DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 14 2000

From for June Gibbs Brown
Inspector General

Subject Review of Outpatient Rehabilitation Services Provided by South Jersey Rehabilitation Associates, Inc. for Calendar Year Ended December 31, 1997 (A-02-99-01026)

To Michael Hash
Acting Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Thursday, November 16, 2000, of our final report entitled, "Review of Outpatient Rehabilitation Services Provided by South Jersey Rehabilitation Associates, Inc. for Calendar Year Ended December 31, 1997." A copy of the report is attached. The objective of our review, which is part of a national study we have coordinated with the Health Care Financing Administration, was to determine whether physical therapy, occupational therapy, and speech pathology services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We found that South Jersey Rehabilitation Associates, Inc. (SJR) did not establish or follow existing procedures for the proper billing of outpatient physical therapy, occupational therapy, and/or speech pathology services.

Our audit at SJR determined that many of the outpatient services claimed by SJR did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for outpatient rehabilitation services which were not reasonable and necessary, lacked sufficient patient treatment plans, and/or were not properly supported by medical record documentation. Based on a statistical sample, we estimate that at least $241,774 in outpatient charges were submitted by SJR, that did not meet Medicare criteria for reimbursement. We also identified $56,034 in costs ineligible for reimbursement, as claimed by SJR on its Calendar Year (CY) 1997 Medicare cost report.

During our audit, SJR voluntarily left the Medicare program. Accordingly, we did not make any recommendations related to SJR's internal control process. We will provide the results of our review to the fiscal intermediary so that it can apply the appropriate adjustments of $241,774 and $56,034 to SJR's CY 1997 Medicare cost report.

The SJR, in its response to our report (see APPENDIX B), believed that services questioned by the Office of Inspector General were sufficiently documented and were medically reasonable and necessary, and that certain costs questioned were eligible for Medicare reimbursement.

We believe that our final audit determinations are correct and no further adjustments to our draft report are necessary.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT REHABILITATION SERVICES PROVIDED BY SOUTH JERSEY REHABILITATION ASSOCIATED, INC. FOR CALENDAR YEAR ENDED DECEMBER 31, 1997

JUNE GIBBS BROWN
Inspector General

NOVEMBER 2000
A-02-99-01026

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
26 Federal Plaza
Room 3900-A
New York, NY 10278

A-02-99-01026

Ms. Brenda G. Litwin
President
South Jersey Rehabilitation Associates, Inc.
55 Charter Oak Drive
Newtown Square, Pennsylvania 19073-3007

Dear Ms. Litwin:

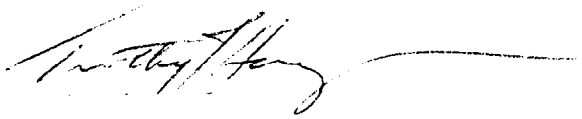
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Rehabilitation Services Provided by South Jersey Rehabilitation Associates, Inc. for Calendar Year Ended December 31, 1997." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to Common Identification Number A-02-99-01026 in all correspondence relating to this report.

Sincerely,



Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Health Care Financing Administration, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

EXECUTIVE SUMMARY

Background

The Medicare program reimburses outpatient rehabilitation facilities (ORF) for the reasonable costs associated with providing outpatient rehabilitation services. The ORFs provide physical therapy, occupational therapy, and speech pathology services. Medicare requirements provide that the patient, to be eligible for coverage, must be under the care of a physician and the services must be rendered in accordance with an established treatment plan. These requirements stipulate that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered only by (or under the supervision of) a skilled therapist.

Medicare further requires that charges reflect reasonable costs and services be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Claims are submitted for services rendered and are reimbursed on an interim basis predicated on submitted charges. At year end, the ORF submits a cost report to the Medicare fiscal intermediary (FI) for final settlement.

Objective

The objective of our review was to determine whether physical therapy, occupational therapy, and speech pathology services rendered on an outpatient basis by South Jersey Rehabilitation, Inc. (SJR) were billed for and reimbursed in accordance with Medicare requirements. We also reviewed the reasonableness of expenses reported on the related Medicare cost report.

Summary of Findings

In Calendar Year (CY) 1997, SJR submitted for Medicare reimbursement approximately $1.8 million in charges for outpatient rehabilitation services. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we reviewed the medical and billing records for 100 statistically selected claims with charges totaling $83,300. These charges were made on behalf of patients in nursing homes located in southern New Jersey who received physical therapy, occupational therapy, and/or speech pathology services. Our analysis showed that $18,000 of these charges did not meet the Medicare criteria for reimbursement. Charges found unallowable were for services which were not reasonable and necessary, lacked sufficient patient treatment plans, and/or were not properly supported by medical record documentation.

