The Law Offices of
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Late Transmission of Inpatient Rehabilitation Facility Patient Assessments Can Lead to Increased Scrutiny and Penalties

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Inpatient rehabilitation facilities (IRFs) are required to transmit patient assessment data on their Medicare patients to the Centers for Medicare & Medicaid Services (CMS). IRFs that do not transmit such data timely face a 25 percent reduction in claims payment as a penalty. Unfortunately, CMS has done a relatively poor job in educating IRFs on the policies, processes and penalties surrounding this regulatory obligation. In addition, CMS systems issues have hampered enforcement efforts. With a series of reviews and reports, the Department of Health and Human Services, Office of Inspector General (OIG) hopes to change this. The OIG has used these reports to highlight the general failure of CMS and its contractors to enforce payment penalties on IRF claims for the late-submission of patient assessment data. In response, CMS has taken steps to address systems issues and encourage its Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) to conduct post-payment reviews of IRF claims to determine whether the corresponding IRF-Patient Assessment Instrument (IRF-PAI) data was transmitted late. IRFs should expect increased audit activity around the timeliness of IRF-PAI data transmissions and be prepared to challenge alleged overpayments.

Please feel free to reach us at the phone number or email address to the left if you have questions about IRF-PAI late penalties or for assistance in challenging such penalties.

IRF-PAI Late Penalty. In 1997, Congress enacted the Medicare, Medicaid, and Children's Health Provisions of the Balanced Budget Act (BBA) of 1997.[1] Section 4421 of the BBA established a unique prospective payment system (PPS) for IRFs at section 1886(j) of the Social Security Act ("the Act").[2] Under these provisions, Congress instructed the Secretary to establish patient case-mix groups (CMGs) as a means of classifying patients based on resource utilization. In addition, these provisions authorized the Secretary to collect data from IRFs in order to administer the IRF PPS.[3]

The Secretary established data collection procedures, called IRF-PAI, through rulemaking.[4] The IRF-PAI regulations establish the patients for which IRFs must submit IRF-PAI data to CMS, the assessment schedule and related completion and encoding dates, as well as the mechanism and time frame for transmitting data to CMS.[5] The regulations also require IRFs to submit data for all Medicare Part A beneficiaries, regardless of whether they are Medicare fee for service (FFS) or Medicare Advantage participants.[6] However, IRFs are

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not required to transmit data for part A beneficiaries where Medicare does not remit payment for the claim, e.g., a private payer is responsible for claim payment.[7] IRF-PAI data includes completing and encoding an admission assessment and a discharge assessment for each inpatient stay according to a specified schedule.[8] Notably, *IRFs must transmit IRF-PAI data to the CMS-designated database within 27 days after the patient's discharge date*, or face a penalty in the amount of a 25% reduction to the CMG payment for the related claim(s).[9] The late penalty does not apply to Medicare Advantage patients; however, IRFs are prohibited from counting those patients towards the 60 percent requirement to maintain IRF status.[10]

On November 1, 2001, CMS issued Transmittal A-01-131 stating that "if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied."[11] The Transmittal further indicated that providers would not be required to include the IRF-PAI data transmission date on its billed claims. Additionally, CMS stated that it would "utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment."[12] CMS did not provide any details on the post-payment review process.[13]

Two years after Transmittal A-01-131, CMS amended the regulation to include an exemption from the 25% late penalty. CMS stated that, under this exemption, it "may waive the consequences of failure to submit complete and timely IRF–PAI data ... when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data."[14] Examples of "extraordinary situations" include natural disasters and "a data transmission problem that is beyond the control of the inpatient rehabilitation facility."[15] The IRF must fully document an extraordinary situation to avoid the late-transmission penalty.[16]

Recent OIG Report. The OIG recently issued a report entitled *Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims With Late Patient Assessment Instruments for Calendar Years 2009 and 2010.*[17] The OIG's objective was to determine whether IRFs had in fact received reduced CMG payments for claims where IRF-PAI data was submitted late. The OIG determined that, nationwide, IRFs submitted a total of 509,957 claims valued at $8.6 billion for CY 2009 and 2010 dates of services. Of those claims, the OIG determined that 2,414 claims totaling $41.6 million were at high risk of having been overpaid because the IRF-PAI transmission date in the database was after the deadline. A sample of 108 claims was selected for audit. The OIG found that 20 of these claims were cancelled or paid correctly. However, for the remaining 88 claims, the OIG determined that IRFs were not assessed the 25% payment penalty for submitting IRF-PAI data after the 27-day deadline. The OIG extrapolated these findings to estimate that a total of $8.4 million in overpayments were made because both IRF and Medicare payment controls were inadequate.

