DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

NOV 29 2006

Report Number: A-04-04-02010

Lourdes Acevedo-Sanz
Vice President of Reimbursement
Absolute Therapy, Inc.
50 East Sample Road, Suite 303
Pompano Beach, Florida 33064

Dear Ms. Acevedo-Sanz:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Absolute Therapy, Inc." A copy of this report will be forwarded to the action official noted on the next page for his review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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.

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Please refer to report number A-04-04-02010 in all correspondence.

Sincerely,

Peter J Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosure

Direct Reply to HHS Action Official:

Dale K. Kendrick
Associate Regional Administrator for Medicare, Region IV
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY THERAPY SERVICES PROVIDED BY ABSOLUTE THERAPY, INC.

Daniel R. Levinson
Inspector General

November 2006
A-04-04-02010

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons.

Prior to implementation of the prospective payment system, CORFs received payment under a cost-based reimbursement methodology. The Balanced Budget Act of 1997 (BBA) (sections 4523 (d) and 4541)) amended the Social Security Act and required the payment for hospital outpatient services, including services furnished by CORFs to be made under a prospective payment system.

Absolute Therapy, Inc. (Absolute) is a CORF located in Davie, Florida. With the assistance of a program safeguard contractor (PSC), we reviewed selected claims submitted by Absolute and paid by Medicare. The claims selected for review included multiple physical and occupational therapy services with dates of service from January 1, 2002, through December 31, 2002. In total, Absolute received $6,614,212 for 14,157 claims during the period of our review.

OBJECTIVE

Our objective was to determine whether payments to Absolute for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Absolute received $5,928 in unallowable payments for therapy services associated with 20 sampled claims, which contained 246 services that did not meet Medicare reimbursement requirements. By projecting the results of our random sample to the entire population, we estimate that Absolute received $414,712 in payments for unallowable services.

The PSC's medical reviewers determined that 20 of the 100 sampled claims for CORF therapy services were not appropriately paid. These 20 claims contained 246 CORF therapy services that did not meet Medicare reimbursement requirements because:

- services were rendered under unapproved or incomplete plans of care,
- documentation did not indicate that the plan of care was reviewed at least every 60 days, and
- documentation did not meet Medicare standards to support that services were actually provided.

Medical reviewers determined that Absolute did not always follow Medicare requirements or fiscal intermediary (FI) guidance. Absolute had written policies and procedures that, if followed, would have precluded the errors the medical reviewers identified.

However, Absolute did not always follow its policies and procedures for ensuring that plans of care contained all required elements, for documenting that plans of care were reviewed at least every 60 days, or for documenting that services were actually provided.

RECOMMENDATIONS

We recommend that Absolute:

- refund to the Medicare program the $414,712 in payments for services Absolute billed from January 1, 2002, through December 31, 2002, that did not meet Medicare reimbursement requirements;

- follow its policies and procedures for ensuring plans of care contain all required elements, for documenting that plans of care were reviewed at least every 60 days, and for documenting that services were actually provided; and

- identify and submit adjusted claims for services provided subsequent to our audit period that did not meet Medicare reimbursement requirements.

We will provide the results of this audit to First Coast Service Options, Inc., the Medicare FI, so that appropriate adjustments can be made.

Absolute Comments

Certifications and Recertifications

In written comments to our draft report, Absolute officials generally disagreed with our findings and recommendations. Absolute officials said that claims for services should not be denied in instances where the medical reviewers determined that a physician did not sign or date a certification or recertification. Absolute officials believed that a fax date shown on the physician's certification sufficiently documents a timely certification. Absolute officials also said that 42 CFR § 424.11 (d)(3) allows payment for services that are covered under an appropriately certified plan that is certified late.

Written Plan of Treatment

Absolute officials were of the opinion that the treatment plan changes that the medical reviewers noted were not significant deviations from the patients' approved treatment plan and should not be questioned. Absolute officials said that Section 220.1.2. of the Medicare Benefits Manual provides that a patient's treatment plan should be modified only for significant changes, i.e., those that change long-term goals. According to Absolute officials, Section 220.1.2 considers decreases in frequency and duration of treatment to be insignificant changes.

Office of Inspector General Response

In view of issues Absolute raised in its written comments with respect to certifications and recertifications and written plans of treatment, we requested the PSC review its findings relative to the 27 claims we originally questioned in the draft report. Accordingly, we adjusted our findings and recommendations based on the results of the PSC's reevaluation of those 27 claims.

Absolute Comments

Inadequate Documentation That Services Were Performed

Absolute officials agreed that a billing error occurred when Absolute performed 4 units of procedure code 97530 but billed 4 units of 97535.