We extrapolated these results to the population of claims at SJR during CY 1997 and estimated that SJR overstated its billings to Medicare by $241,774. We found that SJR did not establish

and/or follow existing Medicare procedures for the proper billing of outpatient rehabilitation services.

Medicare requires that costs claimed for ORF services be reasonable, allowable, allocable, and related to patient care. We reviewed the $1,470,978 in costs reported by SJR on its CY 1997 Medicare cost report and found that $56,034 in owner's compensation and miscellaneous unsupported costs were ineligible for reimbursement under the Medicare program.

Recommendations

Since SJR is no longer a Medicare ORF provider, we did not make any recommendations related to their internal control process. However, we will provide the results of our review to Riverbend Government Benefits Administrator (Riverbend), the cognizant Medicare FI, so that it can apply the appropriate adjustments of $241,774 for unallowable charges and $56,034 for unallowable costs during the settlement of SJR's CY 1997 Medicare cost report.

In response to our draft report (see APPENDIX B), SJR believed that the services questioned by the OIG were sufficiently documented and were medically reasonable and necessary, and that certain costs questioned were eligible for Medicare reimbursement.

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed starting on page 8 of this report.

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INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (Act), provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA).

Section 1861(p) of the Act defines outpatient physical therapy services as "...physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency...to an individual as an outpatient." A rehabilitation agency is defined in section 120 of the HCFA Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (Manual) as a provider of outpatient physical therapy, occupational therapy, and/or speech pathology services. In recent years, the term "rehabilitation agency" has become synonymous with "outpatient rehabilitation facility" or ORF in the Medicare provider community.

Section 1861 of the Act also includes a provision that the outpatient therapy services may be rendered at a facility (such as an ORF), a physical therapist's office, or an individual's home. Although there is no requirement that services be rendered on the ORF's premises, providers must maintain a centralized location with adequate space, equipment, and staff to treat patients.

Medicare covers outpatient physical therapy, occupational therapy, and speech pathology services rendered in an ORF setting. The conditions for coverage for ORF services are outlined in sections 270 through 273 of the Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered only by (or under the supervision of) a skilled therapist.

Medicare requires ORFs to demonstrate that the services were: (1) required for the patient; (2) furnished under a treatment plan that has been reviewed by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving ORF services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record.

Claims are submitted for services rendered and are reimbursed on an interim basis predicated on submitted charges. At year end, the ORF submits a cost report to the Medicare FI for final settlement.

For costs claimed on an ORF's cost report, Medicare requirements stipulate:

- ORFs be reimbursed on the basis of reasonable cost. Reasonable cost is defined as including all necessary and proper costs incurred in the delivery of services to Medicare beneficiaries. To be reasonable, the costs must be related to patient care or the operation of patient care facilities, and should be common and accepted occurrences in the field of the provider's activity. [42 CFR 413.9]

- a provider of services adheres to prudent buyer principles and minimizes expenses through cost-conscious management. [Medicare Intermediary Manual (MIM) section 2103]

- cost-reimbursed providers must maintain sufficient documentation to support the costs payable under the Medicare program. This data must be capable of verification by qualified auditors. [42 CFR 413.20]

The SJR was a licensed ORF with an administrative office located in Edgemont, Pennsylvania. The SJR contracted with consultants to provide physical therapy, occupational therapy, and speech pathology services primarily to Medicare beneficiaries who were residents of nursing homes located in southern New Jersey. For CY 1997, SJR provided 18,087 Medicare services and 380 non-Medicare services, and submitted for Medicare reimbursement 2,143 claims totaling $1,770,325.

In July 1999, during our audit, SJR voluntarily left the Medicare program. In August 2000, we were informed by SJR representatives that the owner intends to seek protection under the Federal bankruptcy laws.

Blue Cross of New Jersey (Horizon) was the cognizant FI during the audit period and during our audit field work. In August 2000, Riverbend replaced Horizon as the FI for New Jersey ORF providers.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether physical therapy, occupational therapy, and speech pathology services rendered on an outpatient basis by SJR were billed for and reimbursed in accordance with Medicare requirements. We also reviewed the reasonableness of expenses reported on the related Medicare cost report. Our review included services provided during CY 1997.

