DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 3, 2004

Report Number: A-05-04-00060

Mr. Mike Wagner
Corporate Treasurer and Vice President of Government Operations
Blue Cross and Blue Shield of Montana, Inc.
560 North Park Avenue
Helena, Montana 59601

Dear Mr. Wagner,

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of Blue Cross and Blue Shield of Montana, Inc." 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 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 Report Number A-05-04-00060 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Alex Trujillo – CMS Regional Administrator
Centers for Medicare & Medicaid Services – Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

# INELIGIBLE MEDICARE PAYMENTS TO SKILLED NURSING FACILITIES UNDER THE ADMINISTRATIVE RESPONSIBILITY OF BLUE CROSS AND BLUE SHIELD OF MONTANA, INC.


September 2004
A-05-04-00060

# *Office of Inspector General*

**http://oig.hhs.gov**

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## *Office of Evaluation and Inspections*

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Investigations*

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

## EXECUTIVE SUMMARY

### OBJECTIVE

The audit objective was to determine the extent of ineligible Medicare Skilled Nursing Facility (SNF) payments, attributable to Blue Cross and Blue Shield of Montana, Inc. (BCBS of Montana), contained in a database of payments made under the administrative responsibility of nine Medicare Fiscal Intermediaries (FI's). The nine FIs reviewed are presented in Appendix A.

### FINDINGS

The Medicare program improperly paid an estimated $187,458 to SNF providers that should be recovered by BCBS of Montana. Based on the projected results of a sample of 200 SNF stays, 75.5 percent of the database was not in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of SNF admission.

The cause of the improper SNF payments in the database is not directly attributable to any inappropriate action or inaction by BCBS of Montana. The absence of automated cross-checking, within the Centers for Medicare & Medicaid Services' (CMS) Common Working File (CWF) and BCBS of Montana'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 BCBS of Montana 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 $187,458 were paid without being detected.

Although we believe that the estimated improper payments of $187,458 should be recovered by BCBS of Montana, CMS issued a memorandum, dated November 26, 2003 (see Appendix B), instructing FIs not to initiate any recovery actions specific to the issue identified in this report.

### RECOMMENDATIONS

We recommend that BCBS of Montana:

- Initiate recovery actions estimated to be $187,458 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, BCBS of Montana agrees that overpayments occurred but will not initiate recovery actions on the ineligible payments within our database in accordance with the aforementioned CMS memorandum. As for provider education, BCBS of Montana will perform provider education and work one-on-one with providers as needed. The full text of BCBS of Montana's response is included as Appendix E to this report.

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# 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, Office of Inspector General (OIG) self-initiated review of SNF compliance with the three-day inpatient hospital stay requirement in the State of Illinois, improper Medicare payments were identified for calendar year 1996 of approximately $1 million (CIN A-05-99-00018). Because of the significance of the improper payments in one state, the review was expanded to calendar years 1997 through 2001 and to SNF stays nationwide. In order to quantify the extent of improper SNF payments nationwide, a database was created containing 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, SNF and inpatient hospital claims were matched and 60,047 potentially ineligible SNF claims were identified with improper reimbursements of $200.8 million.

In developing the 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. All SNF claims with a zero dollar payment or identification with a Health Maintenance Organization were excluded. Also, inpatient hospital claims were extracted 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.

A file of inpatient hospital stays was created using the hospital admission and discharge dates for the extracted inpatient claims and a SNF file was created 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. All SNF stays with an inpatient stay within 30 days of SNF admission, but less than three days in length, were extracted. Based on the previous review in Illinois, all SNF stays with no inpatient hospital stay prior to admission were excluded. 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.

The database was arrayed by the FI responsible for the SNF payments. For sampling purposes, the database was then stratified into 18 strata based on the amount of potential improper payments per FI. The 17 FIs with amounts exceeding $1 million were placed in separate strata and a separate OIG report was issued to each. (See Appendix C). The 17 FIs accounted for $197 million of the $201 million dollars (98 percent) in the database. The remaining nine FIs, including BCBS of Montana, were each responsible for amounts less than $1 million. Their combined total of $3.7 million was grouped into one stratum. The nine FIs were responsible for 908 potentially ineligible SNF stays, consisting of 1,312 SNF claims. BCBS of Montana's share of the database of potential improper payments amounted to $236,579, which contained 79 SNF stays consisting of 117 SNF claims.