A. Previous OIG Report on IRF-PAI Late Transmission

The report briefly addressed the OIG's earlier 2010 report dealing with similar issues.[18] The 2010 report, which reviewed CYs 2006 and 2007 claims, found that IRFs did not always receive the late-transmission penalty. The OIG also found that inadequate payment controls were to blame for the overpayments

in 2006 and 2007. Further, inadequate controls resulted in IRF-PAI transmission dates that did not match the actual dates of transmission. The OIG estimated a total of $20.2 million in overpayments to IRFs. The OIG recommended that CMS recover the overpayments and establish corrective actions to detect subsequent overpayments. CMS responded that it took corrective actions to revise the Fiscal Intermediary Standard System (FISS) edit to count the discharge date as day 1 in the 27-day period for transmitting the IRF-PAI. In addition, CMS said that it was developing an interface between the FISS system and the IRF-PAI database[19] that could begin affecting claims submitted as early as October 2012. Furthermore, CMS stated that the MACs and RACs started a post-payment review process to identify and collect on IRF claims that are subject to the 25 percent penalty.

B. The OIG's Sampling Design and Methodology

The OIG approached this issue by interviewing officials from CMS and two MACs to understand the edits in the FISS and other controls that were currently in place to prevent or detect Medicare overpayments to IRFs.[20] To determine the universe, the OIG began by extracting IRF paid claim data from CMS's National Claims History file for CYs 2009 and 2010 and data from CMS on all original submissions of IRF-PAIs for claims with dates of service in CYs 2009 and 2010.[21] The OIG then matched all IRF claims and IRF-PAI submitted data. Next, the OIG eliminated duplicate claims, non-Medicare FFS claims, claims with timely IRF-PAI data, and claims with payments less than or equal to $1,000. This methodology resulted in 2,414 IRF claims with late IRF-PAIs for a total paid claim amount of over $41 million. The OIG organized these claims into four strata based upon the claim paid amount. Thirty claims were randomly selected from each stratum, except for the highest dollar value stratum from which every claim was selected. The sample included 108 claims and the sample unit was one IRF claim. The OIG reviewed the IRF-PAI data for each claim to:

> (1) validate claim information extracted from the National Claims History file, (2) verify that the late-assessment penalty had not been applied, and (3) determine whether any of the selected claims had been canceled; contacted representatives from the 49 IRFs that submitted the 108 sampled claims to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare requirements.[22]

C. The OIG's Findings

The OIG identified two primary causes of overpayments. First, it found that there were inadequate controls at IRFs to ensure that the reported IRF-PAI transmission dates on claims matched the actual IRF-PAI transmission dates.[23] The OIG concluded that this error was the result of miscommunications between clinical staff and billing staff about the proper IRF-PAI transmission dates. Second, the OIG found that CMS-related services failed to detect and prevent Medicare overpayments.[24] For example, the OIG found that "the prepayment controls were not designed to compare the PAI transmission dates on claims paid by the FISS with the actual dates on which IRFs transmitted the PAI to the Database."[25]

The OIG acknowledged that CMS had begun to work on the interface between the FISS system and the IRF-PAI database during the OIG review, to fix the key problem with the FISS system – that it was not counting the beneficiary's discharge date as day 1 of the 27-day time frame.[26] In addition, CMS had stated that MAC and RAC post-payment reviews had started, but none were completed by the end of the OIG's fieldwork for this report. Importantly, the OIG found that, until April 2010, CMS did not provide specific education to IRFs on the importance of submitting IRF-PAIs on time.[27]

D. The OIG's Recommendations to CMS

At the conclusion of the report, the OIG recommended that CMS:

