

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MANY INPATIENT
REHABILITATION FACILITY
STAYS DID NOT MEET
MEDICARE COVERAGE AND
DOCUMENTATION
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Daniel R. Levinson
Inspector General

September 2018
A-01-15-00500

Office of Inspector General

<https://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 Office of Audit Services (OAS) provides 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. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/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 for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: September 2018
Report No. A-01-15-00500

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



Why OIG Did This Review

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

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

How OIG Did This Review

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

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

What OIG Found

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

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

What OIG Recommends and CMS's Comments

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

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review	1
Objective	1
Background	2
Inpatient Rehabilitation Facilities	2
Inpatient Rehabilitation Facility Prospective Payment System	2
Reasonable and Necessary Care	3
Oversight of Inpatient Rehabilitation Facility Compliance	4
How We Conducted This Review	5
FINDINGS.....	6
Medicare Coverage Requirements	7
Medicare Documentation Requirements	7
Most Sampled Stays Were Not Reasonable and Necessary	8
Coverage Requirements Not Met	8
Documentation Requirements Not Met	10
Causes of Noncompliance With Medicare Requirements.....	10
Estimate of Medicare Payments Made for Care That Was Not Reasonable and Necessary	12
RECOMMENDATIONS	12
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	13
APPENDICES:	
A: Audit Scope and Methodology	14
B: Prior Office of Inspector General Reports	16
C: Statistical Sampling Methodology	17
D: Sample Results and Estimates	19

E: Details of Inpatient Rehabilitation Facility Documentation Deficiencies Found in the Sample	20
F: Sampled Stays That Were Reasonable and Necessary	25
G: MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments	28
H: CMS Comments.....	30

INTRODUCTION

WHY WE DID THIS REVIEW

This review of Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs) expands on our prior reviews of an individual hospital-based IRF and recent hospital compliance reviews that included a limited number of IRF claims. (Appendix B contains a list of prior Office of Inspector General (OIG) reports.)

Our prior reviews found that some hospitals did not comply with Medicare coverage and documentation requirements for IRFs. The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for Medicare payments to IRFs increased from 9 percent in 2012 to 62 percent in 2016.¹ According to the Medicare Payment Advisory Commission (MedPAC)—a nonpartisan, legislative branch agency that provides the U.S. Congress with Medicare Program analysis and policy advice—in 2013 Medicare spent \$6.8 billion on fee-for-service (FFS) IRF care provided in about 1,160 facilities.² In recent years, Medicare FFS has paid for the majority of the services IRFs provide.³

OBJECTIVE

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

¹ CMS, *Medicare Fee-for-Service, Improper Payments Report and Appendices*, 2012 through 2016. CERT published a payment report and an appendix for each year. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html>. Accessed March 8, 2018. CERT reported an IRF error rate of 17.2 percent for 2013, the year we reviewed in this report.

² Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015. Available at <http://www.medpac.gov/docs/default-source/reports/chapter-10-inpatient-rehabilitation-facility-services-march-2015-report-.pdf?sfvrsn=0>. Accessed May 9, 2017.

³ For example, MedPAC stated, "On average, Medicare fee-for-service accounts for about 61 percent of IRFs' discharges." See MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015 (2013). See also MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 9, p. 237, March 2016 (60 percent, 2014), and MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 257, March 2017 (60 percent, 2015).

BACKGROUND

Inpatient Rehabilitation Facilities

Inpatient rehabilitation hospitals and rehabilitation units of acute-care hospitals, collectively known as IRFs, provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, because of the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (the *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 1, § 110).

Inpatient Rehabilitation Facility Prospective Payment System

The Social Security Act (the Act) established a Medicare prospective payment system (PPS) for IRFs (§ 1886(j)). CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the PPS, CMS established a Federal prospective payment rate, based on clinical characteristics and resource needs, for each of 92 intensive rehabilitation subcategories called case-mix groups (CMGs).⁴

Under the PPS, IRFs are reimbursed at a rate generally 2.5 times greater than the acute inpatient prospective payment system (IPPS) rate. In exchange, Medicare requires IRFs to provide intensive rehabilitation to higher severity patients.⁵ MedPAC has recommended IRF payment reform based on a closer alignment of cost with payment.⁶

⁴ Medicare Learning Network (MLN), *Inpatient Rehabilitation Facility Prospective Payment System*, ICN 006847, Jan. 2017. According to the MLN:

Federal rates are adjusted to reflect patient case-mix, which is the relative resource intensity typically associated with each patient's clinical condition as identified through the patient assessment process. Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the IRF. Cases are further grouped into case-mix groups which group similar cases according to their functional motor, cognitive scores, and age. Finally, cases are grouped into one of four tiers within each CMG, according to patient's comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay).

⁵ B. Gage, L. Smith, et al., *Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities*, Report to Congress, September 2009, p. 13. Prepared for CMS by RTI International, RTI Project Number 0211995.

⁶ Among several other recommendations, MedPAC recommended for fiscal year (FY) 2018 a payment rate reduction of 5 percent, "coupled with an expansion of the high-cost outlier pool, as previously recommended by MedPAC, to redistribute payments within IRF PPS and reduce the impact of potential misalignments between IRF payments and costs." (MedPAC, *Report to Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 259, March 2017). See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

During our audit period, CMS contracted with Medicare administrative contractors (MACs) to process and pay Medicare FFS claims and perform other services, including medical reviews for selected claims. CMS also contracted with (1) Recovery Audit Contractors (RACs) to identify and correct Medicare FFS improper payments and (2) the Supplemental Medical Review/Specialty Contractor (SMRC) to perform and provide support for a variety of tasks to lower the improper payment rates and increase the efficiencies of the medical review functions of Medicare and Medicaid.

Reasonable and Necessary Care

No Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

Effective for discharges on or after January 1, 2010, all coverage⁷ and documentation⁸ requirements must be met for IRF care to be considered by Medicare as reasonable and necessary under the Act (42 CFR §§ 412.622(a)(3), (4), and (5) and 74 Fed. Reg. 39762, 39788 (Aug. 7, 2009)).⁹ If the claim is deemed not reasonable and necessary, the entire payment will be in error.

