



June 9, 2010

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

**FROM:** /Daniel R. Levinson/  
Inspector General

**SUBJECT:** Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007 (A-01-09-00507)

The attached final report provides the results of our review of inpatient rehabilitation facilities' transmission of patient assessment instruments 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 at (410) 786-7104 or through email at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-01-09-00507 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NATIONWIDE REVIEW OF INPATIENT  
REHABILITATION FACILITIES'  
TRANSMISSION OF PATIENT  
ASSESSMENT INSTRUMENTS FOR  
CALENDAR YEARS 2006 AND 2007**



Daniel R. Levinson  
Inspector General

June 2010  
A-01-09-00507

# *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**

Under the prospective payment system for inpatient rehabilitation facilities (IRF), the Centers for Medicare & Medicaid Services (CMS) establishes a prospective payment rate for each of 92 distinct case-mix groups. Medicare Part A fiscal intermediaries, under contract with CMS, use the Fiscal Intermediary Shared System (FISS) to process and pay claims submitted by IRFs.

To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains. Each IRF must report the date that it transmitted the instrument to the Database on the claim that it submits to the fiscal intermediary. If an IRF transmits the instrument more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.

Our audit covered 10,338 claims totaling \$166 million that were at high risk of having been overpaid because IRFs had transmitted the patient assessment instruments to the Database after the 27-day deadline.

### **OBJECTIVE**

Our objective was to determine whether IRFs received reduced case-mix-group payments for claims with patient assessment instruments that were transmitted to the Database more than 27 days after the beneficiaries' discharges.

### **SUMMARY OF FINDINGS**

IRFs did not always receive reduced case-mix-group payments for claims with patient assessment instruments that were transmitted to the Database more than 27 days after the beneficiaries' discharges. Of the 200 claims that we sampled, which had dates of service in calendar years 2006 and 2007, 8 were either canceled or paid correctly. Our findings on the 192 remaining claims follow:

- IRFs did not receive reduced case-mix-group payments for 113 claims with patient assessment instruments that were transmitted to the Database after the 27-day deadline. Overpayments occurred because IRF and Medicare payment controls were inadequate. Based on our sample results, we estimated that fiscal intermediaries made a total of \$20.2 million in overpayments to IRFs.
- IRFs initially transmitted patient assessment instruments to the Database within the 27-day deadline for 79 claims. However, IRFs subsequently retransmitted these instruments after the deadline to correct errors in the initial transmissions. Because CMS's written guidance does not address the applicability of the 25-percent penalty in these situations, we could not determine whether the claims should have received reduced case-mix-group

payments. Based on our sample results, we estimated that fiscal intermediaries may have made an additional \$19 million in overpayments to IRFs.

## **RECOMMENDATIONS**

We recommend that CMS:

- adjust the 113 sampled claims for overpayments of \$424,141;
- determine whether any of the \$323,504 potential payment penalty should apply to the 79 sampled claims with modified patient assessment instruments that were transmitted after the 27-day deadline;
- immediately reopen the 10,138 nonsampled claims, review our information on these claims (which have overpayments estimated at \$19.8 million and set-aside payments estimated at \$18.7 million), and recover any overpayments;
- alert IRFs to the importance of reporting the correct patient assessment instrument transmission dates on their claims;
- consider establishing a process that would allow the FISS to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect patient assessment instrument transmission dates;
- ensure that fiscal intermediaries (1) have access to Foundation reports that document late or missing patient assessment instrument transmissions and (2) use these reports to conduct periodic postpayment reviews;
- revise the FISS edit to count the discharge date as day 1 in the 27-day counting sequence used to apply the 25-percent payment penalty; and
- establish written policies to address whether patient assessment instruments that are retransmitted after the 27-day deadline to correct errors in the initial timely transmissions are subject to the 25-percent payment penalty.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In comments on our draft report, CMS concurred with our recommendations and described the steps that it had taken or planned to take to address the issues we identified. CMS's comments, except for technical comments, are included as Appendix C.

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## INTRODUCTION

### BACKGROUND

#### **The Prospective Payment System for Inpatient Rehabilitation Facilities**

Inpatient rehabilitation facilities (IRF) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, implemented the prospective payment system for cost-reporting periods beginning on or after January 1, 2002. Under the system, CMS establishes a Federal prospective payment rate for each of 92 distinct case-mix groups. The assignment to a case-mix group is based on the beneficiary's clinical characteristics and expected resource needs.

