JUL 2 3 2004

Office of Audit Services
Region I, Room 2425
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number: A-01-04-00504

James E. Fanale, MD
Chief Operating Officer
Mercy Medical Center
271 Carew Street
Springfield, Massachusetts 01102

Dear Dr. Fanale,

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Review of Medicare Inpatient Rehabilitation Facility Prospective Payments At Weldon Rehabilitation Hospital For Fiscal Year 2003." A copy of this report will be forwarded to the action official noted below for her 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.

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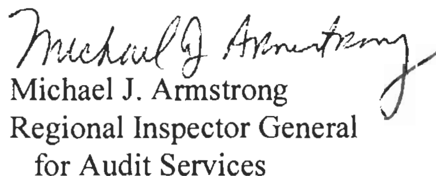
To facilitate identification, please refer to report number A-01-04-00504 in all correspondence relating to this report.

Sincerely,



Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, J.F.K. Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENTS AT WELDON REHABILITATION HOSPITAL FOR FISCAL YEAR 2003

July 2004
A-01-04-00504

Office of Inspector General

http://oig.hhs.gov

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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.

EXECUTIVE SUMMARY

BACKGROUND

Section 1886(j) of the Social Security Act established a prospective payment system (PPS) for inpatient rehabilitation facilities (IRF). The Centers for Medicare & Medicaid Services (CMS) implemented a PPS for IRFs for cost reporting periods beginning on or after January 1, 2002. The IRF payment system utilizes federal prospective payment rates across 100 distinct case mix groups. A number of adjustments may apply to the case mix group payment including adjustments for transfer cases, interrupted stays, and late transmission of patient assessment instruments.

The following Medicare regulations apply:

- An IRF must complete a patient assessment instrument upon the patient's admission and discharge and transmit both assessments, in accordance with PPS regulations, within 17 days of the patient's discharge.
- An IRF's discharge payment must be adjusted when patients are transferred to acute care or other post-acute care facilities and the IRF stay is less than the average length of stay for nontransfer cases in the same case mix group.
- An IRF stay containing an interruption of three days or less must be billed as a single discharge.

OBJECTIVE

The objective of our review was to determine whether Weldon Rehabilitation Hospital (Weldon) billed IRF claims for fiscal year 2003 in compliance with Medicare PPS regulations. We identified 60 claims out of 577 claims billed during the period that had a high risk of incorrect billing.

FINDINGS

We found that Weldon had established adequate procedures for completing and transmitting the patient assessment instruments. However, we found that Weldon billed 49 claims that were not in compliance with Medicare PPS regulations. Specifically, Weldon:

- billed 47 of the claims using an incorrect patient status code for patients transferred to other facilities; and

- billed 2 separate claims for one IRF interrupted stay for services provided to a patient who returned to Weldon after a brief acute care hospital stay.

As a result of the 49 claims billed by Weldon contrary to PPS reimbursement regulations, the hospital received Medicare overpayments totaling $202,872.

Overpayments occurred because Weldon did not: (1) establish adequate controls for properly coding patient status; and (2) adhere to existing controls for billing interrupted stays.

RECOMMENDATIONS

We recommend that Weldon:

- implement policies and procedures for correct coding of patient status codes in compliance with Medicare PPS regulations and provide requisite training and internal monitoring to ensure successful implementation;

- monitor adherence to its existing controls for billing interrupted stays; and

- refund overpayments of $202,872 to the Medicare program.

Weldon agreed with our findings and identified what steps they have taken to address our recommendations.

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INTRODUCTION

BACKGROUND

Law

The Social Security Amendments of 1983 established prospective payment systems (PPS) for most inpatient services but excluded certain specialty hospitals such as inpatient rehabilitation hospitals and distinct part rehabilitation units in hospitals. To control escalating costs, section 1886(j) of the Social Security Act as amended by section 125 of the Balanced Budget Refinement Act of 1999 and section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000, established a PPS for inpatient rehabilitation facilities (IRF). The Centers for Medicare & Medicaid Services (CMS) implemented the PPS for cost reporting periods beginning on or after January 1, 2002.

Payment For IRF Services

The IRF payment system utilizes federal prospective payment rates across 100 distinct case mix groups. The federal payment rates are established by applying a budget neutral conversion factor to a set of relative payment weights that account for the difference in resource use across the case mix groups.

To classify a patient into a distinct case mix group, the payment system uses information from a patient assessment instrument. The IRF performs a patient assessment upon admission to classify Medicare Part A fee-for-service patients into a case mix group. The IRF also performs a patient assessment at discharge to determine the relevant weighting factors, if applicable, associated with comorbidities.