For discharges starting in 2010, CMS updated IRF requirements to reflect best practices in medicine that enhance the quality of care for patients.¹⁰ These requirements address the unique responsibility¹¹ of the rehabilitation physician to closely supervise and coordinate a medical and functional rehabilitation course of care for the patient and to clearly and comprehensively document these decisions and processes in the medical records.¹²

As of 2010, CMS no longer considers trial admissions (IRF admissions of 3 to 10 days to allow the physician to determine whether the patient would benefit from IRF treatment) to be reasonable

⁷ 42 CFR § 412.622(a)(3), as interpreted in the Medicare Benefit Policy Manual (the Manual), Pub. No. 100-02, chapter 1, §§ 110.2, 110.3.

⁸ 42 CFR §§ 412.622(a)(4) and (5), as interpreted in the Manual, chapter 1, §§ 110.1, 110.2.4, 110.2.5.

⁹ “All requirements must be met” as interpreted by the Manual, chapter 1, § 110. These requirements apply equally to all Medicare patients regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.29 (b)(2) and used by Medicare for classifying a hospital or unit of a hospital as an IRF.

¹⁰ 74 Fed. Reg. 39762, 39790 (Aug. 7, 2009).

¹¹ 74 Fed. Reg. 39796 (Aug. 7, 2009).

¹² CMS National Provider Training Call Transcript, “Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements,” Nov. 12, 2009, p. 4. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

and necessary. A rehabilitation physician must review and approve the need for care only after a comprehensive preadmission screening within the previous 48 hours has been documented.^{13, 14} CMS stated that the purpose of the coverage requirements is to clarify that patients who do not require, cannot participate in, or cannot benefit from the intensive rehabilitation therapy program offered in an IRF should be referred to another setting. Additionally, CMS stated that the purpose of the documentation requirements is to provide clear, up-to-date instructions for determining and documenting the medical necessity of the IRF admission.¹⁵

Oversight of Inpatient Rehabilitation Facility Compliance

CMS aims to improve the quality and coordination of care for Medicare beneficiaries and to reduce improper payments. This work includes corrective action for Medicare compliance and the testing of new care and reimbursement models. Examples are:

- educational outreach programs and publications for IRF stakeholders,¹⁶

¹³ For the purposes of this report, “rehabilitation physician” is the IRF physician, with specialized training and experience in rehabilitation, in charge of the patient during the inpatient rehabilitation stay, as opposed to ancillary physicians, such as cardiologists, neurologists, internal medicine specialists, and others who assist the rehabilitation physician at the IRF.

¹⁴ The Manual, Pub. No. 100-02, chapter 1, § 110.1.1.

¹⁵ CMS National Provider Training Call Transcript, “Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements,” Nov. 12, 2009, pp. 4–5. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html>. Last accessed March 8, 2018.

¹⁶ CMS’s Medicare compliance education for IRFs includes detailed transcripts of IRF national provider training sessions, which have been consistently posted on the CMS website since late 2009. These transcripts give providers access to specific and comprehensive Medicare requirement clarifications. The transcripts for November 12, 2009, and May 31, 2012, are available at the IRF coverage web page at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html>. Last accessed on March 5, 2018.

CMS provides access to regulatory updates in the IRF payment system and educational materials, such as MLN publications. For example, (1) Inpatient Rehabilitation Therapy Services: Complying With Documentation Requirements, MLN ICN 905643, July 2012; (2) Inpatient Rehabilitation Facility Prospective Payment System, MLN ICN 006847, Jan. 2017; (3) Inpatient Rehabilitation Facility (IRF) Medical Review Changes, SE 17036, Dec. 11, 2017; (4) Provider Compliance Tips for Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units, ICN 909406, Feb. 2018; and (5) “MLN Connects”—Centers for Medicare & Medicaid Services IRF PPS: New IRF-Patient Assessment Instrument (PAI) Items Effective October 1, 2015, National Provider Call, Jan. 15, 2015; and Centers for Medicare & Medicaid Services IRF-PAI Therapy Information Data Collection, National Provider Call, Jan. 12, 2017. In addition, MACs provide access to educational materials on their websites.

CMS also administers the Program for Evaluating Payment Patterns Electronic Report (PEPPER) resources, which provides provider-specific Medicare data statistics for discharges and services vulnerable to improper payments. The PEPPER reports, which can be downloaded by each IRF, compare an IRF to other IRFs in three comparison groups: Nation, MAC jurisdiction, and State. These comparisons enable an IRF to determine if it differs from other IRFs.

- innovative demonstration projects such as the Comprehensive Care for Joint Replacement Model,¹⁷ and
- postpayment reviews.

For example, the goal of the CERT A/B MAC Outreach & Education Task Force for Error-Free Medicare Claims is to give providers educational opportunities aimed at reducing the Part A and Part B error rates.¹⁸ This task force has specifically targeted education outreach about IRF Medicare compliance by continuing to offer web-based training to explain IRF Medicare regulations that have been in effect since 2010. Additional CMS educational outreach programs include open-door compliance forums for other types of providers and consumers.¹⁹

In addition to CMS's educational and outreach efforts for the IRF community and CERT's improper payment evaluations, several RACs and MACs performed postpayment reviews from 2013 through 2017. These reviews tested medical necessity, CMG coding, and compliance with documentation requirements and identified overpayments of \$18.5 million. In 2016, CMS also directed the SMRC to perform IRF postpayment medical review.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$6.75 billion in Medicare payments to 1,139 IRFs for 370,872 IRF stays in CY 2013.²⁰ We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling \$11,277,251 for stays at 164 IRFs. We used an independent medical review contractor

¹⁷ This model program for joint replacement care at acute-care hospitals began in April 2016 and tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute-care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery (80 Fed. Reg. 73274 (Nov. 24, 2015); 82 Fed. Reg. 180 (Jan. 3, 2017)). Regulations, notices, and fact sheets are available at <https://innovation.cms.gov/initiatives/cjr>. Last accessed on March 5, 2018.

¹⁸ CMS designed The CERT A/B Task Force to assist Medicare FFS contractors in strengthening customer service to improve provider experience. It is composed of volunteers from MACs who reimburse for services in Medicare Part A (hospital insurance) and Part B (medical insurance).