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 IRFs.<sup>1</sup> Fiscal intermediaries use the Fiscal Intermediary Shared System (FISS) for claim processing.

#### **Patient Assessment Instruments**

Section 1886(j)(2)(D) of the Act requires IRFs to transmit sufficient patient data to allow CMS to administer the IRF prospective payment system. These data are necessary to assign beneficiaries to the appropriate case-mix groups, to monitor the effects of the IRF prospective payment system on patient care and outcomes, and to determine whether adjustments to the case-mix groups are warranted.

To meet its data needs, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains.<sup>2</sup> Each IRF must report the date that it transmitted the patient assessment instrument to the Database on the claim that it submits to the fiscal intermediary. If an IRF transmits the patient assessment instrument more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.

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<sup>1</sup> Effective October 1, 2005, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace fiscal intermediaries by October 2011.

<sup>2</sup> CMS contracts with the Foundation, which specializes in health care quality improvement and medical information management, to store and manage IRF patient assessment data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether IRFs received reduced case-mix-group payments for claims with patient assessment instruments that were transmitted to the Database more than 27 days after the beneficiaries' discharges.

### **Scope**

Nationwide, IRFs submitted a total of 781,708 claims valued at \$11.9 billion with dates of service in CYs 2006 and 2007. Our audit covered 10,338 claims totaling \$166 million that were at high risk of having been overpaid because IRFs had transmitted the patient assessment instruments to the Database after the 27-day deadline.

Our objective did not require an understanding or assessment of the complete internal control structures of IRFs, CMS, the fiscal intermediaries, or the Foundation. Therefore, we limited our review at IRFs to the controls related to reporting patient assessment instrument transmission dates on Medicare claims. We limited our review at CMS, selected fiscal intermediaries, and the Foundation to the controls related to preventing or detecting Medicare overpayments to IRFs for claims with patient assessment instruments that were transmitted to the Database after the 27-day deadline.

Our fieldwork consisted of contacting IRFs nationwide and visiting four IRFs in Florida and Massachusetts. We also contacted three fiscal intermediaries and visited the Foundation in Des Moines, Iowa. We conducted our fieldwork from March through June 2009.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed officials of CMS, three fiscal intermediaries, and the Foundation to obtain an understanding of edits in the FISS and other controls intended to prevent or detect Medicare overpayments to IRFs;
- extracted IRF paid claim data from CMS's National Claims History file for CYs 2006 and 2007;
- obtained from the Foundation a database of all patient assessment instruments for claims with dates of service in CYs 2006 and 2007;
- developed a computer match between the National Claims History file and the Database that identified 10,338 claims:

- 8,800 claims with patient assessment instrument transmission dates that did not match the late dates on which IRFs transmitted the instruments to the Database and
- 1,538 claims with patient assessment instrument transmission dates that were exactly 28 days from (and including) the beneficiaries' discharge dates;
- selected a stratified random sample of 200 claims from the 10,338 claims (Appendix A);
- reviewed data from CMS's Common Working File for the 200 sampled claims to validate the results of our computer match and to verify that the selected claims had not been canceled;
- contacted representatives from the 142 IRFs that submitted the 200 sampled claims to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for our sampled claims by reducing the prospective payment rate for the applicable case-mix group by 25 percent;
- estimated the total value of overpayments and the amount set aside for CMS review based on our sample results (Appendix B); and
- discussed the results of our review with CMS.

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**

IRFs did not always receive reduced case-mix-group payments for claims with patient assessment instruments that were transmitted to the Database more than 27 days after the beneficiaries' discharges. Of the 200 claims that we sampled, which had dates of service in CYs 2006 and 2007, 8 were either canceled or paid correctly. Our findings on the 192 remaining claims follow:

- IRFs did not receive reduced case-mix-group payments for 113 claims with patient assessment instruments that were transmitted to the Database after the 27-day deadline. Overpayments occurred because IRF and Medicare payment controls were inadequate. Based on our sample results, we estimated that fiscal intermediaries made a total of \$20.2 million in overpayments to IRFs.

- IRFs initially transmitted patient assessment instruments to the Database within the 27-day deadline for 79 claims. However, IRFs subsequently retransmitted these instruments after the deadline to correct errors in the initial transmissions. Because CMS's written guidance does not address the applicability of the 25-percent penalty in these situations, we could not determine whether the claims should have received reduced case-mix-group payments. Based on our sample results, we estimated that fiscal intermediaries may have made an additional \$19 million in overpayments to IRFs.