To accomplish our objective, we:

- reviewed criteria related to outpatient rehabilitation services.

- interviewed appropriate SJR administrative personnel to obtain an understanding of how the medical records were maintained and how outpatient rehabilitation services were documented and billed.

- used the HCFA Outpatient Standard Analytical File (part of the HCFA National Claims History File) to identify the universe of 2,143 claims valued at $1,770,325.

- employed a simple random sample approach to select a statistical sample of 100 outpatient rehabilitation claims.

- performed detailed audit testing on the billing and medical records for the claims selected in the sample.

- interviewed beneficiaries (or knowledgeable acquaintances) regarding the services billed on the selected claims.

- utilized medical review staff from the FI to analyze the medical records supporting the selected claims.

- used a variables appraisal program to estimate the dollar impact of improper charges in the total population.

In addition, we reviewed the appropriateness of $1,470,978 in outpatient rehabilitation costs, after reclassifications and adjustments, on SJR's CY 1997 Medicare cost report through analysis of supporting documentation.

We limited consideration of the internal control structure to those controls relating to the submission of claims to Medicare because the objective of our review did not require an understanding or assessment of the entire internal control structure at SJR.

Our review was made in accordance with generally accepted government auditing standards. Our field work was performed at SJR's administrative office in Edgemont, Pennsylvania, and at various nursing homes throughout New Jersey.

FINDINGS AND RECOMMENDATIONS

In CY 1997, SJR submitted for Medicare reimbursement approximately $1.8 million in charges for outpatient rehabilitation services. We reviewed the medical and billing records for 100 statistically selected claims comprising 833 services totaling $83,300 in charges. Our analysis showed that $18,000 of the sampled charges did not meet the Medicare criteria for reimbursement. Based on an extrapolation of the statistical sample, we estimate that SJR overstated its CY 1997 Medicare outpatient rehabilitation charges by $241,774. Charges found

unallowable were for services which were not reasonable and necessary, lacked sufficient patient treatment plans, and/or were not properly supported by medical record documentation.

The SJR claimed about $1.5 million in costs for providing these outpatient rehabilitation services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed these outpatient rehabilitation costs, and found that costs totaling $56,034 were unallowable under Medicare guidelines. These unallowable costs included unreasonable owner's compensation and miscellaneous unsupported expenses.

Findings from our review of the outpatient rehabilitation charges and costs are described in detail below.

OUTPATIENT REHABILITATION SERVICES

The SJR provided outpatient rehabilitation services including physical therapy, occupational therapy, and speech pathology services. From our sample of 100 outpatient rehabilitation claims, we found that $18,000 for 180 services on 22 claims did not meet Medicare criteria for reimbursement as detailed below. Further, services on 4 of the 22 claims were denied for more than one reason.

Services Not Reasonable and Necessary

Medicare covers outpatient physical therapy, occupational therapy, and speech pathology services rendered in an ORF setting. The conditions for coverage of ORF services are outlined in sections 270 through 273 of the Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered only by (or under the supervision of) a skilled therapist.

The SJR did not have adequate procedures in place for ensuring that services billed to the Medicare program were reasonable and necessary for the treatment of the patient's condition. We found $10,600 in charges for 106 services on 14 claims for which the documentation did not demonstrate that the level of treatment was reasonable and necessary.

With the assistance of medical review staff from the FI, we identified:

- $5,100 in charges for 51 services to patients who had no reasonable expectation for improvement.

For example, on one claim SJR billed $800 for eight physical therapy services rendered during the period December 5, 1997 through December 31, 1997. In this case, the beneficiary had been receiving physical therapy services for 8 months. The FI medical reviewer noted that: "Therapy is not achieving true lasting improvement. No expectation for improvement in reasonable and generally predictable period of time. 8 months of therapy."

- $2,200 in charges for 22 services to patients which were determined to be excessive based on the patient's condition.

  For example, on one claim SJR billed $500 for five occupational therapy services provided during the period January 2, 1997 through January 9, 1997. These services were denied by the FI medical reviewer as being excessive, as the reviewer noted: "3X/week for positioning is excessive. 33 visits is excessive."

- $3,200 in charges for 32 services to patients for which there was no indication the patient needed therapy.

  For example, five speech pathology services billed on one claim were denied because the beneficiary did not have speech problems. Specifically, the medical reviewer noted: "No speech difficulty. Skills of therapist not necessary."