¹⁹ CMS sponsors regularly scheduled "Open Door Forums," providing an opportunity for conversation between CMS and the stakeholder community on a variety of topics. During 2016 and 2017, CMS presented a series of open-door forums, "The IMPACT ACT and Improving Care Coordination," for IRFs and other post-acute-care providers and solicited feedback pertaining to the Improving Medicare Post-Acute Care Transformation Act of 2014, P.L. No. 113-185, Oct. 6, 2014. This legislation requires the Secretary of Health and Human Services to submit a report to Congress, expected in 2022, that will include recommendations and a technical prototype for a post-acute-care PPS. Available at <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Last accessed on March 5, 2018. See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

²⁰ CY 2013 IRF claims data were the most recent data available at the start of the audit.

to determine whether sampled IRF stays met coverage requirements. In addition, we determined whether the IRFs complied with Medicare documentation requirements. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains sample results and estimates, and Appendix E contains deficiencies in documentation for the IRFs associated with our sampled claims.

FINDINGS

IRFs complied with Medicare coverage and documentation requirements for 45 of the 220 sampled stays. However, for the remaining 175 sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare coverage and documentation requirements. Specifically, 146 stays did not meet both coverage and documentation requirements, and 29 stays met coverage requirements but did not meet documentation requirements.

These errors occurred because of a number of contributing factors: Many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions; CMS's extensive educational efforts and recent postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide \$5.7 billion (84 percent of the dollars covered by our audit) in 2013 for care to beneficiaries that was not reasonable and necessary.

Information about the 45 stays that complied with Medicare coverage and documentation requirements could be informative to CMS as it works with providers to reduce noncompliance. (See Appendix F.)

MEDICARE COVERAGE REQUIREMENTS

The coverage requirements (42 CFR § 412.622(a)(3)) specify that, at the time of admission, the IRF must have a reasonable expectation that the patient meets all of the following requirements:²¹

- needs the multiple active and ongoing therapies of an acute inpatient rehabilitation interdisciplinary program, one of which must be physical or occupational therapy;
- requires supervision by a rehabilitation physician to assess the patient, both medically and functionally, and modify the course of treatment as needed to maximize the benefit from the rehabilitation process; and
- is sufficiently stable to be able to actively participate and benefit from an intensive rehabilitation therapy program and demonstrate measurable improvement that is of practical value to the patient in improving functional capacity or adaptation to impairments.

MEDICARE DOCUMENTATION REQUIREMENTS

The Medicare IRF requirements (42 CFR §§ 412.622(a)(4) and (5)) specify that the patient's medical record at the IRF must include the following types of documentation with all required elements:²²

- comprehensive preadmission screening;
- a postadmission rehabilitation physician evaluation;
- an individualized overall plan of care developed and documented by a rehabilitation physician; and
- a demonstration that the patient requires an interdisciplinary approach to care, with weekly interdisciplinary team meetings led by a rehabilitation physician.

²¹ The Manual, Pub. No. 100-02, chapter 1, "Medical Necessity Criteria," §§ 110.2–110.2.5, 110.3.

²² We identify the required component elements of these types of documentation in Appendix E, Details of the Inpatient Rehabilitation Facility Documentation Deficiencies Found in the Sample.

MOST SAMPLED STAYS WERE NOT REASONABLE AND NECESSARY

For 175 of the 220 sampled claims, the IRFs did not meet all coverage and documentation requirements. Medicare paid 135 IRFs \$8,325,940 for these stays.²³ Neither coverage nor documentation requirements were met for 146 of the 175 stays.

The other 29 of the 175 stays generally met coverage requirements but did not meet all of the documentation requirements.²⁴ We will provide CMS with a list of the 135 IRFs with sampled stays that did not meet coverage or documentation requirements separately for further review.

Coverage Requirements Not Met

Of the 175 stays, 146 did not meet the coverage requirements. Specifically, the medical records for the stays did not reflect that the patients had the medical needs and functional rehabilitation goals that require the complexity and intensity of inpatient rehabilitation. Medical reviewers determined that, for these IRF stays, appropriate care would have required only individual therapy interventions rather than an intense interdisciplinary program with rehabilitation physician supervision. In some of these stays, the therapy would be expected to consist of general exercises and regular activities, such as walking or exercises to improve tolerance for sitting. In other stays, nonskilled caregivers would have been able to provide needed assistance with only intermittent skilled therapy oversight.

For all of these stays, the high level of physician supervision that accompanies acute intensive rehabilitation therapy services would not have been required. These patients did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In some stays, the patients were unable to participate in an intensive therapy program regardless of medical and rehabilitation needs.

We found that stays that did not meet coverage requirements were predominantly, but not exclusively, related to the following:

- generalized weakness, overall fatigue, and impaired mobility for which appropriate therapy would be regular activities, such as walking, use of a wheelchair, or just general exercises (56 stays);

²³ When they receive Medicare contractor denials, IRFs are eligible to bill Part B inpatient services if the service (1) was denied under Part A because the inpatient admission was not reasonable and necessary *and* (2) is not by definition solely an outpatient service that would not be provided to an inpatient (42 CFR § 414.5). There are time limits for rebilling: rebilling will be rejected as untimely when the bill is filed later than 1 CY after the date of the service (42 CFR §§ 414.5(c) and 424.44(a)).

²⁴ Of these 29 stays, 22 had more than 1 documentation deficiency and 7 had a single documentation deficiency. By documentation deficiency, we mean that an element of required documentation was missing. Based on these 29 stays, we estimated that \$571 million of the total estimated \$5.7 billion was paid for stays that might have qualified as reasonable and necessary if documentation requirements had been met.

- simple fractures, single extremity deficits, simple or minor trauma, elective or emergency single joint or other orthopedic repair without postoperative complications, or no new and acute significant impairing event or condition (48 stays);
- miscellaneous conditions without complications or other new impairing events to include other orthopedic, central nervous system, cardiac, and pulmonary conditions (25 stays); or
- inability to participate in intense rehabilitation and demonstrate measurable improvement of practical value to the patient (17 stays).

Examples of Information Contained in the Medical Records for Stays That Were Not Reasonable and Necessary

Example 1: According to the medical review contractor, the patient had his right hip partially replaced after a fall, and there were no significant postoperative complications. At the time of IRF admission, he was able to tolerate bearing weight, perform transfers from sitting to standing and from a bed to a chair with minimal assistance, and walk 40 feet with minimal assistance. There was no expected need to modify the patient's treatment to maximize the patient's capacity to benefit from rehabilitation. The patient did not require a physician's supervision at an acute rehabilitation level of care, interdisciplinary rehabilitation, or the intensity of acute-level rehabilitation. In addition, the documentation did not include all the required elements for the individualized, overall plan of care and the interdisciplinary team meetings.

