May 4, 2010

TO: Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007 (A-01-09-00508)

The attached final report provides the results of our review of Medicare payments for interrupted stays at inpatient psychiatric facilities for calendar years 2006 and 2007.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov. Please refer to report number A-01-09-00508 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

NATIONWIDE REVIEW OF MEDICARE PAYMENTS FOR INTERRUPTED STAYS AT INPATIENT PSYCHIATRIC FACILITIES FOR CALENDAR YEARS 2006 AND 2007

Daniel R. Levinson
Inspector General

May 2010
A-01-09-00508

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed and implemented a prospective payment system for inpatient psychiatric facilities (IPF) effective for cost-reporting periods beginning on or after January 1, 2005. Under the IPF prospective payment system, CMS pays a variable per diem rate, which includes higher payments at the beginning of a stay to cover the higher costs of providing admission-related services, such as psychiatric evaluations, and which declines as treatment progresses. Medicare Part A fiscal intermediaries, under contract with CMS, use the Fiscal Intermediary Shared System (FISS) and the Common Working File to process and pay claims submitted by IPFs.

To discourage inappropriate discharges and readmissions to IPFs, CMS has established a 3-day policy for interrupted stays. An interrupted stay occurs when a beneficiary is discharged from an IPF and admitted to the same or a different IPF within 3 consecutive days. In such a case, the "readmission" is considered a continuation of the initial stay. In section 190.7.1, chapter 3, of the *Medicare Claims Processing Manual*, Pub. No. 100-04, CMS provides an exception to the 3-day policy when the beneficiary is admitted to a different IPF within 3 days and the second IPF is unaware of the beneficiary's immediately preceding stay in the first IPF.

OBJECTIVE

The objective of our review was to determine whether fiscal intermediaries properly paid IPFs nationwide for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days.

SUMMARY OF FINDINGS

For 25 of the 100 claims in our sample, fiscal intermediaries properly paid IPFs for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days. For these claims, the admitting IPFs told us that they were not aware of the prior IPF stay. Further, in these cases, the first IPF coded the claims as "beneficiary discharged to home," and our review of paid claim history did not identify an intervening stay at an institutional provider (e.g., a skilled nursing facility) that would have put the second IPF on notice of a preceding stay.

For the 75 remaining sampled claims, fiscal intermediaries incorrectly paid IPFs $19,268 for the second parts of interrupted stays as new stays. Based on these sample results, we estimated that fiscal intermediaries made $3.9 million in improper Medicare payments to IPFs nationwide in calendar years 2006 and 2007 for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days. These overpayments occurred because Medicare payment controls were not adequate to prevent or detect the overpayments. In addition, CMS's billing instructions did not explain how to bill for the second part of an interrupted stay when an IPF was aware of the beneficiary's preceding stay at another IPF.

RECOMMENDATIONS

We recommend that CMS:

- instruct its fiscal intermediaries to recover $19,268 for the 75 sampled claims with payment errors;

- review our information on the 20,605 unsampled claims for IPF interrupted stays, which had potential overpayments estimated at $3.8 million, and work with its fiscal intermediaries to recover any overpayments;

- establish edits in its Common Working File to prevent and detect overpayments to IPFs that admitted beneficiaries from another IPF and did not bill the claim as part of an interrupted stay;

- instruct its fiscal intermediaries to initiate the necessary modifications to the FISS to process and pay IPF interrupted stays correctly;

- consider conducting periodic postpayment reviews for claims submitted after our review to identify claims incorrectly paid as new stays rather than as the second part of interrupted stays; and

- revise its billing instructions to address appropriate billing for the second part of interrupted stays involving two separate IPFs when the second IPF is aware of the preceding stay.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations. CMS's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Prospective Payment System for Inpatient Psychiatric Facilities

As mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. No. 106-113, together with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 (MMA), CMS implemented a prospective payment system for inpatient psychiatric facilities (IPF).[1] The prospective payment system was effective for cost-reporting periods beginning on or after January 1, 2005. A prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF.