## OBJECTIVE, SCOPE AND METHODOLOGY

The audit objective was to determine the extent of ineligible Medicare SNF payments, attributable to BCBS of Montana, contained in a database of payments made under the administrative responsibility of nine Medicare FIs.

The audit was performed in accordance with generally accepted government auditing standards. This audit is part of a nationwide review of ineligible SNF payments. Accordingly, this report is part of a series of reports to be issued to the FIs identified in our national database. A roll-up report will be issued to CMS, addressing the major issues resulting from the FI audits. This review was limited to testing the extent of ineligible Medicare SNF payments associated with the financial and administrative responsibility of the nine FIs reviewed. The database identified 908 potentially ineligible SNF stays, which included 1,312 SNF claims reimbursed in the amount of $3.7 million under the responsibility of the nine FIs reviewed.

Because of the limited scope of our review, we did not review the overall internal control structures for any of the nine FIs. Our internal control testing was limited to a questionnaire relating to the claim processing system edits in place at the previously reviewed 17 FIs.

The fieldwork was performed in the Chicago Regional Office during May and June 2004.

**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, the validation process consisted of determining whether any eligible SNF stays were inadvertently included in the database. A statistical sample of 200 SNF stays was selected from the database (reimbursed at $801,685) and compared the SNF admission to inpatient information on the CWF system. For each of the 200 SNF stays selected, the Inpatient Listing (INPL) claims screen from the various CWF host sites were reviewed to identify any inpatient stays omitted from the database which would make the SNF stay eligible for Medicare reimbursement.

The amount of SNF payments eligible for Medicare reimbursement was projected using the Department of Health and Human Services, Office of Inspector General, Office of Audit

Services RAT-STATS Unrestricted Variable Appraisal Program. Since the database was intended to quantify only ineligible Medicare reimbursements, the "difference estimator" estimation method was used to measure the amount of eligible Medicare reimbursements that were inadvertently included in the database. The database of ineligible SNF payments was adjusted by using the difference estimator and the upper and lower limits were calculated at the 90 percent confidence level. We estimate that the lower limit of the 90$^{th}$ percentile of ineligible SNF payments under the nine FIs reviewed amounted to $2.9 million during the period January 1, 1997 to December 31, 2001. To calculate BCBS of Montana's share of the estimated $2.9 million overpayment, we computed BCBS of Montana's percentage (6.4%) of the $3.7 million database value and applied the percentage to the overall sample projection. Details of the sample methodology and estimation are presented in Appendix D.

## FINDINGS AND RECOMMENDATIONS

The Medicare program improperly paid SNF providers an estimated $187,458 that can be attributed to BCBS of Montana. Seventy-five and one half percent of the 908 SNF stays in the 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 the database did not have the required inpatient stay and should be recovered.

### No Automated Matching

The significant amount of improper Medicare SNF payments is attributed to the lack of automated procedures within the CWF and BCBS of Montana'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 BCBS of Montana 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 BCBS of Montana's 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 are identified in the 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. 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 the lack of a cross check between hospital and SNF claims in the claims processing systems 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.

The cause of the improper SNF payments in the database is not directly attributable to any inappropriate action or inaction by BCBS of Montana, however, there is a need for BCBS of Montana to educate SNF providers about the Medicare reimbursement regulations.

## EFFECT

Out of the potential unallowable database of $3.7 million, improper Medicare SNF payments for the nine FIs reviewed during the period January 1, 1997 through December 31, 2001 amounted to an estimated $2.9 million, of which $187,458 was attributable to BCBS of Montana. From the database, 151 of the 200 SNF stays sampled were confirmed as not being in compliance with Medicare regulations requiring a three consecutive day inpatient hospital stay within 30 days of the SNF admission.