- adjust the 88 sampled claims to recover overpayments of $696,371 to the extent allowed under the law;
- work with the OIG to resolve the remaining 2,306 non-sampled claims with potential overpayments estimated at $7.7 million and recover overpayments to the extent allowed under the law;
- continue to provide specific education to IRFs on the importance of reporting the correct IRF-PAI transmission dates on their claims;
- complete the process that would allow the FISS to interface with the IRF-PAI database to identify, on a prepayment basis, IRF claims with incorrect IRF-PAI transmission dates; and
- support MAC and RAC efforts to conduct periodic post-payment reviews of IRF claims.[28]

E. CMS Response and Comments

At Appendix C to the OIG report is a letter from CMS responding to the OIG report. CMS concurred with each of the OIG's recommendations. CMS agreed with adjusting the 88 claims noted to have been overpaid, and with resolving the 2,306 questionable claims by sharing OIG data with its contractors to encourage review. CMS also concurred that it must provide IRFs with specific education about the IRF-PAI data requirements because CMS believed that insufficient education resulted in much of the confusion at the provider level. CMS noted that since April 2010, NACD sends alerts to IRFs when IRF-PAIs are late, noting they might receive a late-transmission penalty. However, CMS stated it was updating the alert for IRF-PAIs submitted on or after October 1, 2012 to include more detail about the late-transmission policy, including the 27-day deadline. CMS also indicated it would be instructing MACs and FIs to educate IRFs about recording the correct transmission date on claims, as well as working with associations representing the IRF industry to reiterate the importance of correctly reporting IRF-PAI transmission dates.

In addition, CMS noted two releases that address the OIG's recommendations. First, CMS issued Change Request (CR) 7760 for implementation with the October 1, 2012 quarterly system release. This CR implements a system change to revise the FISS edit in order to count the discharge date as day 1 and an interface between the FISS and the IRF-PAI database, which will permit the FISS to screen IRF-PAI data to compare actual transmission dates against the dates denoted on matching claims.

CMS anticipated that this update would affect claims as early as October 1, 2012. Second, CMS stated that it will issue a Joint Signature Memorandum/Technical Direction Letter to MACs and RACs with a link to this OIG report, as well as specific claims information, to alert them to the OIG's findings for consideration in future post-payment review actions. CMS said that MACs and RACs have initiated a post-payment review process to audit claims for overpayments when IRF-PAI late-submission penalties have not been applied.

Future OIG Reviews. The OIG has made it clear that it will continue to review IRF compliance with the IRF-PAI transmission deadlines and CMS enforcement efforts. In its Work Plan for FY 2013, the OIG included a project called "Inpatient Rehabilitation Facilities—Transmission of Patient Assessment Instruments."[29] The project will aim to "determine whether IRFs received reduced payments for claims with patient assessment instruments that were transmitted to CMS's National Assessment Collection Database more than 27 days after the beneficiaries' discharges."[30] Work is in progress on various reviews, with an issue date of FY 2013.

RAC Post-Payment Reviews. Recent releases from RACs have similarly indicated a commitment to the issue of IRF-PAI data submission. To date, all four RAC regions have posted identical issue statements, entitled "Late Submissions of IRF-PAI Data," for identifying overpayments as a result of failed enforcement of the IRF-PAI data late-submission penalty.[31] The issue statement typically reads as follows:

> Inpatient rehabilitation facility-patient assessment instrument (IRF-PAI) data, which is collected on a Medicare Part A fee-for-service inpatient, must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge. Transmission of the IRF-PAI data record 28 or more calendar days after the discharge date, with the discharge date itself starting the counting sequence, will result in the claim incurring a 25 percent (25%) late transmission penalty.

Regions A and D will be reviewing claims having a claim paid date within three years of the admission discharge reference (ADR) date, while Regions B and C will review claims as old as October 1, 2007.[32]

What IRFs Can Do to Minimize IRF-PAI Late Penalties. IRF providers can expect to face increased scrutiny of their IRF-PAI data submissions and related Medicare claims. CMS has advised its contractors, including FIs, MACs and RACs, to focus on IRF compliance with IRF-PAI data transmission deadlines to recover the overpayments identified in the OIG reports and to look for additional overpayments. Accordingly, all four RACs have approval to review the late-submission of IRF-PAI data. IRFs subjected to these reviews will face recoupment actions for any overpayments that are identified based upon late IRF-PAIs where the 25 percent penalty was not previously imposed.

