Memorandum

Date SEP 15 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Illinois Skilled Nursing Facility Claims Lacking a Preceding 3-Day Inpatient Hospital Stay (A-05-99-00018)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report which provides you with the results of our limited scope review of claims submitted by Illinois skilled nursing facilities (SNF) to determine if the claims met Medicare's prior hospitalization requirement. Under the Medicare program, a SNF claim generally qualifies for reimbursement only if the SNF stay was preceded by an inpatient hospital stay of at least 3 days and the hospital discharge was within 30 days of the SNF admission. The objective of our limited review was to determine the extent to which claims paid to Illinois SNFs met this requirement.

For the most part, SNF care in Illinois is preceded by the required 3-day hospital stay. However, our review did find some SNF claims were inappropriately paid because the SNF stay was not preceded by the required 3-day hospital inpatient stay. From the universe of 152,139 SNF claims submitted by Illinois providers with dates of service in Calendar Year (CY) 1996, we identified 787 claims totaling $1.8 million which appeared to have a hospital inpatient stay of less than 3 days. From this universe of 787 claims, we reviewed a statistical sample of 100 claims and determined that 57 SNF claims, totaling approximately $119,000, were indeed not preceded by the required 3-day hospital stay. We estimate that Medicare improperly paid Illinois providers over $900,000 for SNF services during CY 1996 because the 3-day hospital stay requirement was not met.

Although a 3-day inpatient hospital stay is required before a SNF claim is eligible for Medicare reimbursement, there is no comparison of dates entered on the SNF claim to inpatient hospital claims history in order to verify that a qualifying hospital stay preceded the SNF admission. Rather, fiscal intermediaries (FI) merely test compliance with the 3-day hospital stay requirement by verifying that a stay of at least 3 days is entered on the SNF claim and rely on the SNF to accurately enter the actual hospital stay dates on its claim. This control weakness allows ineligible SNF claims to be paid and not be detected.

The FIs involved in our sample reviewed the medical records and data for the sampled claims and concurred that the SNF stays were ineligible for Medicare reimbursements. Consistent with their normal policy, they said that they would request refunds for each incorrect payment identified. Therefore, we recommend that the Health Care Financing Administration (HCFA):

- monitor the FIs' recovery actions identified in Illinois and report the results through the normal audit resolution process;
- issue a program memorandum to advise all FIs and SNFs of our results; and
- consider having the FIs perform a review of the 3-day hospital stay requirement as part of their payment safeguard activities.

In a written response to our draft report, officials from HCFA have concurred with our recommendations. The full text of HCFA's response is included with this report as Appendix B. Please advise us within 60 days on the status of any further action taken or contemplated on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-05-99-00018 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS SKILLED NURSING FACILITY CLAIMS LACKING A PRECEDING 3-DAY INPATIENT HOSPITAL STAY

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 2000
A-05-99-00018

Memorandum

Date SEP 15 2000

From for June Gibbs Brown
Inspector General

Subject Illinois Skilled Nursing Facility Claims Lacking a Preceding 3-Day Inpatient Hospital Stay (A-05-99-00018)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our limited scope review of claims submitted by Illinois skilled nursing facilities (SNF) to determine if the claims met Medicare's prior hospitalization requirement. Under the Medicare program, a SNF claim generally qualifies for reimbursement only if the SNF stay was preceded by an inpatient hospital stay of at least 3 days and the hospital discharge was within 30 days of the SNF admission. The objective of our limited review was to determine the extent to which claims paid to Illinois SNFs met this requirement.

For the most part, SNF care in Illinois is preceded by the required 3-day hospital stay. However, our review did find some SNF claims were inappropriately paid because the SNF stay was not preceded by the required 3-day hospital inpatient stay. We reviewed a statistical sample of 100 Illinois SNF claims for services rendered in Calendar Year (CY) 1996 which appeared to lack a 3-day hospital stay and determined that 57 SNF claims, totaling approximately $119,000, were indeed not preceded by the required 3-day hospital stay. We estimate that Medicare improperly paid Illinois providers over $900,000 for SNF services during CY 1996 because the 3-day hospital stay requirement was not met.

