

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**INELIGIBLE MEDICARE PAYMENTS  
TO SKILLED NURSING FACILITIES  
UNDER THE ADMINISTRATIVE  
RESPONSIBILITY OF MUTUAL OF  
OMAHA**



**JANET REHNQUIST**  
Inspector General

March 2003  
A-05-02-00083

# *Notices*

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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 HHS divisions will make final determination on these matters.





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OFFICE OF AUDIT SERVICES  
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CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

CIN: A-05-02-00083

March 14, 2003

Mr. Richard Reeves  
Vice President and Director, Medicare  
Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175

Dear Mr. Reeves,

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 Mutual of Omaha." 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-02-00083 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Joe Tilghman, Regional Administrator  
Centers for Medicare & Medicaid Services – Region VII  
Richard Bolling Federal Building  
Room 235  
601 East 12<sup>th</sup> Street  
Kansas City, Missouri 64106

## **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 Mutual of Omaha (Mutual).

### **FINDINGS**

We estimate that the Medicare program improperly paid \$41.5 million to SNF providers that should be recovered by Mutual. Based on a sample of 200 SNF stays, we estimate that 89 percent of the Mutual 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 Mutual'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 Mutual 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 \$41.5 million were paid without being detected.

### **RECOMMENDATIONS**

We recommend that Mutual:

- Initiate recovery actions estimated to be \$41.5 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, Mutual generally concurred with our recommendation to collect overpayments for ineligible SNF stays but will wait for CMS's direction before proceeding with collection efforts. Although Mutual contends our report is misleading and inappropriately singled out Mutual for a lack of automated procedures to match an inpatient stay to a SNF admission, this does not consider our reference to improper payments not being directly attributable to any inappropriate action or inaction by Mutual. In addition, Mutual questions the accuracy of our database but does not consider our described methodology for its development, which addresses Mutual's concerns. In regard to collection, Mutual believes, and we disagree, that the beneficiaries will ultimately be responsible for overpayments made on their behalf. A summary of Mutual's response and our comments begin on page 5 of the report. The full text of Mutual's response is included as Appendix B to this report.

# 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 Mutual is responsible for 7,500 potentially ineligible SNF stays, consisting of 13,798 SNF claims and reimbursed by Medicare in the amount of \$47.5 million.

## **OBJECTIVE, SCOPE AND METHODOLOGY**

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

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 the first in 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 Mutual. Our database identified 7,500 potentially ineligible SNF stays, which included 13,798 SNF claims reimbursed by Mutual in the amount of \$47.5 million.

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

Our fieldwork was performed in the Chicago Regional Office during August and September 2002.

**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 Mutual database (reimbursed at \$1,267,059) 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 90<sup>th</sup> percentile of ineligible SNF payments under Mutual's responsibility amounted to \$41.5 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 \$41.5 million that Mutual should recover. Eighty-nine percent of the 7,500 SNF stays in the Mutual 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 Mutual'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 Mutual 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 Mutual 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 Mutual database is not directly attributable to any inappropriate action or inaction by Mutual, we believe that our review has identified the need for Mutual to educate SNF providers about the Medicare reimbursement regulations.

## **EFFECT**

Out of the potential unallowable database of \$47.5 million, we estimate that improper Medicare SNF payments under Mutual's responsibility for the period January 1, 1997 through December 31, 2001 amounted to \$41.5 million. From the Mutual database, we confirmed that 178 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 22 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 22 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 89 percent of the 7,500 SNF stays and \$41.5 million of the payments in the Mutual 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 Mutual officials.

## **RECOMMENDATIONS**

We recommend that Mutual:

- Initiate recovery actions estimated to be \$41.5 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.

## **MUTUAL'S RESPONSE**

Mutual contends that our report is misleading in that the cited condition is common to all contractors processing SNF claims and it is inappropriate to address our recommendations individually to Mutual. Mutual believes that, due to their systemic nature, the recommendations should be directed to CMS.

Although Mutual agrees that the improper Medicare reimbursements appear to be the result of invalid or incomplete information furnished by skilled nursing facilities, they believe that an expanded OAS review of medical records would have identified database errors in classifying reimbursements as improper. In its response, Mutual cites various factors that might effect the accuracy of our database but disregards our described methodology which eliminated these factors through data analysis screening.

They also cited the possibility that CMS may have approved a waiver of the qualifying hospital stay due to a physical disaster.

Mutual generally concurred with our recommendation to collect overpayments for ineligible SNF stays but will wait for CMS direction before proceeding to recover the overpayments. In regard to collections, Mutual also believes that beneficiaries are liable for the charges incurred during an unqualified SNF stay and that collection efforts may cause a financial hardship on the beneficiary. The full text of Mutual's response is presented in Appendix B.

## **OAS COMMENTS**

Our report is factual in stating that neither the CWF nor Mutual's claims processing systems have an automated means to match an inpatient stay to a SNF admission and to identify

inappropriate payments on a prepayment basis. We disagree that our report is misleading. We clearly state that the payments in our database are not directly attributable to any inappropriate action or inaction by Mutual. However, regarding those payments, Mutual has a fiduciary responsibility to perform a post-payment review and to recover reimbursements that they determine to be improper.