A number of adjustments may apply to the payment including adjustments for transfer cases, interrupted stays, and late transmission of patient assessment instruments.

Weldon Rehabilitation Hospital

The Weldon Rehabilitation Hospital (Weldon), located on the campus of Mercy Medical Center in Springfield, MA, provides comprehensive inpatient, outpatient and day-patient rehabilitation. Weldon and Mercy Medical Center are operated by the Sisters of Providence Health System, which is a non-profit organization. The Sisters of Providence Health System operates three hospitals, a regional conference laboratory, adult day programs, home care and five skilled nursing facilities (SNF) in the Springfield area.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether Weldon billed IRF claims during fiscal year 2003 in compliance with Medicare PPS regulations.

Scope

The audit included Medicare PPS payments to Weldon for IRF claims with dates of service between October 1, 2002 and September 30, 2003. During this period, Weldon received Medicare payments of $7,915,282 for 577 claims.

Our review of internal controls at Weldon was limited to obtaining an understanding of its controls related to the development and submission of Medicare claims.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- extracted Weldon paid claims data from CMS's Standard Analytical File for fiscal year 2003 and selected 60 claims that were a high risk for incorrect billing with total payments of $1,105,983;
- reviewed the inpatient claims history detail from CMS's Common Working File to verify that the selected claims had not been cancelled and determine if the patient was transferred from the IRF to another acute or post-acute facility;
- discussed procedures related to the development and submission of Medicare claims and patient assessment instruments with hospital personnel;
- reviewed patient assessment instruments for each selected claim to determine whether the assessment was transmitted to CMS's patient database in accordance with Medicare regulations;
- recalculated the correct payment for the incorrectly billed claims to determine overpayment amounts; and
- discussed the results of our review with Weldon and its fiscal intermediary, Mutual of Omaha.

We performed our field work at Weldon in Springfield, Massachusetts during January 2004.

The review was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We found that Weldon had established adequate procedures for completing and transmitting the patient assessment instruments. However, we found that Weldon billed 49 claims that were not in compliance with Medicare PPS regulations. Specifically, Weldon:

- billed 47 of the claims using an incorrect patient status code for patients transferred to other facilities; and

- billed 2 separate claims for one IRF interrupted stay for services provided to a patient who returned to Weldon after a brief acute care hospital stay.

As a result of the 49 claims billed by Weldon contrary to PPS reimbursement regulations, the hospital received Medicare overpayments totaling $202,872.

Overpayments occurred because Weldon did not: (1) establish adequate controls for properly coding patient status; and (2) adhere to existing controls for billing interrupted stays.

CRITERIA

Two specific categories of criteria apply to payments for IRF claims:

Transfer Regulations

- According to 42 CFR § 412.602 and § 412.624(f), IRFs may receive a transfer payment when patients are transferred to another IRF, an acute-care prospective payment hospital, long-term care hospital or a nursing home that qualifies to receive Medicare or Medicaid payments. The transferring IRF's prospective payment will be adjusted to a per-diem payment if the IRF stay is less than the average length of stay for nontransfer cases in the same case mix group. CMS instructed IRFs to use specific patient status codes to identify claims subject to the transfer regulation.

Interrupted Stay Regulations

- According to 42 CFR § 412.602(3), an interrupted stay is a stay at an IRF during which a Medicare inpatient is discharged from the IRF and returns to the same IRF within three consecutive days. The duration of the interrupted stay begins with the day of discharge from the IRF and ends on midnight of the third day. For payment purposes, § 412.624(g)(2) states that IRFs will receive one discharge

payment for an interrupted stay based on the case mix group classification which is determined by the patient assessment performed at admission.

CONDITION

Incorrect Patient Status Codes For 47 Claims

We found that Weldon did not always comply with Medicare PPS regulations regarding billing for patients transferred to acute care or other post-acute care facilities. In this respect, Weldon billed 47 claims that were transfers to either SNFs or acute care hospitals using an incorrect patient status code. These claims should have been coded with one of the specific patient status codes CMS has instructed IRFs to use to identify claims subject to the transfer regulations. Claims with incorrect patient status codes were billed as follows:

Number of Miscoded Claims	Patient Status Coded Billed	Correct Patient Status Code
37	**05** – Discharged/transferred to another type of facility	**03** – Discharged/transferred to skilled nursing facility
7	**01** – Discharged to home/self care	**03** – Discharged/transferred to skilled nursing facility
2	**06** – Discharged/transferred to home/under home health agency care	**02** – Discharged/transferred to another short term general hospital
1	**05** – Discharged/transferred to another type of facility	**02** – Discharged/transferred to another short term general hospital

Interrupted Stay Billed as Two Claims

We also identified an isolated instance in which Weldon billed an interrupted stay as two separate IRF claims contrary to the Medicare PPS regulations. Consequently, Medicare paid Weldon two PPS payments rather than the appropriate single payment. Weldon transferred one patient to an acute care hospital and billed Medicare for an IRF transfer that resulted in a payment of $3,396. Two days later, the patient was readmitted to Weldon and was discharged after a stay of several weeks. Weldon billed Medicare and received a full payment of $12,077 for the second stay.

EFFECT

Overpayments Resulting From Incorrect Billing

Weldon was overpaid $202,872 for incorrectly billed claims. Of this amount, $202,179 in overpayments resulted from Weldon receiving full discharge payments rather than the appropriate per-diem transfer payments for 34 claims where the length of stay was less than the average length of stay for the case mix group. The remaining $693 overpayment resulted from Weldon billing the interrupted stay as two separate claims. After combining the total charges for both claims involved in the interrupted stay and applying

the formula for outlier payment calculation, we found that Weldon should have received one full discharge payment with an additional outlier payment.

CAUSE

Billing Controls Not Established Or Not Followed

- Weldon incorrectly billed claims primarily because billing controls had not been established to ensure that the correct patient status code was entered on the Medicare claim. In this respect, medical records department coders entered an internal code into the billing system that did not translate into the correct patient status code on the Medicare claim. According to hospital staff, the coders believed that entering an internal code of "APP" would result in a patient status code of "03" in the billing system and on the Medicare claim. However, the internal code "APP" actually resulted in a patient status code "05" being applied to the claim. Consequently, Weldon submitted claims for patients transferred to certain skilled nursing facilities with a patient status code that is not identified as a transfer by the fiscal intermediary's claims processing system.

- We also identified some instances where transfers were miscoded (1) because the patient's status at discharge was not clearly documented in the medical record or (2) as the result of clerical error.

- Weldon did not comply with the Medicare PPS regulations for the payment of interrupted stays in this one instance because the billing department did not follow their established billing controls of combining the two stays into one claim.

RECOMMENDATIONS

We recommend that Weldon:

- implement policies and procedures for correct coding of patient status codes in compliance with Medicare PPS regulations and provide requisite training and internal monitoring to ensure successful implementation;

- monitor adherence to its existing controls for billing interrupted stays; and

- refund overpayments of $202,872 to the Medicare program.

AUDITEE COMMENTS

Weldon agreed with our findings and recommendations. The full text of Weldon's comments are included as the Appendix to this report.

APPENDIX

SISTERS OF PROVIDENCE
HEALTH SYSTEM

Legal Services
P. O. Box 9012
Springfield, MA 01102-9012
413-748-9080
413-748-9264
Fax 413-748-9363
mercycares.com

Michael J. Armstrong
Regional Inspector General for Audit Services
JFK Federal Building, Room 2425
Boston MA 02203

Date: July 13, 2004

RE: Weldon Rehabilitation Hospital Prospective Payment System (PPS) Review
- Draft Report -

Dear Mr. Armstrong:

We have reviewed the Office of Audit Services' draft report entitled "Review of Medicare Inpatient Rehabilitation Facility Prospective Payments at Weldon Rehabilitation Hospital for Fiscal Year 2003", and have prepared the following requested formal response.

Based on the recommendations made by your audit services personnel, we have:

- implemented policies and procedures for correct coding of patient status codes, and we are providing requisite training and internal monitoring to ensure successful implementation of these policies and procedures; and,

- established a process by which we will monitor adherence to existing controls for billing interrupted stays; and,

- resubmitted the identified claims that resulted in overpayment to Weldon Rehabilitation Hospital to the fiscal intermediary for re-processing and correction.

My understanding at the writing of this letter is that the fiscal intermediary has received all of the resubmissions of claims related to this matter, but may not have completed the re-processing. We will continue to monitor this until each of the corrections is complete. Meanwhile, if you have any questions regarding any of the above information, please contact my office at your convenience (413) 748 - 9000.

Sincerely:

Timothy D. Sullivan, Esq.
Compliance/Privacy Officer
Sisters of Providence Health System
271 Carew Street
Springfield, MA 01102