During our audit period (calendar years (CY) 2006 and 2007), CMS contracted with Medicare Part A fiscal intermediaries to process and pay claims submitted by institutional providers, including IPFs.[2] Fiscal intermediaries use the Fiscal Intermediary Shared System (FISS) and the Common Working File for claim processing.

Interrupted Stay Policy

Under the IPF prospective payment system, CMS pays a variable per diem rate, which includes higher payments at the beginning of a stay to cover the higher costs of providing admission-related services, such as psychiatric evaluations, and which declines as treatment progresses. CMS also makes outlier payments for IPF stays that have extraordinarily high costs.

To discourage inappropriate discharges and readmissions to IPFs, CMS has established a 3-day policy for interrupted stays. An interrupted stay occurs when a beneficiary is discharged from an IPF and admitted to the same or a different IPF within 3 consecutive days. For example, if a beneficiary is discharged from an IPF on March 10 after an initial stay of 7 days and is admitted to another IPF on March 12 (before midnight of the third consecutive day), the "readmission" is considered a continuation of the initial stay. Therefore, day 1 of the readmission will be considered day 8 of the combined stay for purposes of applying the variable per diem rate and any applicable outlier payments. In explaining this policy, CMS stated that an absence from an IPF of less than 3 days would not necessitate repeating many admission-related services, such as psychiatric evaluations.[3]

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[1] The prospective payment system applies to inpatient services of psychiatric hospitals and psychiatric units of acute-care hospitals. See the *Medicare Claims Processing Manual*, Pub. No. 100-04, § 190.1.

[2] The MMA, which became effective on October 1, 2005, amended certain sections of the Act to require that Medicare administrative contractors replace fiscal intermediaries and carriers by October 2011.

[3] 69 Fed. Reg. 66963 (Nov. 15, 2004).

Section 190.7.1, chapter 3, of CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), instructs IPFs to bill for interrupted stays using Occurrence Span Code 74 and to identify the dates of interruption in the stay. However, the Manual does not address how IPFs should use Occurrence Span Code 74 in billing for interrupted stays involving two separate IPFs. As an exception to the interrupted stay rule, the Manual states that if an IPF is unaware of an immediately preceding stay in another IPF, the admitting IPF may bill as if the second stay were not a continuation of the preceding stay.

Prior Office of Inspector General Review

In a prior review,[4] we found that Medicare Part A IPF claims paid by National Government Services, Inc. (NGS), during CYs 2005 and 2006 did not always comply with Medicare regulations for interrupted stays. We recommended, among other actions, that NGS conduct postpayment reviews for claims submitted after our review and educate IPFs about the importance of identifying beneficiaries who were admitted to an IPF within 3 days of being discharged from the same or a different IPF. Although NGS concurred with our findings, it stated that it could not implement all of our recommendations without further guidance from CMS and modifications to the Common Working File and the FISS.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether fiscal intermediaries properly paid IPFs nationwide for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days.

Scope

Our review covered 20,705 Medicare Part A claims totaling $202.3 million that fiscal intermediaries paid to 1,535 IPFs in CYs 2006 and 2007 for new stays within 3 days of a discharge from another IPF. These 20,705 claims were paid by 12 Medicare fiscal intermediaries.

We limited our review to claims for interrupted stays at two different IPFs because our prior review and our review of nationwide data for CYs 2006 and 2007 identified a low risk of Medicare overpayments when a beneficiary was readmitted to the same IPF.

Our objective did not require an understanding or assessment of the complete internal control structures of IPFs or fiscal intermediaries. Therefore, we limited our review to obtaining an understanding of (1) IPFs' procedures for submitting claims for beneficiaries who were admitted to an IPF within 3 consecutive days of discharge from a different IPF and (2) fiscal intermediaries' policies and procedures for paying such claims.

[4] *Review of Medicare Part A Claims Paid by National Government Services for Interrupted Stays at Inpatient Psychiatric Facilities During Calendar Years 2005 and 2006* (A-01-08-00530, issued December 2008).

