

Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009 (OEI-02-09-00200)

WHY WE DID THIS STUDY

In recent years, the Office of Inspector General has identified a number of problems with billing by skilled nursing facilities (SNF), including the submission of inaccurate, medically unnecessary, and fraudulent claims. Further, the Medicare Payment Advisory Commission has raised concerns about SNFs' improperly billing for therapy to obtain additional Medicare payments. In fiscal year (FY) 2012, Medicare paid \$32.2 billion for SNF services.

HOW WE DID THIS STUDY

We based this study on a medical record review of a stratified random sample of SNF claims from 2009. The reviewers determined whether the information reported by the SNFs on the Minimum Data Set (MDS) was supported by and consistent with the medical record. The MDS is a standardized tool that SNFs use to assess each beneficiary. SNFs use the information on the MDS to classify beneficiaries into resource utilization groups (RUG). The RUGs determine how much Medicare pays the SNFs.

WHAT WE FOUND

SNFs billed one-quarter of all claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded; many of these claims were for ultrahigh therapy. The remaining claims in error were downcoded or did not meet Medicare coverage requirements. In addition, SNFs misreported information on the MDS for 47 percent of claims. SNFs commonly misreported therapy, which largely determines the RUG and the amount that Medicare pays the SNF.

WHAT WE RECOMMEND

We recognize that CMS has recently made several significant changes to SNF payments. However, more needs to be done to reduce inappropriate payments to SNFs. We recommend that CMS:

- (1) Increase and expand reviews of SNF claims,

(2) Use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs,

(3) Monitor compliance with new therapy assessments,

(4) Change the current method for determining how much therapy is needed to ensure appropriate payments,

(5) Improve the accuracy of MDS items, and

(6) Follow up on the SNFs that billed in error.

CMS concurred with all six recommendations.