## **PROGRAM REQUIREMENTS**

Pursuant to 42 CFR § 412.614, IRFs must electronically transmit to the Database timely, complete, and accurate encoded data from the patient assessment instrument for each Medicare Part A beneficiary. In addition, pursuant to 42 CFR § 412.610(e), encoded patient assessment data must accurately reflect the beneficiary's clinical status at the time of the patient assessment. Federal regulations do not define clinical status.

CMS guidance in Transmittal A-01-131, dated November 1, 2001, elaborates on the requirement for timely transmission of the patient assessment instrument set forth in 42 CFR § 412.614(c) and (d). The guidance states that an IRF must transmit patient assessment instrument data to the Database by the 17<sup>th</sup> calendar day from the date of the beneficiary's discharge. If the actual transmission date is more than 10 calendar days from the mandated transmission date, the patient assessment instrument is considered late and the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent. Therefore, if the IRF transmits the patient assessment instrument more than 27 calendar days from the discharge date, with the discharge date itself starting the counting sequence, the 25-percent penalty should be applied.

CMS's written guidance does not address the applicability of the 25-percent penalty when the initial timely transmission of a patient assessment instrument that contains patient status errors is followed by a second untimely transmission of a corrected version.

Additional CMS guidance in Transmittal 291, dated August 27, 2004, states that for a discharge on or after October 1, 2004, the IRF must record the date of the patient assessment instrument transmission in the "Service Date" field of the claim.

## **LATE TRANSMISSION OF PATIENT ASSESSMENT INSTRUMENTS**

Contrary to Medicare regulations, IRFs did not receive reduced case-mix-group payments for 113 sampled claims with patient assessment instruments that were transmitted to the Database more than 27 days after the beneficiaries' discharges. These IRFs received overpayments totaling \$424,141.

### **Incorrect Transmission Dates on Claims**

IRFs reported timely patient assessment instrument transmission dates on 80 of the 113 overpaid claims, but the instruments were actually transmitted to the Database after the 27-day deadline. CMS uses the dates that IRFs report on their claims to determine compliance with the timely

filing requirement. As a result, fiscal intermediaries made full case-mix-group payments for these claims rather than payments that were reduced by the 25-percent payment penalty. The 80 claims resulted in Medicare overpayments totaling \$288,926.

### **Reported Transmission Dates 1 Day Past Deadline**

For 33 of the 113 overpaid claims, IRFs reported patient assessment instrument transmission dates that were 1 day late; that is, the claims indicated transmission on the 28<sup>th</sup> day. For 28 of these claims, the reported transmission dates on the claims accurately reflected the dates that the IRFs transmitted the patient assessment instruments to the Database. For the remaining 5 claims, the reported transmission dates on the claims were not accurate; i.e., the transmissions to the Database actually occurred more than 28 days after the beneficiaries' discharges. Because fiscal intermediaries erroneously made full case-mix-group payments instead of reduced payments for the 33 claims, IRFs received a total of \$135,215 in overpayments.

### **Causes of Overpayments**

#### *Inadequate Controls at Inpatient Rehabilitation Facilities*

IRFs did not have adequate controls to ensure that the patient assessment instrument transmission dates reported on their claims matched the actual dates on which the IRFs transmitted the instruments to the Database. Specifically, IRF officials informed us that clinical staff who transmitted patient assessment instruments to the Database did not always effectively communicate this information to billing staff who recorded the dates on the claims. Instead, the billing staff often recorded the beneficiaries' discharge dates as the patient assessment instrument transmission dates. Additionally, some IRFs' clinical staff did not enter the transmission dates in the IRFs' internal reporting systems, causing the systems to default to the beneficiaries' discharge dates. Because the IRFs' billing systems used information from the internal reporting systems, the beneficiaries' discharge dates were incorrectly entered on some claims.

#### *Inadequate Medicare Payment Controls*

Medicare prepayment controls were not designed to compare the patient assessment instrument transmission dates on claims paid by the FISS with the actual dates on which IRFs transmitted the instruments to the Database. In addition, CMS did not provide fiscal intermediaries with access to reports produced by the Foundation that document late or missing patient assessment instrument transmissions. Fiscal intermediaries could have used these reports to conduct periodic postpayment reviews. Finally, FISS payment edits were designed to identify patient assessment instruments that were transmitted to the Database more than 27 days from, but not including, the discharge dates. Thus, these edits were unable to identify patient assessment instruments that were transmitted to the Database 1 day late because the edits began the 27-day counting sequence on the day after the discharge rather than the day of the discharge.