Although a 3-day inpatient hospital stay is required before a SNF claim is eligible for Medicare reimbursement, there is no comparison of dates entered on the SNF claim to inpatient hospital claims history in order to verify that a qualifying hospital stay preceded the SNF admission. Rather, fiscal intermediaries (FI) merely test compliance with the 3-day hospital stay requirement by verifying that a stay of at least 3 days is entered on the SNF claim and rely on the SNF to accurately enter the actual hospital stay dates on its claim. This control weakness allows ineligible SNF claims to be paid and not be detected.

The FIs involved in our sample reviewed the medical records and data for the sampled claims and concurred that the SNF stays were ineligible for Medicare reimbursements. Consistent with their normal policy, they said that they would request refunds for each

incorrect payment identified. Therefore, we recommend that the Health Care Financing Administration (HCFA):

- monitor the FIs' recovery actions identified in Illinois and report the results through the normal audit resolution process;
- issue a program memorandum to advise all FIs and SNFs of our results; and
- consider having the FIs perform a review of the 3-day hospital stay requirement as part of their payment safeguard activities.

In a written response to our draft report, officials from HCFA concurred with our recommendations. The full text of HCFA's response is included with this report as Appendix B.

BACKGROUND

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 a 3-day duration and the hospital discharge was within 30 days of the SNF admission.

Occasionally a beneficiary's hospital stay will include a day of outpatient services, such as emergency room or observation care, that precedes the actual inpatient services. When this situation occurs, the Medicare Hospital Manual section 400D states that the outpatient services rendered during the hospital stay are treated as inpatient services for billing purposes only, but the first day of inpatient hospital services is the day that the patient is formally admitted as an inpatient; i.e., subsequent to the patient's release from the emergency room or from observational care.

When a SNF submits a bill to Medicare, it simply enters the dates of a hospital stay in field 36 of the UB-92 claim form (see Appendix A). As the SNF claim is processed through the FI's claims processing system and HCFA's common working file (CWF), edits are in place to ensure that the SNF identified the dates of a hospital stay and that the hospital dates indicate a stay of at least 3 days. However, neither the FIs' claims processing systems nor CWF performs a cross-match of SNF claims against a history file of hospital inpatient claims. In essence, SNFs are on an honor system regarding Medicare billing and reimbursement. If the SNF intentionally or mistakenly enters false or inaccurate hospital dates reflecting a 3-day hospital stay, the FI and CWF edits are unable to detect the errant data that renders the claim ineligible for Medicare reimbursement and allows the claim to be processed for payment.

SCOPE

Our limited scope review was conducted in accordance with generally accepted government auditing standards. Our

objective was to identify SNF claims that did not have the required preceding inpatient hospital stay. Our review was limited to claims submitted by Illinois SNFs.

To accomplish our objective, we extracted data from the standard analytical subset file of HCFA's national claims history (NCH) file to create a database of SNF claims submitted by Illinois providers with dates of service in CY 1996 and a database of hospital inpatient claims filed nationwide during CYs 1995 and 1996. We matched the databases to identify SNF claims which did not meet Medicare's 3-day hospital stay requirement within 30 days of the SNF admission. Based on this data match, we did a risk assessment of the potential errors found and determined the area of greatest problems was SNF claims for which there was a hospital stay within 30 days of SNF admission, but the hospital stay was less than 3 days.

Our match of the SNF and hospital inpatient claim databases identified a universe of 787 claims totaling $1.8 million in which there was an apparent hospital inpatient stay of less than 3 days. We selected a statistically random sample of 100 claims. For each sample item, we reviewed hospital medical records to determine whether adequate documentation existed to support a 3-day hospital inpatient stay prior to SNF admission and consulted with the medical reviewers in the Fraud Control Unit of one FI's Chicago office to confirm our findings that the SNF claims did not meet the eligibility criteria. The SNF claims we identified as ineligible for Medicare reimbursement were submitted by providers whose claims are currently processed by six different FIs. We contacted these FIs, provided them with the medical records and other documentation used in determining the improper SNF payments, and requested that they effectuate recovery action.