Our fieldwork consisted of contacting 86 IPFs and 12 Medicare fiscal intermediaries from February through July 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted paid claim data from CMS's National Claims History file for CYs 2006 and 2007;
- developed a computer application to identify IPF stays nationwide that were billed and paid as new stays for beneficiaries who were discharged from one IPF and readmitted to a different IPF within 3 consecutive calendar days;
- excluded from our sampling frame 1,234 claims that were paid in CY 2006 and included in our previous review;
- selected a stratified random sample of 100 claims from the sampling frame of 20,705 claims for potential interrupted stays (Appendix A);
- reviewed the Common Working File records for the 100 sampled claims to validate the results of our computer match and to verify that the selected claims had not been canceled;
- used CMS's PRICER program and fiscal intermediaries' provider-specific information to combine each incorrectly paid interrupted stay into a continuous stay and reprice the resulting stay;
- estimated the total value of overpayments based on our sample results (Appendix B);
- contacted representatives from the 86 IPFs that submitted the 100 claims to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare regulations;
- contacted CMS and 12 fiscal intermediaries associated with the IPF claims to obtain an understanding of edits in the Common Working File and the FISS to prevent and detect Medicare Part A overpayments to IPFs; and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

For 25 of the 100 claims in our sample, fiscal intermediaries properly paid IPFs for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days. For these claims, the admitting IPFs told us that they were not aware of the prior IPF stay. Further, in these cases, the first IPF coded the claims as "beneficiary discharged to home," and our review of paid claim history did not identify an intervening stay at an institutional provider (e.g., a skilled nursing facility) that would have put the second IPF on notice of a preceding stay.

For the 75 remaining sampled claims, fiscal intermediaries incorrectly paid IPFs $19,268 for the second parts of interrupted stays as new stays. Based on these sample results, we estimated that fiscal intermediaries made $3.9 million in improper Medicare payments to IPFs nationwide in CYs 2006 and 2007 for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days. These overpayments occurred because Medicare payment controls were not adequate to prevent or detect the overpayments. In addition, CMS's billing instructions did not explain how to bill for the second part of an interrupted stay when an IPF was aware of the beneficiary's preceding stay at another IPF.

PROGRAM REQUIREMENTS

Federal regulations (42 CFR § 412.424(d)(3)(iii)) require an adjustment in an IPF's per diem payment for an interrupted stay in which a beneficiary is discharged from an IPF and is admitted to the same or another IPF within 3 consecutive calendar days. The second stay is considered a continuation of the first stay for the purposes of determining (1) what the appropriate variable per diem adjustment is and (2) whether the total cost of the stay meets the criteria for outlier payments.

In the IPF prospective payment system final rule (69 Fed. Reg. 66963 (Nov. 15, 2004)), CMS illustrated the application of the interrupted stay policy using an example of a beneficiary who was discharged from a psychiatric unit of a hospital to receive acute care and was then transferred to a freestanding psychiatric hospital at the completion of the hospital stay. CMS stated that if the beneficiary were admitted to the psychiatric hospital within 3 days of the initial psychiatric unit stay, Medicare "would not pay the psychiatric hospital the variable per diem adjustments for the initial days of original psychiatric stay otherwise applicable to the stay." CMS would not pay the adjusted rate because "the transferring hospital would send the psychiatric hospital the patient's medical record that will include information regarding the prior psychiatric stay in accordance with the hospital condition of participation for discharge planning (42 CFR § 482.43)." The purpose of this policy, CMS explained, was to prevent "the 'shuffling' of patients from hospital to hospital."

SECOND PART OF INTERRUPTED STAYS INCORRECTLY PAID AS NEW STAYS

For 75 of the 100 claims that we sampled, fiscal intermediaries incorrectly paid IPFs for the second stays as new stays rather than as part of interrupted stays. These IPFs received full payment for the second parts of the interrupted stays instead of the adjusted payment that IPF regulations require. The resulting overpayments totaled $19,268. In each of these 75 cases, the second IPF was aware of the beneficiary's preceding stay in the first IPF because (1) the coding on the claim showed that the beneficiary was discharged from the first IPF directly to the second IPF, (2) the beneficiary's claim history showed that the beneficiary was discharged directly from an intervening stay at an institutional provider (e.g., a skilled nursing facility) to the second IPF, or (3) IPF officials told us that they had identified the prior IPF stay.

