MEMORANDUM

To: ATRA

From: Peter Thomas and Christina Krysinski

Date: October 25, 2018

Re: OIG Report: High Rate of IRF Medical Necessity and Documentation Errors

On September 27, 2018, the Office of Inspector General for the Department of Health and Human Services (OIG) issued a new report on inpatient rehabilitation hospital and unit (IRF) services. The report’s title, “Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements,” only scratches the surface for the findings in the report. Under the report’s audit of 2013 IRF claims, the OIG calculates an error rate of 84 percent! This translates to an estimated $5.7 billion in claims inappropriately paid under the Medicare program out of $6.8 billion paid to IRF providers in calendar year 2013.

This memorandum summarizes the central findings and recommendations of the report. The full report can be read at https://oig.hhs.gov/oas/reports/region1/11500500.pdf.

Background

Due to steadily increasing rates of payment error as identified by the Comprehensive Error Rate Testing (CERT) contractor, the OIG undertook an audit of 2013 IRF claims. In 2013, the Medicare program made payment on claims from 1,139 IRFs, totaling $6.75 billion. Under the audit, 164 IRFs were selected, and 220 claims were sampled. The OIG hired an independent medical review contractor to conduct the audit, but the name and credentials of the contractor were not included in the report. Of those 220 claims, 175 claims were determined by the contractor to be paid in error, representing 135 out of the 164 audited hospitals. Applying this error rate (84 percent) to the overall IRF payments in 2013, the OIG arrived at the $5.7 billion overpayment figure.

The audit was constructed as a stratified random sample. The strata were based on the dollar value of the claims. The sample included a much higher proportion of high-value claims than lower value claims. However, the lower value claim strata actually had higher error rates than the higher value strata.

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1 For 2012, the CERT reported an error rate of nine percent for IRF payments. The CERT-reported error rate for IRFs increased to 17.2 percent in 2013, 20.7 percent in 2014, 45.5 percent in 2015; and 62.4 percent in 2016.
Detailed Findings

Of the 175 claims determined to be inappropriately paid, the contractor found 146 admissions failed on both coverage (i.e., medical necessity) and documentation grounds; an additional 29 stays were determined to be inappropriate solely on the grounds of missing documentation. For the stays denied on the grounds of medical necessity, the OIG summarized the reasons for denial as follows:

- Patients did not have medical needs and functional goals that required the complexity and intensity of inpatient rehabilitation;
- Appropriate care would have required only individual therapy interventions rather than an intense interdisciplinary program with rehabilitation physician supervision;
- The high level of physician supervision that accompanies acute intensive rehabilitation therapy services would not have been required;
- The patients did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program; and
- The patients were unable to participate in an intensive therapy program regardless of medical and rehabilitation needs.

As can be seen from the reasons set forth above, there are some contradictions in the reasons given for denial (i.e., patient did not require physician supervision but was nevertheless too impaired to participate in intensive therapy). The OIG failed to explain the contradictory rationale for denials. It is likely that the report was not written precisely and that the different rationales applied to different patients, but that is not clear from the language of the report.

Of the claims determined to be inappropriate on the grounds of documentation (including those otherwise denied on medical necessity grounds), 28 had a single documentation deficiency and 147 had more than one documentation deficiency. Specifically:

- 101 claims lacked a complete preadmission screening;
- 62 claims lacked a valid post-admission physician evaluation;
- 166 claims lacked a complete individualized plan of care; and
- 106 stays had deficient documentation of the required weekly team meetings.

