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# Medicare Hit by $5.7B in Problem Payments to Rehab Facilities (2)

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- 84 percent of 2013 rehab payments were unnecessary
- Inspector general recommends restructuring payment system

About $5.7 billion in Medicare payments to inpatient rehabilitation facilities in a single year were unreasonable and unnecessary, a federal government watchdog said.

The Oct. 2 report by the Health and Human Services Office of Inspector General looked at $6.75 billion in payments to 1,139 facilities and found about 84 percent of them didn't meet Medicare's coverage and documentation requirements.

The findings come on the heels of projections that the Medicare Hospital Insurance trust fund will run out in 2026, in part because of higher-than-expected spending. The trust fund finances care in hospitals, skilled nursing facilities, and IRFs, among other facilities.

The OIG used data from 2013 for its review. The inspector general used data from 2013 because it was the most recently available when this audit began, Donald White, a spokesman for the OIG, told Bloomberg Law. This report included an extensive medical review, and the funding was held up, which delayed the results, White said.

**Consider Preauthorization?**

The OIG recommended that the Centers for Medicare & Medicaid Services consider restructuring the inpatient rehabilitation facilities payment system so that it could include preauthorization for payment.

The OIG also recommended the CMS study the relationship between prospective payments to the facilities and the actual costs. The CMS concurred with this recommendation and the OIG's other recommendations in an Aug. 16 letter.

The OIG also recommended the CMS educate the facilities' personnel on the coverage and documentation requirements and increase post-payment medical review.

Improper payments to the facilities increased from 9 percent in 2012 to 62 percent in 2016, according to the CMS's comprehensive error rate testing program.

Inpatient rehabilitation facilities will get a 1.3 percent boost in Medicare payments, or $105 million, in fiscal year 2019 under an August final rule. Fiscal 2019 started on Oct. 1.

**Fallout: Improve Compliance?**

The CMS has tweaked payment systems in the past as a result of these types of reports, so it is likely it will do that in this situation, Bob Wade, a health-care attorney at South Bend, Ind.-based Barnes & Thornburg, told Bloomberg Law.

Usually the CMS will have additional training on documentation standards for facilities after these reports, Wade said. He also expects payers will look more closely at the documentation and audit process for claims from these facilities.

Wade recommends IRFs step up their compliance and monitoring efforts. A similar report about hospice facilities resulted in Medicare audits on those facilities.

The American Medical Rehabilitation Providers Association has "grave reservations about the assumptions, process, and supposed outcomes of this report," Richard Kathrins, board chair of the Washington-based organization, told Bloomberg Law. "We all want to give Medicare beneficiaries—our patients—only appropriate care to achieve the best outcomes."

(Updates with comments from health-care attorney.)

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