- $100 in charges for one service which was not covered by Medicare.

Insufficient Patient Treatment Plans

Section 270.1 of the Manual requires ORFs to demonstrate that the services were: (1) required by the patient; (2) furnished under a treatment plan that has been reviewed by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving ORF services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record. Medicare guidelines state that no payment may be made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that the services were medically necessary to treat the individual's condition.

From our review of the billing and medical records for the 100 outpatient rehabilitation claims in our sample, we identified 6 claims with $5,800 in charges for 58 services to patients who had treatment plans which did not comply with Medicare guidelines or were otherwise missing. With the assistance of medical review personnel from the FI, we identified:

- $5,600 in charges for 56 services to patients whose treatment plans did not contain a date, or were signed and dated after the service dates.

For example, SJR billed $1,200 for nine occupational therapy services and three physical therapy services on one claim. Although all of the therapy services were rendered during the period April 1, 1997 through April 17, 1997, the treatment plan was not signed and dated by a physician until May 27, 1997.

- $200 in charges for two physical therapy services provided to a patient whose treatment plan was not signed by a physician.

Without an up-to-date and proper treatment plan prescribed by a physician to identify the type, amount, frequency, and duration of services to be furnished to the patient, we could not determine with any certainty that the services were reasonable and necessary.

Services Not Supported by Medical Records

Medicare eligibility and reimbursement requirements for ORF services require the provider to maintain sufficient medical record documentation to support the services billed. In addition, section 270.1 of the Manual further establishes that a patient receiving ORF services be seen by a physician every 30 days and documentation of the visit be maintained in the medical record.

Our audit showed a weakness in SJR's system of internal controls regarding medical record documentation supporting services. Our review of 100 outpatient rehabilitation claims disclosed that 3 claims with $1,600 in charges representing 16 services were not properly supported in the medical records. With the assistance of medical review personnel from the FI, we noted instances where there were no available medical records or services were not documented as rendered.

For example, on 1 claim SJR billed $2,100 for 21 speech pathology services rendered during the period August 4, 1997 through August 31, 1997. Documentation was only available to support 19 of the 21 visits billed. The medical reviewer concluded, "Cannot cover services not documented as rendered."

As a result, we determined that $1,600 in ORF charges did not have adequate documentation required for Medicare billing and, therefore, did not meet Medicare's criteria for reimbursement. Without complete medical record documentation, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies provides little guidance to physicians and therapists to develop future treatment. In this regard, the lack of required documentation, as described above, precluded us from determining whether those services were rendered.

OUTPATIENT REHABILITATION COSTS

The SJR claimed $1,470,978 in costs for providing outpatient rehabilitation services, after reclassifications and adjustments, on its CY 1997 Medicare cost report.

Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. Medicare cost principles limit reimbursement to those items that would be incurred by a reasonable, prudent, and cost-conscious management. Regulatory guidance contained in 42 CFR 413.9 specifies that all payments to providers must be based on the "reasonable cost" of services and related to the care of Medicare beneficiaries or the operation of patient care facilities, and are usually costs that are common and accepted occurrences in the field of the provider's activity. In addition, to be a reasonable cost, the expenditure must be adequately supported by the provider's financial documentation.

We reviewed the $1,470,978 in ORF costs and found that $56,034 of these costs were unallowable under Medicare regulations and guidelines. These unallowable costs included unreasonable owner's compensation and miscellaneous unsupported expenses.

As reported on the SJR Medicare cost report, the owner was compensated $125,000, which consisted of a salary of $92,500 and a management fee of $32,500. According to FI officials, reasonable compensation to the president of an ORF should be comparable to the maximum compensation of $81,870 allowable by Medicare to an administrator of a 100-bed skilled nursing facility in the locality. It is our opinion that the owner's compensation of $125,000 is unreasonable, and we take exception to excessive costs totaling $43,130.

We also found that SJR claimed $12,904 for cost items that were not supported by financial documentation, including:

- contractual expenses for occupational, physical, and speech pathology services of $11,328. These Medicare costs related to credit adjustments made to the subsidiary ledgers that were not carried over to the cost report.

- employee benefit expenses of $1,576. The SJR was unable to locate sufficient supporting documentation for these costs.