## **MODIFIED PATIENT ASSESSMENT INSTRUMENTS**

For 79 sampled claims, IRFs initially transmitted the patient assessment instruments to the Database by the 27-day deadline. However, IRFs subsequently retransmitted these instruments after the 27-day deadline to correct errors in the initial transmissions. Because Federal regulations do not define clinical status, we could not determine whether clinical status was accurately reflected in the initial transmissions. Furthermore, CMS's written guidance does not address the applicability of the 25-percent penalty to claims with late retransmitted patient assessment instruments. Therefore, we are setting these claims aside for CMS to determine whether the claims should have received reduced case-mix-group payments. The potential payment penalty associated with the 79 claims is \$323,504.

## **PAYMENT ESTIMATES**

Based on our sample results, we estimated that for services provided in CYs 2006 and 2007, fiscal intermediaries made a total of \$20.2 million in overpayments to IRFs for claims that should have been reduced by the 25-percent penalty because the associated patient assessment instruments were transmitted to the Database more than 27 days after the beneficiaries' discharges. We also estimated that fiscal intermediaries may have made as much as an additional \$19 million in overpayments to IRFs for claims with modified patient assessment instruments that were transmitted after the 27-day deadline.

## **RECOMMENDATIONS**

We recommend that CMS:

- adjust the 113 sampled claims for overpayments of \$424,141;
- determine whether any of the \$323,504 potential payment penalty should apply to the 79 sampled claims with modified patient assessment instruments that were transmitted after the 27-day deadline;
- immediately reopen the 10,138 nonsampled claims, review our information on these claims (which have overpayments estimated at \$19.8 million and set-aside payments estimated at \$18.7 million), and recover any overpayments;
- alert IRFs to the importance of reporting the correct patient assessment instrument transmission dates on their claims;
- consider establishing a process that would allow the FISS to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect patient assessment instrument transmission dates;
- ensure that fiscal intermediaries (1) have access to Foundation reports that document late or missing patient assessment instrument transmissions and (2) use these reports to conduct periodic postpayment reviews;

- revise the FISS edit to count the discharge date as day 1 in the 27-day counting sequence used to apply the 25-percent payment penalty; and
- establish written policies to address whether patient assessment instruments that are retransmitted after the 27-day deadline to correct errors in the initial timely transmissions are subject to the 25-percent payment penalty.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In comments on our draft report, CMS concurred with our recommendations and described the steps that it had taken or planned to take to address the issues we identified. 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 provided technical comments, which we addressed as appropriate. CMS's comments, except for technical comments, are included as Appendix C.

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

# **APPENDIXES**

## **APPENDIX A: SAMPLING DESIGN AND METHODOLOGY**

### **POPULATION**

The population consisted of claims for inpatient rehabilitation facility (IRF) Medicare Part A stays during calendar years (CY) 2006 and 2007.

### **SAMPLING FRAME**

The sampling frame was a database of 10,338 IRF claims totaling \$166,014,561 for services provided to beneficiaries in Medicare Part A stays during CYs 2006 and 2007 that were at high risk of having been overpaid because IRFs had transmitted the patient assessment instruments to the Centers for Medicare & Medicaid Services' (CMS) National Assessment Collection Database (the Database) after the 27-day deadline. We stratified the frame into two strata. Stratum 1 consisted of 8,800 claims with patient assessment instrument transmission dates of 27 days or fewer from the discharge dates according to the IRFs but more than 27 days from the discharge dates according to the Database. Stratum 2 consisted of 1,538 claims on which IRFs reported transmission dates of exactly 28 days from (and including) the discharge dates.

### **SAMPLE UNIT**

The sample unit was an IRF claim.

### **SAMPLE DESIGN**

We used a stratified random sample.