We conducted our review during the period February 1999 through November 1999 at the Office of Inspector General Chicago regional office.

RESULTS OF REVIEW

We determined that 57 of our 100 sampled SNF admissions were not preceded by a 3-day hospital stay. The improper payments amounted to $119,060. Projecting our sample results, we estimate that 449 SNF claims (57 percent of the universe), totaling $937,006, were improperly paid to Illinois providers for services rendered in CY 1996. The estimated dollar amount of $937,006 is the point estimate between the lower limit of $739,153 and an upper limit of $1,134,858.

We determined that 43 of our 100 sampled SNF admissions were in fact preceded by a 3-day hospital stay. For 27 of these 43 claims, even though the NCH file did not show a 3-day hospital stay, we were able to find a qualifying 3-day stay on CWF. We are concerned that these inpatient claims were missing from the NCH file and will pursue this issue in a separate review. For 16 of the 43 claims, the medical reviewers determined that there was evidence to support a 3-day stay.

For all 57 cases involving the improper payments, the SNF claims, submitted by the SNFs and paid by the FI, identified that at least 3 days of hospital services had taken place before the SNF services began. However, the related 57 hospital claims, processed and paid by the FI and listed on the CWF, showed less than 3 inpatient days of service had in fact occurred. The FI processed and paid the SNF claims without validating the actual hospital dates listed on the SNF claim forms to the hospital claim itself. Since the problem resulted from an inherent weakness in the FI and the CWF claims processing systems, we believe this situation may be occurring in other States.

It appears that some SNFs may not understand that all days in a hospital may not qualify for the 3-day inpatient hospital stay requirement. We noted that for 56 of the 57 ineligible claims in our sample, the hospital medical records indicated that the beneficiary was in the hospital for 3 days prior to the SNF admission, but at least 1 of those days was for either emergency room or observation care. These hospital stays of less than 3 days did not qualify the SNF claims for Medicare reimbursement. In these instances the SNFs, if they had confirmed the nature of the beneficiary's hospital stays, would have determined that the SNF stays were ineligible for Medicare reimbursement. Furthermore, we are concerned that some SNF providers could exploit the situation by submitting SNF claims which falsely list a 3-day inpatient hospital stay if they are aware of the absence of a cross-matching capability.

Although we have detected a weakness in the claims processing system that enables ineligible SNF claims to be processed for payment, we do not believe that a prepayment match of SNF claims to a hospital claim history file would be effective and efficient and would result in a high incidence of inappropriately suspended SNF claims. Since the current FI claims processing systems do not possess sufficient sophistication to link SNF claims with hospital claims, each type of claim is processed separately. Further, under Medicare regulations, providers may have up to 27 months after the date of service to submit a claim. This time frame could result in considerable timing differences between the date a SNF claim is filed and processed for payment and the date that the related hospital claim is filed. Accordingly, these significant timing differences may result in the hospital inpatient claims data not being available. If a SNF provider submits a claim within 60 days of a beneficiary's discharge, but the related hospital stay is not billed until 12 months later, a prepayment match of the SNF claim to a hospital claim history file would result in the SNF claim being unfairly denied for Medicare reimbursement. Based upon these factors, and the incidents of errors detected in our audit, we believe that a post-payment match is appropriate.

RECOMMENDATIONS

The FIs involved in our sample reviewed the medical records and data for the sampled claims and concurred that the SNF stays were ineligible for Medicare reimbursements. Consistent with their normal policy, they said that they would request refunds for each incorrect payment identified. Therefore, we recommend that HCFA:

- monitor the FIs' recovery actions identified in Illinois and report the results through the normal audit resolution process;
- issue a program memorandum to advise all FIs and SNFs of our results; and
- consider having the FIs perform a review of the 3-day hospital stay requirement as part of their payment safeguard activities.

