



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-03-00035

July 16, 2003

Ms. Debra Rittenour
Vice President, Government Business Unit
Veritus Medicare Services
120 Fifth Avenue, Suite P5101
Pittsburgh, Pennsylvania 15222-3099

Dear Ms. Rittenour,

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 Veritus Medicare Services." 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 Report Number A-05-03-00035 in all correspondence relating to this report.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

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Centers for Medicare & Medicaid Services – Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, Pennsylvania 19106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INELIGIBLE MEDICARE PAYMENTS
TO SKILLED NURSING FACILITIES
UNDER THE ADMINISTRATIVE
RESPONSIBILITY OF VERITUS
MEDICARE SERVICES**



**July 2003
A-05-03-00035**

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 HHSIOIGIOAS. Authorized officials of the HHS divisions will make final determination on these matters.



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 Veritus Medicare Services (Veritus).

FINDINGS

We estimate that the Medicare program improperly paid \$6.3 million to SNF providers that should be recovered by Veritus. Based on a sample of 200 SNF stays, we estimate that 79.5 percent of the Veritus 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 Veritus'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 Veritus 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 \$6.3 million were paid without being detected.

RECOMMENDATIONS

We recommend that Veritus:

- Initiate recovery actions estimated to be \$6.3 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, Veritus stated that they expect to complete its review of a reduced universe of overpayment recoveries within their current operating budget. Veritus noted that SNF claims with dates of service prior to October 1, 1998 have been purged from their automated system, thereby reducing the database of potentially recoverable on-line overpayments to \$5.5 million. Since regulations allow Veritus to take recovery action on claims at anytime, if the review indicates just cause that fraud or similar fault may be involved, and since the significance of the estimated overpayments warrants such consideration, we believe that potentially recoverable overpayments purged from the system should be included in Veritus's recovery actions.

Veritus did not agree that provider education is necessary even though our database clearly demonstrates that SNF's are entering inaccurate hospital stay data on their Medicare claims and appear to need continuing education.

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Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CWF	Common Working File
FI	Fiscal Intermediary
HIC	Health Insurance Claim
INPL	Inpatient Listing
SNF	Skilled Nursing Facility

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 Veritus is responsible for 1,294 potentially ineligible SNF stays, consisting of 2,301 SNF claims and reimbursed by Medicare in the amount of \$7.8 million.

OBJECTIVE, SCOPE AND METHODOLOGY

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

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 part of 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 Veritus. Our database identified 1,294 potentially ineligible SNF stays, which included 2,301 SNF claims reimbursed in the amount of \$7.8 million under Veritus's responsibility.

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

Our fieldwork was performed in the Chicago Regional Office during December 2002 and January 2003.

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 Veritus database (reimbursed at \$1,132,430) 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 90th percentile of ineligible SNF payments under Veritus's responsibility amounted to \$6.3 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 \$6.3 million that Veritus should recover. Seventy-nine and one half percent of the 1,294 SNF stays in the Veritus 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 Veritus'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 Veritus 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 Veritus 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 Veritus database is not directly attributable to any inappropriate action or inaction by Veritus, we believe that our review has identified the need for Veritus to educate SNF providers about the Medicare reimbursement regulations.

EFFECT

Out of the potential unallowable database of \$7.8 million, we estimate that improper Medicare SNF payments under Veritus's responsibility for the period January 1, 1997 through December 31, 2001 amounted to \$6.3 million. From the Veritus database, we confirmed that 159 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 41 SNF stays in our sample were eligible for Medicare reimbursement based on a three-day hospital stay. For these 41 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 79.5 percent of the 1,294 SNF stays and \$6.3 million of the payments in the Veritus 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 Veritus officials.

RECOMMENDATIONS

We recommend that Veritus:

- Initiate recovery actions estimated to be \$6.3 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.

VERITUS'S RESPONSE

Veritus generally concurred with our recommendation to initiate recovery actions on the individual stays included in the database and expected to complete the recommended overpayment recoveries within their current operating budget. However, they noted that SNF claims with dates of service prior to October 1, 1998 have been purged from their system, thereby reducing what they viewed as the potential recoverable overpayments in our database from \$6.3 million to \$5.5 million.

Veritus did not agree with our recommendation for provider education. They believe that SNF providers are aware of the three-day hospitalization rule, as evidenced by the mere entry of a three-day hospital stay in the Occurrence Span Code 70 field on their Medicare claims. Veritus refers to our inpatient hospital claim data with dates of confinement, which generally match the SNF claim dates for the inpatient hospital stay, as support for satisfactory SNF understanding. This disregards their statement that the key to an allowable SNF claim is an inpatient hospital stay of three covered days. Rather than education, they contend that a more appropriate recommendation would be to require the CWF to access the covered days of any prior inpatient qualifying inpatient hospital claim.

