

Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Our prior reviews have found that some hospitals did not comply with Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs). The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for IRFs increased, ranging from 9 percent in 2012 to a high of 62 percent in 2016.

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for fee-for-service (FFS) claims for services provided in 2013.

How OIG Did This Review

Our audit covered \$6.75 billion in Medicare payments to 1,139 IRFs nation-wide for 370,872 IRF stays. We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling almost \$11.3 million in payments to 164 IRFs for calendar year 2013, the most recent claims data available at the time the audit started. We used an independent medical review contractor to determine whether the medical records for the sampled IRF stays met coverage requirements. In addition, we determined whether the medical records complied with Federal documentation requirements.

Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements

What OIG Found

IRFs complied with all Medicare coverage and documentation requirements specified for reasonable and necessary care for 45 of the 220 sampled stays. However, for 175 of the sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare's requirements. These errors occurred because many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prepayment review for IRF admissions; CMS's extensive educational efforts and postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide \$5.7 billion for care to beneficiaries that was not reasonable and necessary.

What OIG Recommends and CMS's Comments

We recommend that CMS (1) educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to develop best practices to improve internal controls; (2) increase oversight activities for IRFs, such as postpayment medical review; (3) work with the Office of Medicare Hearings and Appeals to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented at ALJ hearings; and (4) reevaluate the IRF payment system, which could include a demonstration project requiring preauthorization for Medicare Part A FFS IRF stays modeled on Medicare Advantage practices, a study of the relationship between IRF PPS payments and costs and take any necessary steps to more closely align them, and a consideration of the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform. In their written comments to our draft, CMS concurred with our recommendations, described actions that it planned to take to address them, and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while preventing improper payments.