Example 2: According to the medical review contractor, the patient had been treated during a 2-week, acute-care hospital stay for pneumonia caused by a fungal infection and then had acute kidney failure. Before that admission, she had been functionally independent. After the acute-care hospital stay, she was admitted to an IRF. The IRF preadmission screen identified that the patient had generalized weakness and impaired mobility and was suffering from malnutrition and anemia. At admission, the patient was (1) walking 100 feet without an assistive device, (2) performing activities of daily living with minor assistance, and (3) able to respond cognitively at a high level of complexity. The patient was limited by fatigue. The admitting IRF provider found the patient to be in stable condition and did not identify any further functional defects on the postadmission evaluation. She did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In addition, the documentation did not include all the required elements for the individualized overall plan of care.

Documentation Requirements Not Met

The medical record documentation for 175 stays did not contain all of the information required by CMS. Of these stays, medical records for 147 had more than 1 documentation deficiency, and medical records for 28 had 1 documentation deficiency. Twenty of the 147 stays were missing 1 or more elements of all 4 types of required documentation. As a result of these documentation deficiencies, we were unable to determine that IRF care for those 175 stays was reasonable and necessary. For many of the stays, we were unable to determine that a rehabilitation physician had:

- reviewed and concurred with the findings of the preadmission screenings that took place within 48 hours before the IRF admission;
- conducted a postadmission evaluation that identified any relevant changes that might have occurred since the preadmission screening;
- prepared an overall and individualized plan of care; and
- participated in weekly team meetings and concurred with the results, findings, and decisions made at the meetings.

Appendix E contains details of the deficiencies in IRF documentation associated with the sample items.

CAUSES OF NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

A number of factors might have contributed to the admission practices that resulted in IRFs being reimbursed for patients who did not need the complexity and intensity of inpatient rehabilitation. These factors included the following:

- IRFs' internal controls failed to prevent inappropriate admissions, and IRFs lacked monitoring procedures for Medicare documentation compliance. We concluded this solely on the basis of our review of the medical records and the high error rate.
- Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions. By instituting an FFS prior authorization

process, similar to the process used by Medicare Advantage plans, CMS may be able to improve IRF provider compliance.²⁵

- Although Medicare contractors have performed yearly postpayment reviews since 2013, these reviews, together with CMS’s extensive educational and outreach efforts, were insufficient to control the rising and significant increase in the IRF improper payment rate. CERT reported increasing error rates for Medicare payments to IRFs: 9 percent in 2012, 17.2 percent in 2013, 20.7 percent in 2014, 45.5 percent in 2015, and 62.4 percent in 2016.
- ALJ hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted. Previous OIG work²⁶ has shown that (1) for 56 percent of FY 2010 appeals, ALJs reversed prior-level decisions by the CMS Qualified Independent Contractors (QICs) and decided fully in favor of appellants; (2) differences between ALJ and QIC decisions were due to varying interpretations of Medicare policies, in their degree of specialization and the use of clinical experts; (3) these differences may provide appellants an incentive to appeal to the ALJ level where they are likely to receive favorable decisions; and (4) 44 percent of FY 2010 ALJ decisions was fully favorable to appellants when CMS participated, but 60 percent of ALJ decisions (based on all provider appeals including IRFs) was fully favorable when CMS did not participate. Based on CMS data for 2014 through 2017 IRF appeals, the overturn rate with CMS contractor participation was 39 to 53 percent and 55 to 73 percent when CMS contractors did not participate.²⁷ An official we interviewed

²⁵ Medicare Advantage healthcare coverage plans are offered by private companies approved by Medicare to receive reimbursement for services. Some Medicare Advantage plans require the IRF to obtain prior authorization for IRF admissions from the Medicare Advantage plan (a party external to the IRF itself). IRF stays covered by these plans generally follow Medicare FFS coverage and documentation requirements. In addition to requiring an IRF to request prior authorization, some Medicare Advantage plans may require further evaluation for patients with certain conditions. Evaluation criteria may include an assessment of whether the care needed could be safely provided in a less restrictive clinical setting. Some plans also require additional review of medical records after the authorization to increase a length of stay beyond initially approved limits.

²⁶ OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals* ([OEI-02-10-00340](#)), November 2012. As noted in that report on pages 19 and 20, we acknowledge that CMS may have strategic considerations “about which contractors are in the best position to represent CMS and which appeals most warrant CMS participation in ALJ hearings, such as Part A hospital appeals or those from frequent flyers.”

²⁷ The Office of Medicare Hearings and Appeals administers the ALJ hearing program for provider appeals about individual claims for Medicare coverage and payment for items and services furnished to beneficiaries. The ALJs decide appeals at the third level of the Medicare appeals system; the first level is adjudicated by the CMS Medicare Administrative Contractors and the second by CMS QICs. These data include appeal decisions at the QIC and ALJ levels, and CMS contractor participation, in this case, includes paper or testimony presentation by MAC, QIC, or RAC contractors.

at a for-profit facility belonging to a large national IRF corporation stated that the organization expected to have any denials overturned at the ALJ level of appeal.

- The IRF payment system did not align costs with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately. (See Appendix G.)

ESTIMATE OF MEDICARE PAYMENTS MADE FOR CARE THAT WAS NOT REASONABLE AND NECESSARY

On the basis of our sample results, we estimated that for the audit period Medicare paid IRFs nation-wide \$5.7 billion for stays that did not meet the coverage and documentation requirements for care to be considered reasonable and necessary.

RECOMMENDATIONS

We recommend that CMS:

- educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls;
- increase oversight activities for IRFs, such as postpayment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements;
- work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented; and
- reevaluate the IRF payment system, which could include:
 - conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices,
 - studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them, and
 - considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute-care PPS system.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft, CMS concurred with our recommendations and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while protecting taxpayer dollars by preventing improper payments. CMS also provided us written technical comments that we addressed.

In addition to its many educational efforts, CMS stated that it has approved the MACs to review IRF providers under its Targeted Probe and Educate program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. These actions, together with actions taken in response to our recommendations, may significantly reduce the number and amount of improper payments to IRFs.