Forty-nine SNF stays in the sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 49 stays, patient claims were found 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 the database. If these claims had been included in the cross match procedure, the SNF stay would have been eligible and excluded from the database. Based on the results of the sample, an estimated 75.5 percent of the 908 SNF stays and $2.9 million, $187,458 attributable to BCBS of Montana, of the payments in the database were not in compliance with Medicare reimbursement regulations.

The OIG previously issued 17 similar reports to FIs nationwide with recommendations that the FIs initiate recovery actions on the improper payments identified within the OIG developed database. In a memorandum, dated November 26, 2003, CMS instructed the FIs not to initiate any recovery actions. Under the current regulations, the estimated improper payments of $187,458 are the provider's liability. We believe that this amount should be recovered by BCBS of Montana.

## RECOMMENDATIONS

We recommend that BCBS of Montana:

- Initiate recovery actions estimated to be $187,458 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.

## BCBS OF MONTANA'S RESPONSE

BCBS of Montana stated that they were unable to validate a three-day inpatient stay prior to SNF admission and agreed that overpayments occurred. However, they will not initiate recovery actions on the ineligible payments within our database due to the CMS memorandum, dated November 26, 2003, which instructed all Medicare FIs not to seek recovery of overpayments identified by the OIG. Regarding provider education, BCBS of Montana will perform provider education in the form of bulletins and memos specific to the issue of the three-day stay requirement. In addition, BCBS of Montana will also work with individual providers when this issue is identified and general educational efforts have not been successful. The full text of BCBS of Montana's response is included as Appendix E to this report.

# APPENDICES

**APPENDIX A**

## NINE MEDICARE FISCAL INTERMEDIARIES REVIEWED:

Premera Blue Cross

Blue Cross and Blue Shield of Kansas, Inc.

Blue Cross and Blue Shield of Rhode Island

Chisholm Administrative Services

Anthem Heath Plans of New Hampshire, Inc.

Blue Cross and Blue Shield of Wyoming

Blue Cross and Blue Shield of Montana, Inc.

Blue Cross and Blue Shield of Nebraska

Cooperativa – Puerto Rico

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850


JSM-17, 11-20-03

**MEMORANDUM**

**DATE:** November 26, 2003

**FROM:** Acting Director, Financial Services Group
Office of Financial Management

Director, Medicare Contractor Management Group
Center for Medicare Management

**SUBJECT:** Audit Reports on Skilled Nursing Facility (SNF) Benefit's Three-Day Hospital Stay Requirement--ACTION

**TO:** All Medicare Fiscal Intermediaries

The Office of the Inspector General (OIG) has issued a series of local level audit reports to you highlighting a discrepancy in the way the three-day hospital stay is calculated to establish eligibility for SNF care. OIG found that, when an observation day was immediately followed by a short inpatient admission, the observation day was incorrectly counted as an inpatient day in order to establish SNF eligibility; i.e., to meet the three-day hospital requirement.

We agree with OIG that these findings raise significant policy issues related to the technical eligibility criteria for SNF care. However, these findings did not identify any type of deliberate pattern of misrepresentation that would allow us to determine "fault" on the part of the SNFs admitting these beneficiaries as Medicare Part A patients. Similarly, we cannot conclude that the beneficiaries could reasonably have been expected to know they were not eligible for Part A SNF benefits.

Therefore, in the absence of fault, we have concluded that it would not be appropriate to recover payments that were previously made for these claims. You should **not** seek to recover the payments identified by OIG in these studies. If you have already recovered funds as a result of implementing the OIG findings, you should immediately reverse these transactions, and return the payments to the providers.

The Centers for Medicare & Medicaid Services' central office staff are working with OIG to analyze our existing policies, and to make recommendations for future action. We will communicate the results of these deliberations through regular administrative channels.

If you have any questions concerning the policy aspects of the SNF benefit's requirement for a qualifying three-day hospital stay in this context, please contact Bill Ullman on (410) 786-5667. If you have any questions concerning any associated refunds or overpayments, please contact Lisa Vriezen on (410) 786-1492.