We disagree with Mutual's implication that our database contains significant inaccuracies. As our described methodology indicates, we performed substantial data analysis screening to exclude the factors presented in Mutual's response. We believe the resulting database contains a high percentage of errors (estimated to be 89%), which now warrants Mutual's follow-up and recovery where appropriate.

With the exception of CMS-granted waivers, our methodology for constructing the database resolved the error situations presented in Mutual's response. While it is possible that a waiver situation may apply, when we constructed our database, we were not aware of any physical disaster that justified a waiver. This would be an appropriate consideration for Mutual, as they proceed with our recommended recovery action for our database.

In regard to recovery from the beneficiary, we disagree with Mutual that the recoveries will ultimately become 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, which addresses admission procedures to the SNF, specifies that the SNFs, when admitting a beneficiary, should ask the transferring hospital if the beneficiary had a three day qualifying hospital stay. For the majority of these improperly paid SNF claims, we believe that 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 beneficiary was without fault. Since Mutual's assessment indicated that "the errors appear to be the result of invalid information furnished by skilled nursing facilities or incomplete information", it is reasonable to expect that the SNF's should have known that the claim information, submitted on behalf of the beneficiaries, was invalid or incomplete. As Mutual performs the recommended review of our database, they will determine that the SNFs, rather than the beneficiaries, were at fault and are financially liable to repay the Medicare program.

## **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 on 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 \$47,482,041.

#### SAMPLE RESULTS

The results of our review are as follows:

<u>Number of SNF Stays</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of SNF Stays Eligible for Payment</u>	<u>Value of SNF Stays Eligible for Payment</u>
7,500	200	\$1,267,059	22	\$106,927

#### VARIABLE PROJECTION

Point Estimate                      \$4,009,762

90% Confidence Interval

Lower Limit                      \$2,047,458  
Upper Limit                      \$5,972,067

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

Database Value	\$47,482,041	Database Value	\$47,482,041
Upper limit	<u>(-) \$5,972,067</u>	Lower limit	<u>(-) \$2,047,458</u>
<b>Lower Limit As Reported</b>	<b>\$41,509,974</b>	<b>Upper Limit</b>	<b>\$45,434,583</b>

November 20, 2002

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

Re: CIN: A-05-02-0083

Dear Mr. Slamar:

I appreciate the opportunity to respond to the draft report referenced above. The report is inaccurate in the several statements referring to "Mutual's claims processing systems." The report is misleading relative to statements about Mutual lacking an automated means to match an inpatient stay to a SNF admission as we believe this is common to all contractors processing SNF bills. Mutual, like other contractors, uses CMS mandated systems.

Mutual of Omaha Medicare follows CMS rules and regulations for processing SNF bills and uses a CMS standard claims processing system. As noted on page 4 of the draft report: "... the cause of the improper SNF payments in the Mutual database is not directly attributable to any inappropriate action or inaction by Mutual...." Based on the report, the errors appear to be the result of invalid information furnished by skilled nursing facilities or incomplete information. Since the auditors did not review medical records, some conclusions and extrapolation may be inaccurate. Further review of the claim history and medical records will be needed to determine if any other factors were contributory. These factors would include the following situations:

- The qualifying hospital stay occurred at a VA or other non-Medicare facility, for which CWF would have no record.
- The beneficiary may have been in a Medicare + Choice HMO and disenrolled from the HMO before admission to the SNF, in which case CWF would not have a record of the hospital stay.
- A physical disaster situation, such as a hurricane, flood, etc., occurred whereby CMS approved the payment of the SNF stay without a qualifying hospital stay.
- The hospital stay was paid "outside of CWF" in accordance with a special process allowed by CMS to allow payment to be made when there is a system problem.

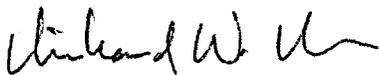
We understand that all recovery action related to the cases mentioned in the report will be coordinated by CMS and we will await their direction before proceeding to recover the overpayments. Regardless of CMS instruction regarding collection of alleged overpayments, recovery of overpayments ultimately will come from the Medicare beneficiaries. Medicare beneficiaries are liable for the charges they incurred because they did not meet the prior

qualifying hospital stay of three days or more, before the day of discharge. Attempting to collect these overpayments from the beneficiaries may create a financial hardship for the beneficiary or exacerbate a financial hardship that already exists.

We feel it is inappropriate to single out Mutual (or any other contractors individually) for a systemic deficiency between standard CMS systems which Mutual is obliged to use. We also believe it is inappropriate to single out Mutual from a nation wide review encompassing multiple contractors facing the same systems deficiencies.

Owing to the systemic nature of this issue, we believe the recommendations should be directed to CMS so that uniform guidance can be developed by CMS for all contractors processing SNF bills. However, we would be glad to assist CMS in developing possible solutions to this issue going forward.

Sincerely,



Richard W. Reeves  
Vice President  
Director of Medicare

Cc: Phil Chiarelli, CMS – Kansas City  
Gary Umscheid CMS – Kansas City  
Karen Miller CMS – Kansas City

# 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*  
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Technical Assistance

Tammie Anderson, *Advanced Audit Techniques*

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