We estimated, based on our sample results, that fiscal intermediaries made $3.9 million in improper Medicare payments to IPFs nationwide for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days.

CAUSES OF OVERPAYMENTS

Inadequate Medicare Payment Controls

Medicare payment controls were not adequate to prevent or detect overpayments to IPFs for the second part of interrupted stays. Specifically, prepayment edits in the Common Working File could not identify whether a beneficiary had been discharged from one IPF and readmitted to another IPF within 3 days. Furthermore, Occurrence Span Code 74 identified the dates of interruption in the stay but not the number of days in the first part of the stay. As a result, the FISS could not determine what number to assign to the first day of the second part of the interrupted stay and was therefore unable to apply the reduced variable per diem payment.[5] Finally, fiscal intermediaries did not conduct periodic postpayment reviews to ensure that IPFs had not received overpayments for stays that were incorrectly paid as new stays rather than as the second half of interrupted stays.

Inadequate Billing Instructions

CMS did not provide adequate billing instructions to admitting IPFs for claims made on behalf of beneficiaries who were discharged from a different IPF within the prior 3 days. Although the Manual instructs IPFs to bill for interrupted stays using Occurrence Span Code 74 and to define the timeframe of the interruption, it does not specify how to use the code in billing for the second part of interrupted stays involving two separate IPFs. Proper use of Occurrence Span Code 74 requires knowledge of certain details of the first part of an interrupted stay that are not generally available to the second IPF.

[5] When beneficiaries are discharged from and readmitted to the same IPF, this problem does not arise because the FISS can extract all necessary information regarding the first stay from the Common Working File.

RECOMMENDATIONS

We recommend that CMS:

- instruct its fiscal intermediaries to recover $19,268 for the 75 sampled claims with payment errors;

- review our information on the 20,605 unsampled claims for IPF interrupted stays, which had potential overpayments estimated at $3.8 million, and work with its fiscal intermediaries to recover any overpayments;

- establish edits in its Common Working File to prevent and detect overpayments to IPFs that admitted beneficiaries from another IPF and did not bill the claim as part of an interrupted stay;

- instruct its fiscal intermediaries to initiate the necessary modifications to the FISS to process and pay IPF interrupted stays correctly;

- consider conducting periodic postpayment reviews for claims submitted after our review to identify claims incorrectly paid as new stays rather than as the second part of interrupted stays; and

- revise its billing instructions to address appropriate billing for the second part of interrupted stays involving two separate IPFs when the second IPF is aware of the preceding stay.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations. CMS stated that it would recover the overpayments consistent with its policies and procedures and requested that we furnish the data necessary for it to review claims and recover the overpayments. CMS also stated that it would work to improve its oversight and move forward in establishing the changes necessary to implement the interrupted stay policy. CMS's comments are included in their entirety as Appendix C.

As requested, we provided the data necessary for CMS to initiate its review and recovery effort.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicare Part A inpatient psychiatric facility (IPF) claims for interrupted stays that fiscal intermediaries nationwide paid during calendar years (CY) 2006 and 2007.

SAMPLING FRAME

The sampling frame was a database of 20,705 Medicare Part A claims totaling $202.3 million that fiscal intermediaries paid to 1,535 IPFs in CYs 2006 and 2007 for new stays within 3 days of a discharge from another IPF. We stratified the frame into two strata: stratum 1 consisted of 9,341 claims for CY 2006, and stratum 2 consisted of 11,364 claims for CY 2007.