/s/
Gerald Walters

/s/
Gregory G. Carson

cc:
All RAs
All CCMOs
Jeff Hinson, CMM/MCMG

# SCHEDULE OF OIG REPORTS ISSUED TO SEVENTEEN INDIVIDUAL FISCAL INTERMEDIARIES

| | *FI Name* | *OIG Report Number* | *Date Issued* |
|---|---|---|---|
| 1 | Mutual of Omaha | A-05-02-00083 | March 14, 2003 |
| 2 | AdminaStar Federal | A-05-02-00086 | March 26, 2003 |
| 3 | United Government Services | A-05-02-00087 | March 26, 2003 |
| 4 | Palmetto GBA | A-05-02-00088 | March 31, 2003 |
| 5 | Riverbend GBA | A-05-03-00015 | April 4, 2003 |
| 6 | Empire HealthChoice, Inc. | A-05-03-00022 | May 8, 2003 |
| 7 | Care First of Maryland | A-05-03-00026 | March 31, 2003 |
| 8 | Veritus Medicare Services | A-05-03-00035 | July 16, 2003 |
| 9 | FirstCoast Service Options, Inc. | A-05-03-00036 | April 9, 2003 |
| 10 | TriSpan Health Services | A-05-03-00050 | September 19, 2003 |
| 11 | Cahaba Government Benefit Adminastrators | A-05-03-00051 | July 16, 2003 |
| 12 | Noridian Mutual Insurance Company | A-05-03-00062 | June 19, 2003 |
| 13 | Medicare Northwest | A-05-03-00063 | October 27, 2003 |
| 14 | Anthem Health Plans of Maine, Inc. | A-05-03-00071 | October 27, 2003 |
| 15 | Blue Cross and Blue Shield of Arizona | A-05-03-00072 | September 30, 2003 |
| 16 | Arkansas Blue Cross and Blue Shield | A-05-03-00086 | October 21, 2003 |
| 17 | Blue Cross and Blue Shield of Georgia | A-05-03-00087 | October 21, 2003 |

## SAMPLING METHODOLOGY

*ESTIMATION METHODOLOGY*

The amount of SNF payments eligible for Medicare reimbursement were projected using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Unrestricted Variable Appraisal Program. Since substantial data analysis identified a database of potentially ineligible Medicare reimbursements, the "difference estimator" estimation method was used to measure the effect of the projected amount of eligible payments in the database and, thus, estimate the extent of ineligible Medicare SNF payments contained in the database. The upper and lower limits of the adjusted estimate of ineligible SNF payments was projected at the 90 percent confidence level, by subtracting the upper and lower limits of the projected eligible payments from the database value of the nine FIs reviewed which totaled $3,699,766.

*SAMPLE RESULTS – NINE FISCAL INTERMEDIARIES*

The results of the review are as follows:

| Number of SNF Stays | Sample Size | Value of Sample | Number of SNF Stays Eligible for Payment | Value of SNF Stays Eligible for Payment |
|---|---|---|---|---|
| 908 | 200 | $801,685 | 49 | $136,032 |

*VARIABLE PROJECTION – NINE FISCAL INTERMEDIARIES*

Point Estimate $617,585

90% Confidence Interval

| | |
|---|---|
| Lower Limit | $466,992 |
| Upper Limit | $768,179 |

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

| | | | | | |
|---|---|---|---|---|---|
| Database Value | | $3,699,766 | Database Value | | $3,699,766 |
| Upper limit | ( - ) | $768,179 | Lower limit | ( - ) | $466,992 |
| **Lower Limit As Reported** | | **$2,931,587** | **Upper Limit** | | **$3,232,774** |

*EXTRAPOLATION OF OVERPAYMENTS ATTRIBUTABLE TO BCBS OF MONTANA*

| | |
|---|---|
| Database Value – BCBS of Montana | $236,579 |
| Database Value – Nine FI's | $3,699,766 |
| BCBS of Montana's % of Database Value | 6.3944% |

| | |
|---|---|
| Estimated Overpayment Amount – Nine FI's | $2,931,587 |
| BCBS of Montana's % of Database Value | 6.3944% |
| **Extrapolated Overpayment Amount – BCBS of Montana** | **$187,458** |