Further, the OIG continues to apply pressure to CMS on this issue with additional IRF-PAI reviews. Fortunately, it appears the OIG report has prompted CMS to better communicate with providers about IRF-PAI data transmission requirements. An example of this is the CMS developed WebEx training video to instruct IRF providers about the IRF-PAI data process, as well as changes from the old NACD system to the QIES/ASAP system. As CMS systems and educational efforts have improved, the onus is on IRFs to self-monitor their compliance with IRF-PAI deadlines to avoid the 25 percent penalties.

The most critical step is to submit IRF-PAI data timely. All IRFs should train staff on the IRF-PAI deadlines, in particular, the 27-day post-discharge timeframe. In addition, staff training should focus on the different systems and CMS components involved. IRF-PAI data are transmitted to the QIES/ASAP system via the CMSNet virtual network, while IRF claims for payment are transmitted to and reviewed by FIs and MACs. IRFs should ensure that they are properly registered and have user IDs to access the various CMS systems. Moreover, IRFs should periodically conduct internal audits to ensure that IRF-PAI data and related claims are being submitted timely and accurately.

IRF providers should approach post-payment reviews by CMS contractors with similar diligence. All requested documentation should be provided promptly. If any delays were attributable to program contractors or otherwise could be deemed "extraordinary circumstances" beyond the IRF's control, they should be well-documented in advance. With careful recordkeeping, IRFs will be prepared to challenge the imposition of 25 percent late penalties in these reviews and any subsequent appeals.

If you have any questions about these and other steps to avoid IRF-PAI late penalties, or for assistance in challenging such penalties, please feel free to reach us at the phone number or email address on page one.

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[1] *See* BBA of 1997, Pub. L No. 105-33 (1997).
[2] *See* Soc. Sec. Act § 1886(j) (implemented at 42 U.S.C. § 1395ww(j)).
[3] *See* 42 U.S.C. § 1395ww(j)(2)(A) and (D), respectively.
[4] 42 C.F.R. § 412.600, *et seq.*
[5] *See id.*
[6] *See id.* § 412.606(b).
[7] *See id.* § 412.614(a)(3). By final rule, CMS relieved IRFs "of the burden of transmitting IRF-PAI data to [CMS] when the IRF is not requesting that Medicare pay for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient." *See* 68 Fed. Reg. 45682 (Aug. 1, 2003).
[8] *See* 42 C.F.R. § 412.610 (subject to rules about interrupted stays at 42 C.F.R. § 412.618).
[9] *See* 42 C.F.R. § 412.614(b)-(d); CPM, Ch. 3 § 140.3.4(a) (CMS required transmission to the National Assessment Collection Database, now it instructs IRFs to use the QIES/ASAP system).
[10] *See* 42 C.F.R. § 412.614(d)(2).
[11] CMS Program Memorandum, Transmittal A-01-131 (Nov. 1, 2001). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/a01131.pdf

[12] *Id.* at 3.
[13] *See id.*
[14] *See* 68 Fed. Reg. 26,786, 26,800 (May 16, 2003).
[15] 42 C.F.R. § 412.614(e).
[16] *See id.*
[17] *See* A-01-11-00534, Sept. 2012 (available at https://oig.hhs.gov/oas/reports/region1/11100534.pdf).
[18] *See Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007,* A-01-09-00507.
[19] CMS required transmission to the National Assessment Collection Database, now it instructs IRFs to use the QIES/ASAP system.
[20] *See* A-01-11-00534 at 3.
[21] *See id.*
[22] *Id.*
[23] *See id.* at 5.
[24] *See id.*
[25] *Id.*
[26] *See id.*
[27] *See id.*
[28] See *id.* at 6.
[29] Department of Health and Human Services, *Work Plan: Fiscal Year 2013*, at 8 (available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf).
[30] *Id.*
[31] *See* RAC Region A Late Submissions of IRF-PAI Data (Sept. 12, 2012), https://www.dcsrac.com/IssuesUnderReview.aspx; RAC Region B Late Submissions of IRF-PAI Data (Sept. 12, 2012), https://racb.cgi.com/Issues.aspx; RAC Region C Late Submissions of IRF-PAI Data (Oct. 22, 2012), http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx; RAC Region D Late Submissions of IRF-PAI Data (Sept. 12, 2012), http://racinfo.healthdatainsights.com/Public1/NewIssues.aspx.
[32] *See id.*

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.