Conclusion

For CY 1997, SJR submitted for reimbursement $1,770,325 in charges for outpatient rehabilitation services. Our audit of 100 statistically selected claims totaling $83,300 in charges disclosed that $18,000 should not have been billed to the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that SJR billed at least $241,774 in error for CY 1997. We attained our estimate using a single stage appraisal program. The details of our sample appraisal can be found in APPENDIX A.

The SJR also claimed about $1.5 million in costs for providing these outpatient rehabilitation services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. We reviewed these costs and found that $56,034 of these costs were unallowable.

Recommendation

Since SJR is no longer a Medicare ORF provider, we did not make any recommendations related to their internal control process. However, we will provide the results of our review to the FI, so that it can apply the appropriate adjustments of $241,774 for unallowable charges and $56,034 for unallowable costs to SJR's CY 1997 Medicare cost report.

AUDITEE COMMENTS AND OIG RESPONSE

The SJR, in its response (see APPENDIX B), believed that services questioned by the OIG were sufficiently documented and were medically reasonable and necessary, and that certain costs questioned were eligible for Medicare reimbursement.

We have summarized the auditee's relevant comments and provide our responses below.

Auditee Comments Regarding Documentation and Medical Necessity of Services

The SJR officials believed that the audit should not be a basis for an overpayment determination, and presented the following issues:

- The SJR believed that certain information provided to the auditors was not forwarded to the FI medical reviewers, and failure to forward said information conflicted with sections 7.41 and 7.42 of the Government Auditing Standards (GAS), which requires that advance comments be objectively evaluated and recognized in the report.

- The SJR believed that the educational background of the medical reviewers was not evaluated. Section 6.17 of GAS states that staff assigned to perform an audit must have the appropriate skills and knowledge for the job. The SJR felt that it was reasonable to question the clinical credentials of the FI's medical reviewers.

- The SJR contended that OIG relied on inappropriate reimbursement standards since SJR felt it was probable that the FI relied upon its local medical review policy, and thus inferred that the FI might not have appropriately applied the HCFA guidelines in MIM section 3911 dealing with these policies.

- An assumption was made by SJR that an FI waiver of liability analysis was not performed, as required by section 1879 of the Act and HCFA MIM section 3708, to determine if the provider was without fault.

- The SJR believed it was unable to address the issues cited by OIG because it could not identify the specific claims from the examples provided in the draft report. The report did not list beneficiaries with the dates of service reviewed and the basis for denial. The SJR felt it did not have a true opportunity to respond to OIG's findings.

- With regard to treatment plan signatures, it was SJR's understanding that a physician's signature was not required prior to commencement of therapy services, as long as the physician gave a verbal order to commence therapy services.

- The SJR contended that the statistical sample was invalid. The report did not address, with adequate specificity, the manner in which the sample was conducted. Therefore, SJR was unable to assess whether the sample complies with Medicare and OIG sampling guidelines.

OIG Response on Documentation and Medical Necessity of Services

We disagree with SJR's contentions that our determinations should be changed. The OIG's response to the specific issues presented by SJR follows:

- All medical record documentation obtained in our audit was forwarded to the medical reviewers and was considered in making the final medical review determinations cited in the audit report. This fact was conveyed in an exit conference meeting held with the owner of SJR. At that meeting, detailed results of the medical review determinations were provided to her in writing.

- The FI medical review staff used on the audit were licensed registered nurses trained to perform medical reviews. It is our opinion that these FI medical reviewers were qualified to make medical review determinations regarding physical therapy, occupational therapy, and speech pathology services. Their determinations were made in accordance with the applicable Medicare criteria for reimbursement.

- In regard to the specific criteria used by the medical reviewers, the determinations were made in accordance with the applicable HCFA Medicare manual sections specifically cited in the report. The HCFA Coverage Issues Manual also provides the Medicare contractors with the authority to make coverage decisions in consultation with its medical staff based on the law, regulations, rulings, and HCFA general program instructions. In this audit, all determinations were properly made in accordance with HCFA criteria.

- We agree that in some instances a provider can be found without fault as described in HCFA MIM section 3708. However, in this audit the FI did in fact

conclude that the provider was responsible for the inappropriate payments and that appropriate adjustments for noncovered services should be made to the SJR CY 1997 Medicare cost report.

- Our OIG reports cannot contain sensitive information on Medicare beneficiaries and others that cannot be released under the Freedom of Information Act. Thus, we met with the owner of SJR and provided her with detailed results in writing which included a listing of beneficiaries with the dates of service reviewed and the basis for denial. The SJR owner reviewed these and supplied some additional documentation which the medical reviewers considered. We again met with the owner in an exit conference and provided her with results in writing which included a listing of beneficiaries with the dates of service reviewed and the basis for denial. We believe ample opportunity was provided for SJR to respond to our audit findings and recommendations.