HCFA'S COMMENTS

In a written response to our draft report, officials from HCFA concurred with each of the three recommendations. The full text of HCFA's response is included with this report as Appendix B.

			3 PATIENT CONTROL NO						
	5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 CON'D	8 N/C	9 C/D	10 L/R	11	
12 PATIENT NAME		13 PATIENT ADDRESS							
14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO
CONDITION CODES 24	25	26	27	28	29	30	31		
32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	A B C
a b c d	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT			

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78

P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
							OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUL 24 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: OIG Draft Report: "Illinois Skilled Nursing Facility Claims Lacking a Preceding Three-Day Inpatient Hospital Stay," (A-05-99-00018)

Thank you for the opportunity to review the above-mentioned report. The Health Care Financing Administration (HCFA) has continued to work to ensure that providers are paid appropriately while protecting beneficiaries and taxpayers from improper payments. Our efforts to date have shown real results. As your annual audits have shown, Medicare reduced its improper payment rate sharply from 14 percent in Fiscal Year (FY) 1996 to less than 8 percent in FY 1999. Since 1993, the Clinton Administration has done more than any previous administration to fight waste, fraud and abuse of the Medicare program, which pays more than $200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments and convictions, as well as new management tools to identify improper payments to health care providers. HCFA remains committed to achieving further reductions in the future.

In calendar year (CY) 1996, HCFA payments for skilled nursing facility (SNF) services in Illinois totaled $378,666,066. The report estimates based on sample results, that improper payments to Illinois SNFs totaled $937,006 for admissions that were not preceded by a three-day hospital stay. This amount represents only one-quarter of one percent (0.25) of total payments to Illinois SNF providers for services rendered in CY 1996. Despite the fact that improper payments to Illinois SNFs represent such a small portion of total Medicare payments to these facilities, we will take action to recover the $937,006 and will work with our contractors to prevent improper payments in the first place.

HCFA will continue its efforts to notify the fiscal intermediaries of the necessity to review the three-day hospital stay requirement as part of their payment safeguard activities. As part of ongoing educational efforts, our fiscal intermediaries provide routine provider education and training to the SNF community through many venues, i.e., provider bulletins, e-mail and on-site training. This three-day qualifying hospital stay requirement is one of the elements already emphasized in the provider education and training.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. We concur with the OIG's recommendations. Our detailed comments on the audit report are as follows:

OIG Recommendation

HCFA should monitor the Fiscal Intermediaries (FI) recovery actions identified in Illinois and report the results through the normal audit resolution process.

HCFA Response

We concur. HCFA and the FIs will begin recovery efforts when OIG sends us the necessary data and workpapers that will allow us to properly identify the exact amounts of overpayments. Once the exact overpayment amounts have been determined, the Chicago Regional Office will follow up with the FIs to ensure that collection efforts are underway. The Office of Financial Management will monitor this activity.

OIG Recommendation

HCFA should issue a program memorandum to advise all FIs and SNFs of our results.

HCFA Response

We concur. We notify our contractors semi-annually of any program vulnerabilities identified by the OIG, GAO, others, and ourselves. When the final report is issued, we will include this vulnerability in that semi-annual report to our contractors. Additionally, the FIs provide routine provider education and training to the SNF community through many venues, i.e., provider bulletins, e-mail, and on-site training. The three-day qualifying hospital stay requirement is one of the elements already emphasized in the provider education and training.

OIG Recommendation

HCFA should consider having the FIs perform a review of the three-day hospital stay requirement as part of their payment safeguard activities.

HCFA Response

We concur. In fact, the three-day qualifying hospital stay is already one of the technical eligibility criteria that we require the FIs to look for when undertaking SNF post-payment medical review.