In determining whether documentation requirements were met, the contractor used not only the regulations but also the guidance from the Medicare Benefit Policy Manual (MBPM), applying the standards from the manual as binding requirements. This practice is under serious scrutiny because the MBPM was not subjected to public notice and comment rulemaking and, therefore, may not have the full force and effect of regulations. For instance, in 33 stays, the contractor determined that the preadmission screening was invalid because it did not detail the conditions causing the need for intensive rehabilitation, the patient’s prior or current level of function, and the risk of clinical complications—all elements that are set forth in the manual but not the regulations. Interestingly, for the 29 claims determined to be inappropriate solely on the basis of documentation errors, 20 of the claims had identified deficiencies in the individualized plan of care, which is arguably the most fluid of the required documents under the regulations, relying almost entirely on manual guidance for details on its completion.
Another notable facet of the audit involves the types of patients reviewed. In describing the types of patients reviewed and determined to be inappropriate for IRF admission, the report indicates that 56 stays involved patients with a diagnosis of debility (i.e., generalized weakness, overall fatigue, and impaired mobility). Furthermore, the report indicates that the appropriate therapy would consist only of “regular activities.” Many of the other patients reviewed were orthopedic in nature (48 stays), and 73 claims were described as having no “new” impairing events. These statements in the report suggest a lack of understanding of IRF patient care and the needs of this patient population.

The OIG’s Conclusions and Recommendations

According to the OIG, the reasons for the high rate of payment error were as follows:

1. Many IRFs did not have adequate internal controls to prevent inappropriate admissions;

2. The Medicare Part A fee-for-service program lacked a prepayment review authority for IRF admissions;

3. The Medicare program’s extensive educational efforts and post-payment reviews were unable to control an increasing improper payment rate reported by the CERT since the 2013 audit period;

4. Administrative law judge (ALJ) hearings for IRF appeals did not always involve contractor participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and,

5. The IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

The first, second, and third reasons posited by the OIG were based on the results of the audit and other elements of the Medicare program (e.g., prior authorization). The fourth echoes back to a prior OIG report issued in 2012, in which the OIG concluded that the high reversal rate at the ALJ appeal level was due to failures by ALJs to understand the coverage standards rather than the possibility that contractors were inappropriately denying claims and more objective ALJs were siding with providers on the merits. The OIG concluded at the time that IRFs may be inappropriately incentivized to appeal denied claims as a result.

The final rationale listed by the OIG also suggests that financial incentives are driving IRF utilization. In positing that IRFs may be admitting patients inappropriately due to financial incentives, the OIG implies that IRFs know that certain patients are not appropriate for admission but admit them anyway. This implication actually raises concerns about fraud and abuse, not simple payment error.

As a result, the OIG makes a number of recommendations, including:
(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 post-payment 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) Re-evaluate the IRF payment system, which could include a demonstration project requiring preauthorization for Medicare Part A fee-for-service IRF stays modeled on Medicare Advantage practices.

(5) Conduct a study on the relationship between IRF PPS payments and costs and take any necessary steps to more closely align them, and include consideration of the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform.

In its written comments to the OIG draft, CMS concurred with all of these recommendations and stated its commitment to implementing them, particularly with respect to provider education and audits. The recommendation to conduct a demonstration project on preauthorization akin to the Medicare Advantage program sends directly conflicting signals from the OIG to CMS. OIG just recently issued a report that was highly critical of Medicare Advantage plans that significantly restrict benefits to beneficiaries through the use of preauthorization. The OIG recommended greater oversight by CMS of MA plans in order to prevent disruption in access to Medicare benefits.

Conclusion

This OIG report is highly concerning, but not necessarily surprising given the OIG’s ongoing focus on inpatient rehabilitation hospital services. Not only have these services been under scrutiny for years, but they constitute relatively high dollar claims as well. An 84% error rate is a devastating audit finding, one that will have policy implications in the future if left unchallenged. Physiatrists practicing in IRFs—and AAPM&R as their representative in Washington—should be just as alarmed by this OIG report as inpatient rehabilitation hospitals—and their representative, the American Medical Rehabilitation Providers Association (AMRPA). Physiatrists practicing in IRFs are responsible for admission decisions as well as completion of much of the required documentation. Deficiencies in these two primary areas were identified by the OIG as the reasons for the high error rate. AAPM&R should respond to this report, either independently or in collaboration with AMRPA in order to counter some of the most egregious aspects of OIG’s findings and recommendations.