### **SAMPLE SIZE**

We selected a total of 200 claims: 140 from stratum 1 and 60 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 SAMPLED UNITS**

We consecutively numbered the sample units in the frame from 1 to 8,800 for stratum 1 and from 1 to 1,538 for stratum 2. After generating 140 random numbers for stratum 1 and 60 for stratum 2, 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**

<b>Stratum</b>	<b>Frame Size</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Claims in Error</b>	<b>Overpayments for Claims in Error</b>	<b>Number of Claims Set Aside for CMS Review</b>	<b>Amount Set Aside for CMS Review</b>
1. Claim transmission date $\leq 27$ days and Database transmission date $> 27$ days from discharge date	8,800	140	\$2,126,473	71	\$250,677	69	\$287,606
2. Claim transmission date exactly 28 days from discharge date	1,538	60	893,094	42	173,464	10	35,898
<b>Total</b>	<b>10,338</b>	<b>200</b>	<b>\$3,019,567</b>	<b>113</b>	<b>\$424,141</b>	<b>79</b>	<b>\$323,504</b>

**Estimated Overpayments**

***(Limits Calculated for a 90-Percent Confidence Interval)***

Point estimate	\$20,203,320
Lower limit	17,471,378
Upper limit	22,935,262

**Estimated Amount Set Aside for CMS Review**

***(Limits Calculated for a 90-Percent Confidence Interval)***

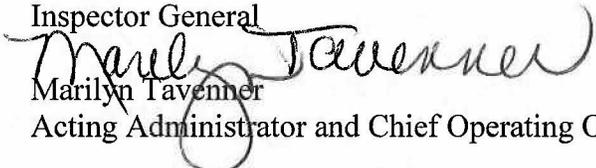
Point estimate	\$18,998,299
Lower limit	15,931,817
Upper limit	22,064,781

*Administrator*

Washington, DC 20201

**DATE:** APR 23 2010

**TO:** Daniel R. Levinson  
Inspector General

**FROM:**   
Marilyn Tavenner  
Acting Administrator and Chief Operating Officer

**SUBJECT:** Office of Inspector General's Draft Report: "Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007" (A-01-09-00507)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to respond to the Office of Inspector General's (OIG) draft report, "Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007."

The objective of the review was to determine whether inpatient rehabilitation facilities (IRFs) received reduced case mix group payments for claims with patient assessment instruments that were transmitted to the CMS contractor's data repository more than 27 days after the beneficiaries were discharged from an IRF. The OIG found that IRFs sometimes received the full case mix group payment for claims associated with late patient assessment instruments. Like the OIG, CMS is concerned that this is occurring and has already taken a number of steps to prevent it, including developing internal systems to check the patient assessment instrument transmission dates on the claims with the actual transmission dates. We are also exploring whether the Recovery Audit Contractors (RACs) should conduct post-payment review of IRF claims to ensure appropriate application of the 25 percent payment penalty.

Payments under the IRF prospective payment system (PPS) are based on information derived from IRF patient assessment instruments. According to the Medicare regulations in 42 Code of Federal Regulations (CFR) section 412.614 and to our guidance published on November 1, 2001, in CMS Transmittal A-01-131, IRFs must submit complete and accurate patient assessment information on all Medicare Part A patients treated in the IRF no later than 27 calendar days from the day of the patient's discharge from the IRF. This ensures that CMS has the necessary information to process IRF claims. Failure to transmit the patient assessment instrument data for a Medicare Part A patient within the required timeframes results in a 25 percent reduction to the case mix group payment.

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IRFs are also required to report the date of transmission of the patient assessment instruments on the IRF claims that they submit to Medicare. CMS's payment systems compare the data transmission date reported on the IRF claim with the discharge date on the IRF claim, and automatically reduce the case mix group payment on the claim by 25 percent if the transmission date is more than 27 days from the discharge date. However, if the IRF records an inaccurate date of transmission on the IRF claim that is within 27 days of the discharge date, then the system does not apply the 25 percent payment penalty.

### **OIG Recommendation 1**

CMS should adjust the 113 sampled claims for overpayments of \$424,141.

### **CMS Response**

CMS concurs that the \$424,141 in overpayments should be recovered. CMS plans to recover the overpayments identified consistent with the Agency's policies and procedures. In order to recover these overpayments CMS needs the OIG 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.). Once CMS receives this information from the OIG, we will investigate these claims and facilities and collect any overpayments made. 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 contractor for action.

### **OIG Recommendation 2**

CMS should determine whether any of the \$323,504 potential payment penalty should apply to the 79 sampled claims with modified patient assessment instruments that were transmitted after the 27-day deadline.