**MEDICARE**
**PART A INTERMEDIARY**

877.567.7202 Provider *(Toll Free Number)*
866.737.8928 Beneficiary *(Toll Free Number)*
406.791.4148 Reimbursement
406.791.4107 Reimbursement (Fax)

July 20, 2004

STEPHEN SLAMAR
OIG OFFICE OF AUDIT SERVICES
DEPT OF HEALTH AND HUMAN SERVICES
233 N MICHIGAN AVE STE 1360
CHICAGO IL 60601

RE: Report No. A-05-04-000600
Skilled Nursing Facility (SNF) Three-Day Inpatient Qualifying Stay

Dear Mr. Slamar:

I am writing in response to your letter to Mike Wagner, Vice President of Government Programs, regarding the review and your request for a formal response to the recommendations made.

While we agree that an overpayment did occur because we were unable to validate the three-day inpatient stay prior to the SNF admit, we believe we are required to follow CMS instructions and not recover the overpayment.

**Our response to your recommendations follows:**

- Follow the most current CMS memorandum instructing fiscal intermediaries (FIs) not to initiate any recovery actions specific to the issue identified in the report.
- Perform provider education in the form of bulletins and memos specific to this issue of the prior three-day stay requirement.
- Work one-on-one with providers when this issue is identified and general educational efforts have not been successful.
- Deny SNF claim when cases are identified in which a three-day stay did not occur.
- Randomly sample SNF claims to verify the inpatient dates as reported.
- Continue to follow the "inpatient versus outpatient" questions from providers, the QIO, and the contractor. This is discussed further in the comments below.

You also invited other comments on this issue. We found the following to be of concern in ensuring compliance with this regulation.

The dates given on the claim and the SNF bill as occurrence Code 70 indicate the qualifying three-day inpatient stay. As the report states, there is no way to validate these dates. Hospital records must be requested to validate that all days were "inpatient." Our providers have asked for clarification and for a formal CMS policy/statement on determining the status of a patient, specifically:

1. When can the status of a patient change from "inpatient" to "outpatient" and "outpatient" to "inpatient"?

2. What specifically is required in the physician's order to indicate that a patient was an "outpatient" for one day and then changed to an "inpatient" status for the next two days?
3. Must the orders actually state, "Admit as outpatient observation; admit as inpatient; change status to inpatient"?
4. Can the order or status clarification be performed post-discharge, in some instances months after the claim has been adjudicated and processed?

Below is the question we submitted to CMS regarding this issue:

> The issue is coming from our hospitals as well as our QIO. We need clarification regarding when a patient's status can be officially determined changed. Some of the input we have had is that the status of whether the person is an inpatient or an outpatient can be changed any time before discharge. This FI, in conjunction with the QIO, have always determined the status of the patient based on Section 230.7 of the Hospital Manual. This section states the patient status should be determined based on "the intent at the time of admission." This section gives some examples. One of those examples addresses the patient who is admitted with the intent of knowingly being treated for a kidney stone … the stone passes within 24 hours and the patient is discharged. This is still to be treated as an inpatient admission.

We received a response from the CO, who indicated that this was becoming more and more of an issue, and that the DAC was currently reviewing this policy and would be issuing clarification. To my knowledge, no specific instruction or clarification has yet been issued on this subject.

It is also important to note that beneficiaries do not always know what their status was. To them, they were "in the hospital" for the entire stay, often in the same bed. It is easy to understand why they would be confused when told the three-day qualifying stay criterion was not met. Although the providers should be aware of this requirement and report it accurately, the SNF may have been unaware of the official status for all days.

It would be beneficial if CMS issued more specific guidelines. If the question of "inpatient versus outpatient" is clarified, it will help ensure accurate reporting of dates and ensure that the three-day stay regulation is met. Thank you for the opportunity to comment.

Sincerely,

Bridgid Harlan RN

Bridgid Harlan, RN
Medicare A MR/LPET/Appeals Manager
BCBS of MT

0720BH1T.ljn

# 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*
David Markulin, *Senior Auditor*

Technical Assistance
Tammie Anderson, *Advanced Audit Techniques*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.