- Although the Manual allows the use of verbal orders, the provider must make a written record of these orders. Since there was no evidence found regarding any verbal orders in the medical records reviewed, we maintain these claims are unallowable.

- Our sampling approach was statistically sound and has been used by OIG, OAS for many years on audits, including audits involving cost report recoveries. We believe our report clearly described our sampling methodology. This methodology was also explained to the SJR owner during our exit conference. As explained in the report, based on an extrapolation of the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that SJR billed at least $241,774 in error for CY 1997. We attained our estimate by using simple random sampling techniques and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confident level is plus or minus 37.32 percent, with a resulting lower limit of $241,774 and an upper limit of $529,706.

Auditee Comments Regarding Documentation and Reasonableness of Costs

The SJR officials believed that the audit should not be a basis for an overpayment determination, and presented the following issues:

- The SJR contended that it had filed its owner's compensation pursuant to a formula furnished to them by Aetna, their initial FI, and thus the strict application of Blue Cross of New Jersey's owner's compensation formula without any outside consideration of the reasonableness of SJR's costs was not appropriate (Blue Cross of New Jersey was the cognizant Medicare FI during the audit period).

- The SJR requested an explanation and opportunity to rebut the $11,328 adjustment to contractual expenses for occupation therapy, physical therapy, and speech pathology services.

OIG Response on Documentation and Reasonableness of Costs

We disagree with SJR's contentions that our determinations should be changed. The OIG response to the specific issues presented by SJR follows:

- Regulatory guidance contained in 42 CFR 413.9 specifies that all payments to providers must be based on the "reasonable cost" of services and related to the care of Medicare beneficiaries or the operation of patient care facilities, and are usually costs that are common and accepted occurrences in the field of the provider's activity. Using this criteria, we appropriately considered and evaluated the reasonableness of SJR's owner's compensation costs during the audit period, and concluded that the costs were excessive and unreasonable.

- As explained in the report, the questioned contractual expenses for occupational therapy, physical therapy, and speech pathology services of $11,328 related to credit adjustments made to the subsidiary ledgers that were not carried over to the cost report. A detailed explanation of this issue was discussed with the owner of SJR.

APPENDIX A

REVIEW OF MEDICARE OUTPATIENT REHABILITATION SERVICES PROVIDED BY SOUTH JERSEY REHABILITATION ASSOCIATES, INC. FOR THE CALENDAR YEAR ENDING DECEMBER 31, 1997

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 2,143 Claims	Items: 100 Claims	Items: 22 Claims
Charges: $1,770,325	Charges: $83,300	Charges: $18,000

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $385,740
Lower Limit: $241,774
Upper Limit: $529,706

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June 28, 2000

Via Federal Express

Timothy J. Horgan
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Common Identification Number: A-02-99-01026

Dear Mr. Horgan:

Thank you for the opportunity to respond to the draft report by the Department of Health and Human Services Office of the Inspector General ("OIG") entitled "Review of Outpatient Rehabilitation Services Provided by South Jersey Rehabilitation Associates, Inc. for Calendar Year Ending December 31, 1997" (the "Report"). We have carefully reviewed this Report. We believe that our findings, which are set forth below in further detail, indicate that this audit should not form the basis of an overpayment determination.

I. Government Auditing Standards Were Not Followed

The Report states that the audit was performed in accordance with generally accepted government auditing standards. (Report, p. 3). We are concerned, however, that several of the standards were not followed in this case.

A. The Provider's Comments Were Not Objectively Evaluated

When the Provider was first notified of the OIG's assertions that certain claims should have been denied, it reviewed each and every claim at issue and prepared very specific discussions of why most patients met Medicare's coverage criteria. The Provider shared this information with the OIG over the course of many telephone conversations and meetings.

This information should have been forwarded to the Intermediary's medical reviewer. However, it is the Provider's understanding that this information was not forwarded in that, among other reasons; the Report does not mention or refute why the additional information does not justify the reversal of the original denials. Failure to forward said information conflicts with §§ 7.41 and 7.42 of the Government Auditing Standards, Reporting Standards for Performance Audits.