CMS's comments, excluding its technical comments, are included in their entirety as Appendix H.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nation-wide review covered 370,872 IRF claims from 1,139 IRFs totaling \$6,751,375,988 in payments for services that were provided from January 2013 through December 2013.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the facilities that were associated with our sampled claims. Instead, we obtained a general understanding of controls related to admission decisions and documentation requirement compliance at facilities associated with a subsample of our claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our data collection from September 2015 through December 2016. CY 2013 IRF claims data were the most recent data available at the start of the audit.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed with CMS officials the 2010 revisions to the Medicare regulations for documenting IRF care;
- extracted from CMS's NCH file paid IRF claims data;
- identified a sampling frame of 370,872 IRF claims from 1,139 IRFs totaling \$6,751,375,988 in payments for services provided from January 2013 through December 2013;
- selected a stratified random sample of 220 claims for our review, for which Medicare paid \$11,277,251 to the associated 164 IRFs (Appendix C);
- reviewed data from CMS's Common Working File for the 220 sampled claims to validate claim information extracted from the NCH file and determine whether any of the selected claims had been canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by the 164 IRFs associated with our sampled claims;

- used an independent medical review contractor to determine whether the documentation for the 220 sampled claims met medical necessity requirements;
- discussed a subsample of the billed claims with certain IRF clinical and billing representatives to determine the underlying causes of noncompliance with Medicare requirements and the internal control procedures needed to foster compliance;
- used our sample results to estimate the total improper payments in our sampling frame (Appendix D); and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
<i>Norwalk Hospital Did Not Comply with Medicare Inpatient Rehabilitation Facility Documentation Requirements (A-01-11-00531)²⁸</i>	February 2013
<i>Medicare Compliance Review of University of Minnesota Medical Center for 2012 and 2013 (A-05-14-00050)</i>	January 2016
<i>Medicare Compliance Review of Hennepin County Medical Center for 2012 and 2013 (A-05-14-00048)</i>	February 2016
<i>Medicare Compliance Review of New York-Presbyterian Hospital for 2011 and 2012 (A-02-13-01027)</i>	August 2016
<i>Medicare Compliance Review of Abbott Northwestern Hospital for 2013 and 2014 (A-05-15-00043)</i>	December 2016
<i>Medicare Compliance Review of North Shore University Health System for 2013 and 2014 (A-05-15-00044)</i>	December 2016
<i>Medicare Compliance Review of Mount Sinai Hospital for 2012 and 2013 (A-02-14-01019)</i>	April 2017

²⁸ Unlike this review, the other reviews include only a limited number of claims from the rehabilitation units of the acute-care hospital.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare FFS claims for services that IRFs provided to beneficiaries in CY 2013.

SAMPLING FRAME

We extracted from the NCH file Medicare inpatient claims for IRF services that were provided to beneficiaries in CY 2013. We created a database of these 442,259 claims, which had \$6,866,084,932 in total payments. We analyzed the claims data and removed claims that met one or more of the following criteria:

- claims in which the claim payment was less than or equal to \$2,500;
- claims submitted by providers that are under investigation by OIG's Office of Investigations; and
- claims already under review by other entities, including those claims marked as being under review by other entities.

The resulting sampling frame consisted of 370,872 IRF claims with payments totaling \$6,751,375,988.

SAMPLE UNIT

The sample unit was an IRF claim.

SAMPLE DESIGN

We used a stratified random sample as follows to review Medicare Part A payments made to nation-wide IRFs for services provided January 1, 2013, through December 31, 2013. To accomplish this, we separated the sample units into four strata as follows:

Stratum	Stratum Bounds	Number of Frame Units	Sample Size	Dollar Value of Frame Units
1	≥ \$2,500 and < \$15,857	156,756	50	1,870,356,189
2	≥ \$15,857 and < \$25,397	162,715	50	3,222,316,883
3	≥ \$25,397 and < \$97,891	51,331	50	1,650,539,578
4 (100% Review)	≥ \$97,891	70	70	8,163,338
Total		370,872	220	\$6,751,375,988

SAMPLE SIZE

We selected 50 claims each from strata 1, 2, and 3 and selected all 70 claims from stratum 4. Our total sample size was 220 IRF claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the claims in strata 1, 2, and 3. After generating 50 random numbers for each stratum, we selected the 150 corresponding claims for review. We reviewed every claim in stratum 4 (70 in total).

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to nation-wide IRFs during the audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS

Table 1: Overall Sample Details and Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims for Care Not Reasonable and Necessary	Value of Claims for Care Not Reasonable and Necessary
1	156,756	\$1,870,356,189	50	\$582,320	46	\$531,520
2	162,715	\$3,222,316,883	50	\$982,171	46	\$909,879
3	51,331	\$1,650,539,578	50	\$1,549,421	33	\$993,221
4	70	\$8,163,338	70	\$8,163,339	50	\$5,891,320
Total	370,872	\$6,751,375,988	220	\$11,277,251	175	\$8,325,940

**Table 2: Overall Estimates
(Limits Calculated for a 90-Percent Confidence Interval)**

	Estimated Value of Improper Payments
Point Estimate	\$5,652,951,081
Lower Limit	\$5,322,701,315
Upper Limit	\$5,983,200,848

APPENDIX E: DETAILS OF THE INPATIENT REHABILITATION FACILITY DOCUMENTATION DEFICIENCIES FOUND IN THE SAMPLE

One or more of the four types of required rehabilitation physician documentation did not include all required elements of each of these documentation types:

- a comprehensive preadmission screening (101 stays);
- a postadmission rehabilitation physician evaluation (62 stays);
- an individualized overall plan of care developed and documented by a rehabilitation physician (166 stays); and
- a demonstration that the patient requires an interdisciplinary approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician (106 stays).