Veritus made additional comments not directly related to our recommendations. They believe that the Executive Summary is misleading because it does not specify that the improper SNF payments are not attributable to any inappropriate action or inaction on their part. Veritus also stated that 352 (27%) of the beneficiary HIC numbers in our database were incorrect.

OAS COMMENTS

We disagree that the amount of potential recoverable overpayments in our database should be reduced simply because Veritus has purged SNF claims from their system. Deletion of overpayments from the contractors automated system or age in relation to the regulatory time period for recoupment does not change the impropriety of the payments. Further, the regulations

allow Veritus to take recovery action on claims at anytime, if the review indicates just cause that fraud or similar fault may be involved. We believe that as the database claims are reviewed, Veritus may find potential fraud or similar fault in claims that would justify considering reviewing claims from the purged period. Accordingly, it will be Veritus' responsibility to retrieve and review those claims.

We also disagree that provider education is unnecessary. The evidence presented in our database clearly shows that the SNF providers are entering inaccurate hospital stay information on their Medicare claims. Our database was specifically created to identify situations in which the period of the hospital stay, as listed on the SNF claim, disagreed with the hospitalization period shown on the inpatient hospital claim. Veritus' own description supports inappropriate SNF billing and a need for provider education. Veritus correctly states that the key to an allowable SNF claim is the Medicare covered days for an inpatient hospital stay rather than the days of confinement. Our database demonstrated that the SNF's incorrectly used the days of confinement. Further, the assertion that a CWF system change would be a more appropriate alternative to provider education ignores the existence of significant billing errors and fails to address the technical infeasibility of such changes that were clearly presented in the report.

Regarding other comments, our Executive Summary is factual and the body of our report clearly states that the improper SNF payments are not directly attributable to any inappropriate action or inaction by Veritus. In regard to the HIC numbers in our database, we created our database from claims data extracted directly from CMS' files and verified its accuracy. We believe data errors cited by the contractors were the result of subsequent reprocessing by contractor staff.

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 in 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 \$7,848,227.

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>
1,294	200	\$1,132,430	41	\$184,418

VARIABLE PROJECTION

Point Estimate \$1,193,184

90% Confidence Interval

Lower Limit \$843,966
Upper Limit \$1,542,402

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

Database Value	\$7,848,227	Database Value	\$7,848,227
Upper limit	<u>(-) \$1,542,402</u>	Lower limit	<u>(-) \$843,966</u>
Lower Limit As Reported	\$6,305,825	Upper Limit	\$7,004,261

Debn Rittenour
Vice President

April 4, 2003

Mr. Paul Swanson
Regional Inspector General for Audit Services
Office of Audit Services
Department of Health and Human Services
223 North Michigan Avenue
Chicago, Illinois 60601

Re: CIN A-05-03-00035

Dear Mr. Swanson:

Veritus Medicare Services (VMS) is responding to your draft report entitled "Ineligible Medicare Payments to Skilled Nursing Facilities Under the Administrative Responsibility of VMS Medicare Services." We appreciate the opportunity to provide comments on this report.

EXECUTIVE SUMMARY * FINDINGS:

It is our opinion that this section is misleading by what it omits, not by what is written. We cannot contest the fact that there are inappropriately reimbursed SNF claims. However, in the sense of fairness, we believe the following should be added to your findings:

The cause of the improper SNF payments in the VMS database is not directly attributable to any inappropriate action or inaction by VMS. This situation is the result of a Medicare Program Vulnerability. Any resolution would require changes to the manner in which the Common Working File (**CWF**) accesses historical information in order to verify the accuracy of inpatient hospital stay information.

System limitations currently limit the ability of all Medicare contractors to identify and/or recover overpayments in situations where the three-day qualifying hospital stay requirement is not met.

(1) The CWF cannot access historical information for a prior admission at a facility to verify the accuracy of inpatient stay information submitted with the **SNF** payment request.

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(2) The CWF cannot routinely access historical information for prior admissions from hospitals outside the region and/or for which the Medicare contractor is not the FT of authority. This precludes an effective and systematic identification and review of all SNF claims that do not comply with the three-day rule.

