322 SNF stays in the BCBS of Arizona 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 BCBS of Arizona'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 BCBS of Arizona 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 BCBS of Arizona 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 BCBS of Arizona database is not directly attributable to any inappropriate action or inaction by BCBS of Arizona, we believe that our review has identified the need for BCBS of Arizona to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of $2 million, we estimate that improper Medicare SNF payments under BCBS of Arizona's responsibility for the period January 1, 1997 through December 31, 2001 amounted to $1.7 million. From the BCBS of Arizona database, we confirmed that 171 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 29 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 29 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 85.5 percent of the 322 SNF stays and $1.7 million of the payments in the BCBS of Arizona 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 BCBS of Arizona officials.

RECOMMENDATIONS

We recommend that BCBS of Arizona:

- Initiate recovery actions estimated to be $1.7 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.

BCBS of ARIZONA'S RESPONSE

BCBS of Arizona noted that the $1.7 million of ineligible SNF payments was an estimate and that ensuring proper recovery on our database would require extensive and costly detailed work that needs to be coordinated through the CMS. Regarding recovery, BCBS of Arizona cited guidance from the CMS New York Regional Office as a precedent requiring the intermediaries to establish the beneficiary liable for repayment. The intermediary believes that recovery actions would create a financial hardship on beneficiaries for payments made, in some cases, six years ago.

BCBS of Arizona agreed that provider education is necessary and stated they will emphasize the three-day stay requirement in newsletter articles, educational seminars and during the next SNF training.

BCBS of Arizona also contended that our database included inappropriate SNF stays.

OAS COMMENTS

We believe that the 85.5 percent estimated error rate within our universe is significant enough to provide a cost effective return on the intermediary's collection efforts.

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,

addressing SNF admission procedures requires SNFs to establish that the beneficiary had a three-day qualifying stay. We believe that the majority of the beneficiaries did not know, at the time of their SNF admission, that their hospital stay did not meet the three-day inpatient requirement. The beneficiaries were not at fault. Rather, the SNF's should have known from hospital information, that the beneficiaries' stays may not qualify and that additional inquiries of the hospital might be warranted. As BCBS of Arizona performs the recommended review of the 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 disagree that our database contained inappropriate SNF stays. The methodology for creating the database is described in our 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 $2,019,426.

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
322	200	$1,282,587	29	$142,127

VARIABLE PROJECTION

Point Estimate $228,824

90% Confidence Interval

Lower Limit	$164,214
Upper Limit	$293,434

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

Database Value		$2,019,426	Database Value		$2,019,426
Upper limit	(-)	$293,434	Lower limit	(-)	$164,214
Lower Limit As Reported		**$1,725,992**	**Upper Limit**		**$1,855,212**

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July 14, 2003

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

Re: Draft Report: Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Arizona, Inc.
Report Number: A-05-03-00072

Dear Mr. Slamar:

Thank you for the opportunity to respond to the draft audit report that was submitted with Mr. Paul Swanson's letter of June 16, 2003.

The audit report states, "We estimate that the Medicare program improperly paid $1.7 million to SNF providers that should be recovered by BCBS of Arizona." This was for the period January 1, 1997 to December 31, 2001. Noted in the report is the fact that we have no automated edits within the Common Working File (CWF) or the Fiscal Intermediary Shared System (FISS) to detect a SNF stay that has not been preceded by a 3-day hospital stay. We must respond that we utilize the FISS under a mandate from CMS. There are various CWF host sites throughout the United States running the CWF system under contract with CMS; BCBSAZ is not a CWF contractor. The editing discussed is attempting to match one claim with another and it must therefore be performed within the CWF system. CMS is responsible for implementing the edits within this system and BCBSAZ has no control over this area. We rely upon the provider to document in the medical record and on the submitted claim that the patient had a qualifying 3-day stay.

We, like all intermediaries, utilize a standard system mandated by the Centers for Medicare and Medicaid Services. This is briefly noted on page 4 of the audit report "...the cause of the improper SNF payments in the BCBS of Arizona database is not directly attributable to any inappropriate action or inaction by BCBS of Arizona..."

Following are responses to the two recommendations:

1. Initiate recovery actions estimated to be $1.7 million or support the eligibility of the individual stays included in the database.

   $1.7 million is an estimate:
   The $1.7 million is simply an estimate as stated in the audit report. We do not have any claims listings from which to make individual claim determinations. To ensure proper recovery, we would need to first examine the listing of SNF stays from the population. We would then review CWF to ensure that a 3-day hospital stay actually qualified the SNF for payment. If there are questionable stays, we will have to contact the provider(s) involved for proper clarification and research. This process would be extremely time consuming and costly. Any efforts to perform this level of detail would need to be coordinated through the CMS Central and Regional Offices as it is not feasible to perform this work within our current operating budget.

Beneficiary Impact:
Another issue that has not been discussed in the audit report is the impact upon the beneficiary. When adjusting these claims, there are multiple beneficiary items that must be considered. First, the beneficiary has already paid the coinsurance on their claims. Secondly, in the New York region, CMS required that the intermediary make the beneficiary liable. This adjustment would cause us to generate a Medicare Summary Notice that would inform the beneficiary that their coinsurance would be refunded from the facility and that they are liable for the entire stay. Forcing the beneficiary to pay the provider six years after the stay will pose a hardship for many beneficiaries as well as the providers trying to collect. We question how this could be handled in this manner since Advanced Beneficiary Notices most likely have not been issued.

Cost Report Impact:

a) Since most of the cost reports for 1997 through 2001 have already had Notices of Program Reimbursement issued, their bad debts have already been audited and paid. We would now be required to review the bad debts paid through the cost report and remove those related to the claims being adjusted.
b) The cost reports have been adjusted to account for paid claims via a PSR adjustment. If we are required to adjust SNF claims, CMS would need to provide guidance on the need to reopen cost reports since the data housed in the various CMS HCRIS systems would now be skewed. Reopening the cost reports could consume a large portion of the audit resources available and we would not be able to perform these within our current operating budget.

2. 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.

   We agree that SNF providers need to be continually educated. We currently educate our providers by writing articles for our newsletters and holding educational seminars with the various provider organizations. We will include an article in our next publication as well as emphasize the three-day stay requirement during our next SNF training.

Additional Comments:

We note that there may be situations where the OIG auditor may not have properly identified eligible SNF stays with less than a 3-day stay.

- The audit report does not address the issue of a beneficiary being admitted to a hospital for a 3 or more day period (thus qualifying them for a SNF stay), transferred to a nursing home, back to the hospital for a one or two-day stay, and then readmitted to the SNF. Both the first and second SNF stays are qualified stays based on the first hospital admission.

- CMS deemed the 3-day stay met for beneficiaries disenrolling from Medicare+Choice plans.

Thank you for the opportunity to respond to this draft report.

Sincerely,

Susie Nash
Vice President and CFO, Medicare
Blue Cross and Blue Shield of Arizona, Inc.

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*

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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.