SAMPLE UNIT

The sample unit was an IPF claim.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

The sample size was 100 IPF claims: 50 from stratum 1 and 50 from stratum 2.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units from 1 to 9,341 in stratum 1 and from 1 to 11,364 in stratum 2. After generating 50 random numbers from each stratum, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Frame Value	Sample Size	Value of Sample	Number of Unallowable Payments	Value of Unallowable Payments
1	9,341	$83,174,404	50	$444,915	40	$12,818
2	11,364	119,156,780	50	633,108	35	6,450
Total	**20,705**	**$202,331,184**	**100**	**$1,078,023**	**75**	**$19,268**

Estimated Value of Unallowable Payments
(*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$3,860,690
Lower limit	3,313,462
Upper limit	4,407,917

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR - 1 2010

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007" (A-01-09-00508)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report, "Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which fiscal intermediaries (FIs) properly paid inpatient psychiatric facilities (IPF) nationwide for claims on behalf of beneficiaries who had been discharged from another IPF within the prior 3 days.

The IPF prospective payment system (PPS) interrupted stay policy stipulates that if a patient is discharged from an IPF and is admitted to the same or another IPF within 3 consecutive calendar days following the discharge, the case is considered to be continuous. This differs slightly from other interrupted stay policies finalized under the inpatient rehabilitation facility PPS and the long term care hospital PPS, which consider the stay continuous if a patient leaves and returns to the same facility. Due to the uniqueness of the IPF PPS interrupted stay policy, implementation was highly complex as it required that Medicare split payment between two different facilities.

We recognize that we did not implement the claims processing changes necessary for the interrupted stay policy to another IPF for the reasons stated above. However, we will work to improve our oversight in the future and move forward in establishing the changes necessary to implement this policy.

OIG Recommendation

Instruct its FIs to recover $19,268 for the 75 sampled claims with payment errors.

CMS Response

The CMS concurs. CMS agrees that the $19,268 in overpayments should be recovered. CMS plans to recover the overpayments identified consistent with the agency's policies and procedures.

The OIG will be requested to furnish for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor-specific data should be written to separate CD-ROMs or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Review our information on the 20,605 unsampled claims for IPF interrupted stays, which had potential overpayments estimated at $3.8 million, and work with its FIs to recover any overpayments.

CMS Response

The CMS concurs. CMS will analyze a subset of the 20,605 unsampled claims to determine the cost effectiveness of conducting review of all claims. CMS will also collect applicable overpayments. CMS will share the results of the cost effectiveness study across fee-for-service claims processing contractors.

OIG Recommendation

Establish edits in its Common Working File (CWF) to prevent and detect overpayments to IPFs that admitted beneficiaries from another IPF and did not bill the claim as part of an interrupted stay.

CMS Response

The CMS concurs. CMS will instruct its FIs and Medicare Administrative Contractors (MACs) to establish edits in the CWF to detect interrupted stays between two different facilities. This will prevent overpayments and underpayments.

OIG Recommendation

Instruct its FIs to initiate the necessary modifications to the Fiscal Intermediary Shared System (FISS) to process and pay IPF interrupted stays correctly.

CMS Response

The CMS concurs. CMS will instruct its FIs and MACs to modify the FISS and IPF Pricer to process and pay IPF interrupted stays between two different facilities correctly.

OIG Recommendation

Consider conducting periodic postpayment reviews for claims submitted after our review to identify claims incorrectly paid as new stays rather than as the second part of interrupted stays.

CMS Response

The CMS concurs. The Recovery Audit Contractors (RACs) review Medicare claims on a post payment basis and are tasked with identifying overpayments and underpayments. While CMS does not mandate areas for RAC review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

OIG Recommendation

Revise its billing instructions to address appropriate billing for the second part of interrupted stays involving two separate IPFs when the second IPF is aware of the preceding stay.

CMS Response

The CMS concurs. CMS will request a new code from the National Uniform Billing Committee for IPFs to demonstrate on their claim the prior stay at another IPF. This code will also be incorporated into the FISS and CWF editing, so that payment can be properly applied. Even if the second IPF is unaware of the preceding stay and does not use the code, the systems will be designed to pay correctly.

The CMS appreciates the OIG's efforts and insight on this report.