The sections referenced above require that advance comments be objectively evaluated and recognized in the report. Because the OIG did not perform the medical necessity reviews, the only way for the OIG to comply with this standard would be to send the reviews to the Intermediary's medical reviewers for response. Medical charts are typically voluminous and it is not unusual for a medical reviewer to miss certain notes in the chart that support coverage and to discuss the chart with the provider before making a final coverage determination. For this reason, an objective review of the Provider's documents is necessary to ensure that the Intermediary's determinations are accurate. Moreover, per government audit standard § 7.42, if the Intermediary medical staff disagreed with the Provider's reviews, the Intermediary medical staff should have been required to state its reasons for rejecting them.

B. The Educational Background of the Medical Necessity Reviewers Was Not Evaluated

Section 6.17 of the Government Auditing Standards' Field Work Standards for Performance Audits states that staff assigned to perform an audit must have the appropriate skills and knowledge for the job. However, just because the medical reviewers are responsible for routine reviews does not mean that they have the background necessary to make these determinations. In fact, according to a recent OIG report, medical reviews performed by fiscal intermediaries are often overturned on appeal.[1] As examples of this, the OIG report states that 81 percent of home health appeals were reversed in 1996 and 78 percent of durable medical equipment appeals were reversed in 1997. It is entirely reasonable, therefore, to question the clinical credentials of the Intermediary's medical reviewers.

II. Results of the Medical Necessity Review are Legally Invalid

The Report alleges that the Provider was paid for services that did not meet Medicare reimbursement criteria. Because the OIG relied on inappropriate reimbursement standards and failed to address certain mandatory criteria, the result set forth in the Report is contrary to law.

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[1] Office of Inspector General Report No. OEI-04-97-00160, September 1, 1999.

A. The Provider Cannot Legally Be Held to the Medical Review Standards Used in the Report

The Report states that the medical necessity review was not performed by OIG staff, but rather was performed by "medical review personnel" of the Provider's fiscal intermediary (Report, p. 3). Though the Report does not list all of the laws, regulations, Medicare Manual provisions, or other documents relied upon by the Intermediary. It is probable that the Intermediary relied upon its Local Medical Review Policy ("LMRP")

As explained in the Medicare Intermediary Manual ("MIM"), LMRPs are policies that are developed by a fiscal intermediary to clarify and provide specific detail as to the applicability of national coverage guidelines for a specific geographic area. (MIM § 3911). LMRPs are adjuncts to national coverage policy and are to be used to make *local* medical coverage decisions. (MIM § 3911). LMRPs from different intermediaries, therefore, may reflect different coverage standards.

HCFA warns intermediaries not to use LMRPs as final coverage guidelines. HCFA has specifically instructed its fiscal intermediaries that it should not always follow an LMRP when evaluating a claim. Instead, the intermediaries must individually review each case to determine whether an exception to the LMRP should be made. Exceptions can be based on extenuating circumstances or particular facts. (MIM § 3911).

B. The OIG Did Not Perform the Waiver of Liability Analysis that is Required by Law

Pursuant to Section 1879 of the Social Security Act, providers are entitled to be reimbursed for services rendered when the provider did not know, and could not reasonably have been expected to know, that payment would not be made (referred to herein as the "waiver of liability analysis"). As explained by HCFA in MIM § 3708, intermediaries are *required* to determine whether the provider is liable for any overpayment. In other words, if an intermediary discovered that a provider was incorrectly paid, the intermediary is not to automatically assume that the provider is not entitled to the reimbursement. Rather, the intermediary must determine whether a provider was without fault. Under §3708.1 of the MIM:

> A provider is without fault if it exercised reasonable care in billing for, and accepting, the payment; i.e. ...On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct ...

There is absolutely no discussion of this requirement in the Report. We assume, therefore, that this required analysis was not performed. *It is inaccurate for the OIG to state that a provider should repay the Medicare program if the OIG has not performed a waiver of liability analysis. A provider cannot be made to repay Medicare until a waiver of liability analysis has been performed.*

III. Insufficient Notice has been given in this OIG Report

The Provider is unable to address the issues cited by the OIG because it cannot identify the specific claim from the examples provided. Unlike other reports containing audit findings, this Report does not list the beneficiaries, the dates of services reviewed and the basis for denial. It only provides a few summaries of the types of denials.