### **CMS Response**

CMS concurs with this recommendation. CMS will review the 79 sampled claims identified by the OIG to determine whether the data transmitted in the initial patient assessment instruments (that were transmitted within the required timeframes) were complete and accurate, as required by 42 CFR section 412.614(b)(1). Based on this review, we will determine whether any of the \$323,504 potential payment penalty should have applied to these claims. We will then issue guidance, in the form of a clarification of our existing policies in 42 CFR section 412.614(b)(1), regarding how patient assessment instruments that are transmitted within the required timeframes and subsequently resubmitted with modifications will be handled with respect to the 25 percent payment penalty.

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**OIG Recommendation 3**

CMS should immediately reopen the 10,138 non-sampled claims, review the OIG's information on these claims (which have overpayments estimated at \$19.8 million and set-aside payments estimated at \$18.7 million), and recover any overpayments.

**CMS Response**

CMS concurs with comments. Upon receipt of the claims data from the OIG, CMS will take appropriate action to review a subset of the 10,138 claims. During the course of review of the subset of claims, CMS will collect applicable overpayments consistent with the Agency's policies and procedures. CMS will also explore a strategy involving the RACs to review claims for this issue after October 1, 2007. RACs review Medicare claims on a post payment basis and are tasked with identifying underpayments and overpayments. While CMS does not mandate areas for RAC review, we do share claims information with the RACs for possible review.

**OIG Recommendation 4**

CMS should alert IRFs to the importance of reporting the correct patient assessment instrument transmission dates on their claims.

**CMS Response**

CMS concurs with this recommendation. CMS recently instructed its contractors to begin sending the following alert to IRFs when they transmit late patient assessment instruments: "This data record has been transmitted late. The transmission date must be reported on your Medicare claim, and may result in a late transmission penalty."

We are also in the process of revising our instructions for completing IRF claims, and we will include new language in these revised instructions to alert IRFs to the importance of reporting the correct patient assessment instrument transmission dates on the IRF claims.

In addition, we will continue to work with IRF industry associations to reiterate the importance of reporting the correct patient assessment instrument transmission dates on the claims.

**OIG Recommendation 5**

CMS should consider establishing a process that would allow the Fiscal Intermediary Shared System (FISS) to interface with the Database to identify, on a prepayment basis, IRF claims with incorrect patient assessment instrument transmission dates.

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**CMS Response**

CMS concurs. CMS has already developed plans toward creating this process and solicited input from the Medicare contractors. CMS will receive official feedback on the process shortly and will use such analysis in the development of the appropriate contractor instruction. Given the need to schedule implementation of an instruction as part of the CMS Quarterly System Release process, we envision all necessary work to develop the instruction, code it, test it and implement it, to be completed with the July 2011 quarterly system release.

**OIG Recommendation 6**

CMS should ensure that fiscal intermediaries (1) have access to Foundation reports that document late or missing patient assessment instrument transmissions and (2) use these reports to conduct periodic postpayment reviews.

**CMS Response**

CMS concurs. The process referred to in the CMS Response for OIG Recommendation 5 will make recommendation 6 unnecessary. The assessment date on the claim will be compared to the actual assessment date within the National database. If the dates do not match, CMS will use the actual transmission date found in the National database for purposes of whether to apply the penalty.

**OIG Recommendation 7**

CMS should revise the FISS edit to count the discharge date as day 1 in the 28-day counting sequence used to apply the 25-percent payment penalty.

**CMS Response**

CMS concurs. In fact, on October 5, 2009, CMS implemented a systems change that revised the FISS edit to count the discharge date as day 1 in the 28-day counting sequence.

**OIG Recommendation 8**

CMS should establish written policies to address whether patient assessment instruments that are retransmitted after the 27-day deadline to correct errors in the initial timely transmissions are subject to the 25-percent payment penalty.

**CMS Response**

CMS concurs with this recommendation. However, we believe that the written policies that the OIG recommends would be clarifications of existing policies regarding the timely transmission

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of complete and accurate data, rather than new policies. Thus, we will issue guidance to further clarify how patient assessment instruments that are transmitted within the required timeframes and then subsequently resubmitted with modifications will be handled with respect to the 25 percent payment penalty.

The CMS thanks the OIG for the opportunity to review and comment on this report. Your report supports CMS's ongoing efforts to ensure timely transmission of the IRF patient assessment instrument data. We look forward to continuing to work closely with the OIG on this issue to ensure accurate IRF PPS payments.