DEFICIENT DOCUMENTATION OF PREADMISSION SCREENING

At the time of admission, a patient’s medical record at the IRF must contain documentation of a comprehensive preadmission screening performed within the 48 hours immediately preceding the IRF admission. A comprehensive and accurate preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care.²⁹ The medical record must also include evidence of the rehabilitation physician’s review and concurrence with the findings of the completed preadmission screening and before the IRF admission. The screening should include a detailed clinical review of the patient’s condition and medical history; serve as the

²⁹ CMS continued: “As we are placing more weight on the rehabilitation physician’s decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind the decision. We realize that this level of detail may exceed what some IRFs may have included in the past, but we believe that it will benefit both IRFs and Medicare contractors who are reviewing IRF claims to have the rationale for the reasoning behind the admission recorded in each patient’s medical record” (74 Fed. Reg. 39791 (Aug.7, 2009)). CMS also stated: “The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not how the process is organized” (The Manual, chapter 1, § 110.1.1).

basis for the initial determination of whether the patient meets the requirements for an IRF admission; and be used to inform a rehabilitation physician, who reviews and documents concurrence with the findings and results of the screening (42 CFR § 412.622(a)(4)).³⁰

For 101 stays, IRF medical records did not include documentation of (1) a rehabilitation physician review and concurrence with the findings of the completed preadmission screening and before the IRF admission (or evidence of preadmission screening actually being performed within the 48 hours immediately preceding the IRF admission) (84 stays), (2) a comprehensive medical and functional assessment (33 stays), and (3) any preadmission screening (7 stays).

The documentation for 84 stays did not include proof that a rehabilitation physician reviewed and concurred with preadmission findings. The approval statements and signatures of rehabilitation physicians were absent, untimely, or illegible, and the names of the rehabilitation physicians were not identified elsewhere in the medical charts. Therefore, we were unable to determine that a rehabilitation physician had reviewed and concurred with the findings of the preadmission screenings taking place within 48 hours before the IRF admission.

The medical records for 33 of the 84 stays did not support IRF admissions because the preadmission screening did not detail the conditions causing the need for intensive rehabilitation, the patient's prior and current level of function, and the risk of clinical complications. Medical records for seven other stays did not include any preadmission screening documentation.

For an additional 10 stays, the IRFs provided documentation of history and physical examinations, progress notes, and consultations from the immediately preceding acute-hospital stay instead of preadmission screening documentation. However, this substitute documentation was not comprehensive, did not include most required clinical information, and did not support that a rehabilitation physician had approved the IRF admission.

³⁰According to the Manual, chapter 1, § 110.1.1, IRFs must support the IRF admission by retaining in the patient's medical record the results of a preadmission screening that was conducted within the 48 hours immediately preceding the admission:

The preadmission documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e. physical therapy, occupational therapy, speech therapy-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

DEFICIENT DOCUMENTATION OF THE REHABILITATION PHYSICIAN'S POSTADMISSION EVALUATION

The patient's medical record at the IRF must include documentation of a rehabilitation physician's postadmission evaluation that meets all of the following requirements: (1) completed within 24 hours of the patient's admission to the IRF, (2) includes a documented history and physical exam, (3) documents the patient's status on admission to the IRF, (4) includes a comparison of observed medical and functional status with the information noted in the preadmission screening documentation, and (5) serves as the basis for the development of the overall individualized plan of care (42 CFR § 412.622(a)(4)).³¹

Although medical records for most stays included documentation of a history and physical exam performed within the first 24 hours after admission, for 62 of the IRF stays the medical records did not include documentation showing that the rehabilitation physicians' postadmission evaluations met all of the requirements. Specifically: (1) documentation of postadmission evaluations did not include a medical and functional status comparison with the information noted in the preadmission screening documentation and (2) the postadmission rehabilitation physicians' evaluations were not completed within 24 hours after admission as required.

For eight of the 62 stays, physician extenders³² documented the history and physical examination, but the documentation did not include evidence that a rehabilitation physician documented a visit with the patient, the patient's status on admission to the IRF, a comparison with the information noted in the preadmission screening documentation, and a basis for the development of the overall individualized plan of care within the 24 hours after the IRF admission.

DEFICIENT DOCUMENTATION OF INDIVIDUALIZED, OVERALL PLAN OF CARE

The patient's medical record for the IRF stay must contain an individualized overall plan of care that is developed by the rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission (42 CFR § 412.622(a)(4)).

It is the sole responsibility of a rehabilitation physician to combine information that is required in the overall plan of care, including an estimated length of stay, and to document it in the patient's IRF medical record. The overall plan of care must detail the patient's medical

³¹ As interpreted by the Manual, chapter 1, §110.1.2.

³² Rehabilitation "physician extenders" in this case include nurse practitioners, physician assistants, and physicians other than rehabilitation physicians (CMS, *National Provider Training Call Transcript, Inpatient Rehabilitation Facility Prospective Payment System*, "Physician Extenders," p. 16, May 31, 2012).

prognosis, anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.³³

For 166 IRF stays, rehabilitation physicians did not document an individualized overall plan of care that met all of the requirements. For the 146 IRF stays not meeting the coverage requirements, medical reviewers could not identify individualized, overall plans of care supporting the medical necessity of the admission. The requirements for the documentation of individualized, overall plans of care were also not met for 20 of the 29 stays that generally met coverage requirements at admission but did not meet all documentation requirements.

For 104 stays, rehabilitation physicians documented only general and brief plans of care, not individualized and detailed plans that included medical prognoses, anticipated interventions, functional outcomes, estimated lengths of stay, and discharge destinations. For these stays, the rehabilitation physicians did not coordinate medical and functional courses of care for the patients, which could have identified and linked medical management to functional interventions and goals and to the complex conditions that require intervention by a rehabilitation physician. For 27 stays, treatment plans were developed and documented by therapists and nurses, not rehabilitation physicians as required, and were intended to be individualized, overall plans of care. These treatment plans did not contain decision making by rehabilitation physicians for a coordinated medical and functional rehabilitation course of care for the patient.

DEFICIENT DOCUMENTATION OF INTERDISCIPLINARY TEAM MEETINGS

For an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care, as evidenced by documentation retained in the patient's medical record. That documentation should contain summaries of interdisciplinary team meetings whose purpose is to foster communication among disciplines to establish, prioritize, and achieve treatment goals.³⁴ These summaries must (1) include the names and professional designations of the participants and (2) the results, findings, and decisions made at the team meetings and the rehabilitation physician's concurrence with those decisions (42 CFR § 412.622(a)(5)).³⁵ In addition, the team meeting must (1) be led by a rehabilitation physician; (2) consist of a registered nurse, social worker, or case manager and a licensed or certified therapist from each therapy discipline involved in treating the patient; and (3) occur at least once a week throughout the stay to implement appropriate treatment services and review progress toward goals.