Until such notice is appropriately given, the Provider will not have a true opportunity to respond to the OIG's findings. For example, the Provider cannot specifically comment on "excessive positioning" (Report, p. 5) because it is unsure of the beneficiary that the OIG is referencing. In support of such positioning treatments, the Provider can generally state that the condition of the patient may have been such that it required the skills of a therapist to range the patient or implement procedures to reduce contractures in addition to positioning thereby requiring intensive and extended therapy sessions.

In regards to "insufficient patient treatment plans" the Provider, without knowing the precise claims at issue, is limited to stating that HCFA Central has maintained that a physician's signature is not required prior to commencement of therapy services, as long as the physician gives a verbal order to commence therapy services. Please see Attachment A for a copy of a letter from Thomas Hoyer of HCFA.

If the medical reviewers in this case, relied upon a LMRP to make determinations regarding the sufficiency of the plan of treatment, they may have relied upon bad policy. Physician signature requirements have been a source of confusion for many in the industry and at the fiscal intermediary level. The Provider would like to understand the specific law and/or policy that was relied upon to make this determination.

The Provider would like to point out that the example cited by OIG concerning medical documentation, (Report, p. 6), was a case that the Provider personally reviewed with the auditors. The Provider furnished the auditors with documentation supporting all of the speech therapy visits that were billed during the period in question. Specifically, the Provider furnished the auditors with a therapy treatment log. In 1997, the Provider used said therapy treatment log in order to prepare bills. The progress notes substantiated the treatments that were provided to the patients. The Provider does not understand why this portion of the claim was still denied.

In regards to the "unreasonable owner's compensation," the Provider would like to state that it filed its owner's compensation pursuant to a formula furnished to the Provider by Aetna, the Provider's initial intermediary. Thus the strict application of Blue Cross of New Jersey's owner's compensation formula to Provider's costs without any outside consideration of the reasonableness of Provider's costs is not appropriate. This is the type of application that HCFA has warned intermediaries against. Please see our discussion under Part II, A.

The Provider is not sure what the Report is referring to in the middle of page seven (7) as "contractual occupational, physician and speech therapy expenses of $11,328." The Provider would like to request an explanation and the opportunity to rebut this adjustment.

IV. The Statistical Sample is Invalid

The Report did not address, with adequate specificity, the manner in which the sample was conducted. Therefore, the Provider is unable to assess whether the sample complies with Medicare and OIG sampling guidelines. In particular, the Provider would like to request that the OIG supply it with information regarding the manner in which the sample was selected; the manner in which the size of the sample was selected; the extrapolation process; and the manner in which it was decided to use a simple rather than stratified sample.

* * * * *

Please do not hesitate to contact me if you have any questions regarding Provider's response to the audit findings. I would like to request that we schedule a telephone conference to discuss these issues in further detail.

Sincerely yours,

Anne K. Flam

Anne Kurtz Flam

Attachment

cc: Brenda Litwin
E. Michael Flanagan, Esq.

A

DEPARTMENT OF HL .H & HUMAN SERVICES
Health Care Financing Administratio

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

Refer to: FARE1

30 JUN 1999

JUL

Ms Donna K. Thiel, Esq.
Gardner, Carton and Douglas
Suite 900, East Tower
1301 K Street, N.W.
Washington, D.C. 20005

Dear Ms. Thiel

I am responding to your request for clarification regarding the Health Care Financing Administration's (HCFA's) physician signature requirements for rehabilitation plans of treatment. You are concerned that HCFA plans to require that the plan of treatment be signed by a physician before therapy services may be delivered.

We are currently reviewing our requirements regarding physician signature on the therapy plan of treatment. As you state in your letter, the SNF Manual requires that covered rehabilitation therapy services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. We are aware, however, that this policy has been subject to different interpretations.

We plan to make a clear statement regarding this physician signature requirement in our final rule on the SNF prospective payment system and consolidated billing. In the interim, we have made no change to our existing policy and expect that providers will continue to manage the rehabilitation plan of treatment according to current Medicare guidelines. Accordingly, although there is no requirement that the physician signature must be obtained prior to the provision of any rehabilitation services to the beneficiary, we do continue to expect physician involvement in the development of the plan of treatment.

I would like to make clear that we have no intention of implementing any new requirements that would impinge on the physician's and therapist's ability to provide needed rehabilitation services in a timely and appropriate manner. Our only goal is to ensure, to the extent possible, that beneficiaries receive high quality care.

I hope that this is helpful. As always, thank you for your interest.

Sincerely,

Thomas E. Hoyer
Director
Chronic Care Purchasing Policy Group
Center for Health Plans and Providers