OBJECTIVE, SCOPE AND METHODOLOGY - METHODOLOGY:

The issue of inappropriate SNF reimbursement is currently being addressed by both CMS and the OIG. VMS began their preliminary review by first looking at the CMS claim data. The CMS data is comprised of 460 inpatient SNF stays (793 claims) with dates of service between 12/14/1998 and 12/31/2000. CMS previously conducted a pilot project based on 1997 data.

The OIG claim data is comprised of 2,301 SNF claims for 1,291 Medicare beneficiaries (i.e., unique HICNs). Our to-date review of the OIG claim data demonstrates that 352 of the HICNs provided by the OIG are incorrect (i.e. do not match the HICN on the claim history). This is 27.27% of the total. These 352 incorrect and/or invalid HICNs account for 646 (28.07%) of the 2,301 claims. Using an internal database, we were able to successfully identify 348 of the 352 misidentified Medicare beneficiaries.

The OIG claim information was made available in two formats: MS Access 2000 and as Excel spreadsheets. Because VMS does not use MS Access, we proceeded with our data review using the Excel spreadsheets. It was not until we were well into the review that we became aware of the fact that the Excel spreadsheets were created by exporting the MS Access data to Excel. MS Access does not correctly export to Excel. Therefore, much of our work had to be re-done.

FINDINGS AND RECOMMENDATIONS - EFFECT:

The OIG began with 2,301 SNF claims; 1,299 inpatient hospital claims; and, a potential overpayment of \$7,848,227.20. After determining that 41 SNF stays in their sample were eligible for Medicare reimbursement based on a three-day hospital stay, the potential overpayment is reduced to \$7,663,809.31 for 2,238 SNF stays.

Dates of service prior to 10/01/1998 have been purged from the VMS internal claim database. Therefore, a comparison of the OIG data to the VMS inpatient SNF claim universe was completed.

With dates of service between 10/01/1998 and 11/30/2001, the OIG data is comprised of the following: 1,598 claims; 427 SNF providers, 883 Medicare beneficiaries; and, a potential overpayment of \$5,462,534.61.

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For the same dates of service, VMS has 667,664 paid inpatient SNF claims. These claims, on behalf of 227,524 Medicare beneficiaries, came from 730 providers. The total reimbursement amount for these 667,465 claims is \$1,896,129,775.00. Even if all of the 1,598 claims identified by the OIG are overpaid, their overpayment amount of \$5,462,534.61 accounts for 0.2880% of the VMS total reimbursement for inpatient SNF claims. We believe this number will decrease because of the apparent inconsistencies in the CMS National Claims History File.

FINDINGS AND RECOMMENDATIONS - RECOMMENDATIONS:

The OIG recommendation for SNF provider education is unnecessary. All SNF providers are aware of the three-day qualifying stay requirement. Their knowledge of this requirement is demonstrated by their use of Occurrence Span Code 70 with the qualifying inpatient hospital stay dates. This code and corresponding dates indicate the 'from' and 'through' dates of at least a three-day hospital stay (excluding the day of discharge or death) that qualifies the patient for Medicare payment of the SNF services billed on this claim. The absence of appropriate entries on the SNF claim results in the claim being returned to the provider with Reason Code 19904. This Reason Code is used to reject initial SNF claims when the qualifying stay dates are missing from the claim.

..

Even the OIG inpatient hospital claim data demonstrates that the SNFs enter 'from' and 'through' dates that, as a rule, match the 'from' and 'through' dates on the inpatient hospital stay. The 'key' to inpatient hospital claim payment is the number of covered days, not the number of days of the confinement. The failure of the CWF to routinely access prior inpatient hospital days would seem to support the fact that this is a Medicare Program Vulnerability, not anything that can be addressed on a local level.

A more appropriate recommendation would be to require the CWF to access the 'Covered Days' of any prior inpatient qualifying inpatient hospital claim. Even though the 'from' and 'through' dates on any claim might span three or more days, it doesn't necessarily mean that all of the days in that period of time are covered by Medicare. (see page 3, paragraph 3 of the OIG 'No Automated Matching' information)

CONCLUSIONS:

While we are expected to complete the overpayment recoveries **within** our current operating budget, it is fair to mention that this is an extremely labor intensive and time-consuming effort made even more difficult by not having current and/or accurate information.

Mr. Paul Swanson
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VMS will continue to correct the data provided by the OIG and proceed with overpayment recoveries.

Please forward any questions to me on behalf of VMS Medicare Services.

Sincerely,



Debra Rittenour
Vice President, Veritus Medicare Services

DR/pm/swansonOIG04042003

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:

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