³³ As interpreted by the Manual, chapter 1, § 110.1.3.

³⁴ CMS also stated: "Though we agree that informal communications among the disciplines on a daily basis are beneficial for the patient, we believe that it is important to require that all treating disciplines meet formally at least once per week to maximize the patient's potential for meeting the treatment goals." (74 Fed. Reg. 39795 (August 7, 2009)).

³⁵ As interpreted by the Manual, chapter 1, § 110.2.5.

For 106 IRF stays, medical record documentation was not compliant with the requirements for weekly interdisciplinary team meetings. The documentation was missing key elements that are intended to demonstrate a collaborative, interdisciplinary approach to care. Specifically, documentation retained in the patients' medical records of interdisciplinary team meetings did not provide enough detail to identify one or more of the following key elements:

- the results, findings, and decisions made at the meetings (74 stays);
- the names and professional designations of the participants (70 stays); and
- the concurrence of the rehabilitation physician with the results, findings, and decisions (50 stays).

Although therapists, nurses, and case management specialists may have individually documented weekly notes about the patient's medical and functional status, those notes were not documented as final decisions made by the interdisciplinary team at a weekly team meeting. The notes also did not clearly identify the rehabilitation physician's concurrence and participation in a meeting.

Documentation for some team meetings included only check boxes as patient status indicators. For other meetings, rehabilitation physicians briefly documented that team meetings took place and what was discussed. For all these stays, this documentation did not show a clear communication among disciplines for a coordination of care through an interdisciplinary team approach.

APPENDIX F: SAMPLED STAYS THAT WERE REASONABLE AND NECESSARY

The IRFs in our review complied with all Medicare coverage and documentation requirements for 45 of the 220 sampled stays. The medical records for these stays supported that IRF care was reasonable and necessary in accordance with Medicare's coverage and documentation requirements. Even though patients with other types of conditions may be suitable candidates for IRF care, these 45 stays were predominantly related to patient needs resulting from injuries and other impairments related to the head and spinal cord.³⁶

The preadmission screening documentation for these patients demonstrated that the patients had (1) complex nursing, medical management, and rehabilitation needs, requiring an interdisciplinary team approach to care supervised by a rehabilitation physician during an inpatient stay and (2) the ability to make measurable improvement that is of practical value to them according to predefined goals.

TWO EXAMPLES OF INFORMATION CONTAINED IN THE MEDICAL RECORDS FOR STAYS THAT WERE REASONABLE AND NECESSARY

The records for both these examples had the appropriate documentation elements required for the preadmission screening; a postadmission rehabilitation physician evaluation; an individualized, overall plan of care; and an interdisciplinary team approach to care. The documentation presented a detailed description of the patient's required needs for acute inpatient rehabilitation.

Example 1: According to the medical review contractor, the patient, who had previously been independent, had had multiple strokes. He had a significant blood circulation disorder in his left lower leg and had undergone emergency procedures to remove blood clots. When admitted for rehabilitation, the patient was at high risk of losing that leg. He was able to follow simple commands and perform transfers only with maximal assistance. He required complex pain management and skilled physical therapy, occupational therapy, and speech therapy services, as well as a high level of medical oversight and nursing care in the treatment of his medical conditions. He was medically stable and able to participate in and benefit from acute-level rehabilitation. With this therapy, it was anticipated that the patient would obtain measurable improvement that was of practical value to him.

³⁶ CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, p. 7. A patient meeting all of the coverage criteria for admission to an IRF, as supported by required medical record documentation, could be a candidate for IRF care. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

Example 2: According to the medical review contractor, the patient, who had previously been independent, injured his spinal cord in a fall. He depended on a ventilator and had bowel and bladder problems, with secondary complications of pneumonia and sepsis. He was able to participate in treatments that included weaning him off the ventilator, physical therapy, and occupational therapy for preventing further secondary complications and for improving mobility. He required speech therapy for swallowing and communication. His therapy goals were to obtain measureable improvement of practical value in recovering from infection, achieving bowel and bladder independence, progressing in the ability to swallow and communicate, developing tolerance for sitting in a wheelchair, and attaining mobility with the use of adaptive equipment. He had both medical needs and rehabilitation goals that required the complexity of acute-level rehabilitation and the specialty care of a spinal cord injury unit. A home discharge had been planned.

PROVIDER INTERNAL CONTROLS

We discussed internal control procedures with staff at several of the IRFs in our sample and determined that the IRFs that demonstrated compliance with Medicare coverage and documentation requirements had established strict admissions and quality control monitoring policies and procedures for Medicare coverage and documentation compliance. These IRFs had strengthened their controls as a result of the establishment of the 2010 Medicare requirements.

AN EXAMPLE OF ONE PROVIDER'S INTERNAL CONTROL PROCESS

We visited an IRF unit of an acute-care hospital that created internal controls in 2010 to comply with IRF coverage and documentation requirements that CMS revised in 2009.

The IRF described its preadmission screening process, which begins soon after it receives the order for the IRF admission. The IRF obtains all applicable medical records from the referring facility. The admission liaison nurse and rehabilitation physician review these records before the patient's admission and document their preadmission screening analysis and admission decision. If the order is for a patient in the acute-care hospital unit of the same facility, the admission nurse liaison and the rehabilitation physician also visit the patient, perform a physical examination, and document their findings. This admission team also visits outside facilities to perform preadmission screening for patients being referred to the team's IRF. Clinicians at this IRF stated that the appropriateness of the IRF admission depends on the completeness and accuracy of the preadmission screening they perform.

The IRF also designed its electronic medical record system to prompt the user to enter documentation required by Medicare and their facility. An electronic message prompts the rehabilitation physician and other users to enter scheduled documentation if it has not been properly completed in a timely manner. The physician director of the rehabilitation unit said these prompts include a reminder to the rehabilitation physician in charge of the patient to document an individualized, overall plan of care almost immediately after the patient's admission. Additional prompts require rehabilitation physicians to document weekly team meetings with a detailed description of patient status and to explain the need for continued inpatient rehabilitation.³⁷

³⁷ In addition, this rehabilitation physician director said he makes it his practice to seek out information at national professional society meetings to determine whether the IRF is providing a high quality of care in comparison to other facilities. He and his fellow physical medicine and rehabilitation physicians make daily visits to the patients, although many rehabilitation physicians at other facilities visit only the minimum number of three times per week as required by Medicare.

APPENDIX G: MedPAC RECOMMENDATIONS FOR REFORM OF INPATIENT REHABILITATION FACILITY AND POST-ACUTE-CARE PAYMENTS

INPATIENT REHABILITATION FACILITY PAYMENTS

MedPAC has made recommendations that could reduce Medicare spending on IRF stays. The Commission reported the following in 2017:

- Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, while Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent.
- IRFs may differ in their assessment and coding of patients' motor and cognitive function. Although aggregate payments may be more than sufficient, payments for some IRFs may be too low relative to the costs incurred in treating their patients, while the payments for other IRFs may be too high.
- There are differences in freestanding and hospital-based IRFs' mix of cases, with some case types being more profitable than others, resulting in higher margins for facilities that admit larger shares of the cases.³⁸

Since 2009, as IRF profit margins have been greater than 10 percent for most of the last 10 years,³⁹ MedPAC has recommended reform in a 0-percent update to IRF payments and concluded, "In the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase. Thus payments have continued to rise."^{40, 41}

POST-ACUTE-CARE PAYMENTS

IRFs provide one post-acute-care setting for Medicare beneficiaries. Other settings, each with a separate payment system, include home health agencies, skilled nursing facilities, and long-term-care hospitals. According to MedPAC, there is a variation in the supply and use of post-acute-care providers across the country and a substantial overlap in types of patients treated

³⁸ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 258.

³⁹ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 7, "Post-Acute Care: The Congress and CMS Must Act To Implement Recommended Changes to PAC Payments," March 2017, p. 190.

⁴⁰ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 259.

⁴¹ Individual market baskets for Medicare payment systems, such as the IRF PPS, are inflation-adjusted price indices that are developed to measure the price changes over time for each type of provider.

across these four settings, while Medicare continues to pay significantly different rates for similar patients depending on the setting.^{42, 43}

MedPAC has stated that an unnecessarily high level of spending—post-acute-care Medicare margins being greater than 10 percent for most of the last 10 years—has been high relative to the cost of treating beneficiaries. In response to the initial mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014, MedPAC has recommended features of a unified post-acute-care payment system based on patient characteristics rather than setting, a closer alignment of costs and payments, more equitable payments across different kinds of patients, and outcomes-based quality measures.

MedPAC estimates that this system would redistribute payments among types of stays (from physical rehabilitation to medically complex care) and from higher cost settings and providers to lower cost settings and providers. Under this system, MedPAC says that (1) profitability should be more uniform across different types of stays or patients; (2) providers should therefore have less financial incentive to admit certain types of patients over others; and (3) payment would no longer be based in part on the number of services furnished, so providers would have less financial incentive to provide unnecessary services.⁴⁴

⁴² MedPAC, *Report to Congress: Mandated Report*, chapter 3, “Developing a Unified Payment System for Post-Acute Care,” June 2016, pp. 57, 63.

⁴³ B. Gage, M. Morley, et al., *The Post-Acute Care Payment Reform Demonstration*, final report, “12.5 Next Steps,” volume 4, March 2012, p. 251. Authorized by section 5008 of the Deficit Reduction Act of 2005, P.L. No. 109-171, and prepared for CMS by RTI International (RTI project number 0209853.005.001).

⁴⁴ MedPAC, *Report to Congress*: chapter 3, “Developing a Unified Payment System for Post-Acute Care,” June 2016, p. 59.

APPENDIX H: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: AUG 16 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

A handwritten signature in blue ink that reads "Seema Verma".

SUBJECT: Office of Inspector General (OIG) Draft Report: Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (A-01-15-00500)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. CMS is constantly looking for ways to improve this process; for example, in February 2018 CMS updated the Medicare Program Integrity Manual and provided guidance to Medicare contractors to clarify instructions for conducting medical review of inpatient rehabilitation facility claims. Specifically, it clarified the process for assessing intensity of services in relation to the inpatient rehabilitation facility benefit which will help ensure consistent interpretation of the policy.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for inpatient rehabilitation services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, the Medicare Administrative Contractors conducted outreach and education events, both one-on-one and seminar-structured events, with inpatient rehabilitation facilities on issues such as Medicare coverage rules, billing instructions, and certification requirements. CMS also maintains a provider resource mailbox specifically for inpatient rehabilitation facilities, through which we provide responses to a wide range of questions related to proper billing and other issues. Further, CMS has approved the Medicare Administrative Contractors to perform reviews of inpatient rehabilitation providers under its Targeted Probe and Educate Program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. Finally, CMS developed standardized denial reason statements for contractors to promote uniformity and help with provider understanding of billing issues and future compliance.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate providers regarding Medicare coverage and documentation requirements for inpatient rehabilitation facilities. Additionally, CMS will explore ways to identify and share compliance requirements so providers can develop or improve internal controls.

OIG Recommendation

The OIG recommends that CMS increase oversight activities of IRFs, such as post payment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will instruct a Medicare review contractor to review a sample of the inpatient rehabilitation facilities identified in the OIG's audit to determine compliance with coverage and documentation requirements. Based on the findings of the sample review, CMS will determine the appropriate follow up course of action.

OIG Recommendation

The OIG recommends that CMS work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented.

CMS Response

CMS concurs with this recommendation. CMS will work with the Office of Medicare Hearings and Appeals, to the extent possible, to explore opportunities for improvement, such as policy education or contractor participation at hearings, so that Medicare coverage and documentation requirements for inpatient rehabilitation facilities are fairly represented and interpreted during Administrative Law Judge hearings.

OIG Recommendation

The OIG recommends that CMS reevaluate the IRF payment system, which could include conducting a demonstration project requiring preauthorization for Part A IRF stays modeled on Medicare Advantage practices, studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make changes necessary to more closely align them, and considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation services payment reform, which may be a component of a unified postacute care PPS system.

CMS Response

CMS concurs with this recommendation. CMS continuously evaluates the inpatient rehabilitation facility payment system on an annual basis and has recently issued the Fiscal Year 2019 Inpatient

Rehabilitation Facilities Prospective Payment System final rule, which updates Medicare policies and payment rates for fiscal year 2019. These changes, specifically the changes to the documentation requirements, may potentially decrease the number of improper payments. CMS will take the OIG's suggestions into account when determining appropriate next steps.