Office of Inspector General Response

We have no additional comments regarding the billing error.

The complete text of Absolute's comments is included as Appendix C.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Comprehensive Outpatient Rehabilitation Facility

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons. To qualify as a Medicare-certified CORF, the facility must provide at least the following services: physicians' services, physical therapy, and social or psychological services. Additional covered CORF services include occupational and speech pathology services.

Comprehensive Outpatient Rehabilitation Facility Legislation

Section 1861 (cc) (2) of the Social Security Act (the Act) provides legislation governing CORFs. Prior to implementation of a prospective payment system (PPS), CORFs received payment under a cost-based reimbursement methodology. The Balanced Budget Act of 1997 (BBA) (sections 4523 (d) and 4541)) required the Centers for Medicare & Medicaid Services (CMS) to implement a PPS for hospital outpatient services, including services furnished by CORFs. Accordingly, CMS implemented a PPS for CORFs effective January 1, 1999.

Comprehensive Outpatient Rehabilitation Facility Prospective Payment System

The BBA added section 1834 (k) to the Act so that all services furnished by CORFs would be paid an applicable fee schedule amount. As such, the Medicare physician fee schedule became the applicable fee schedule as defined by the Act. Payment of CORF services is to be made at 80 percent of the lesser of (1) the actual charge for the service or (2) the applicable fee schedule amount.

To qualify as a Medicare-certified CORF, the facility must provide at least the following services: physicians' services, physical therapy, and social or psychological services (the Act, section 1861 (cc) (2)). Additional covered CORF services include occupational and speech pathology services (the Act, section 1861 (cc) (1)).

Fiscal Intermediary Responsibilities

Providers, such as CORFs, generally receive payments for covered services furnished to Medicare beneficiaries through fiscal intermediaries (FI) under contract with CMS (42 CFR § 421.103). Agreements between CMS and an FI specify the functions to be performed by the FI, which include, but are not limited to, processing claims, assisting in the application of safeguards against unnecessary utilization of services, conducting provider audits, resolving provider disputes, and reconsidering payment denial determinations to providers that furnished services (42 CFR § 421.100).

Absolute Therapy, Inc.

Absolute Therapy, Inc. (Absolute) became a Medicare-certified CORF in October 1999 and is located in Davie, Florida. The FI for Absolute is First Coast Service Options, Inc. (First Coast), located in Jacksonville, Florida.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether payments to Absolute for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

Scope

Our review covered services dates for calendar year 2002. For this period, Absolute received Medicare payments of $6,614,212 for 14,157 claims.

Although we did not perform detailed tests of internal controls, we did review Absolute's written policies and procedures related to documentation and submission of claims for CORF therapy services.

We conducted fieldwork at Absolute in Davie, Florida. Medical review functions were performed by the program safeguard contractor (PSC).

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, Medicare guidelines, and FI guidance[1] for CORF therapy services;
- used the CMS's Data Extraction System user interface to retrieve all Absolute claim information for the period of our audit;
- selected a stratified sample of 100 paid claims containing 2,668 services totaling $63,623 (Appendix A);
- met with PSC staff to develop a payment error matrix;
- obtained supporting medical and billing records from Absolute for each sampled claim;

[1]Local Medical Review Policies (LMRP) outline how FIs will review claims to ensure that they meet Medicare coverage requirements. First Coast, because of its location, must follow the LMPRs for Florida.

- contracted with the PSC to review all medical and billing records and to determine whether the CORF therapy services rendered by Absolute met Medicare reimbursement requirements;

- reviewed Absolute's written policies and procedures manual to determine whether policies existed to prevent the errors that the medical reviewers identified;

- utilized a variable appraisal program to estimate overpayments to Absolute (Appendix B); and

- met with members of Absolute management to provide them with the preliminary results of our review.

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Absolute received $5,928 in unallowable payments for therapy services associated with 20 sampled claims, which contained 246 services that did not meet Medicare reimbursement requirements. By projecting the results of our random sample to the entire population, we estimate that Absolute received $414,712 in payments for unallowable services.

The PSC's medical reviewers determined that 20 of the 100 sampled claims for CORF therapy services were not appropriately paid. These 20 claims contained 246 CORF therapy services that did not meet Medicare reimbursement requirements because:

- services were rendered under unapproved or incomplete plans of care,

- documentation did not indicate that the plan of care was reviewed at least every 60 days, and

- documentation did not meet Medicare standards to support that services were actually provided.

Medical reviewers determined that Absolute did not always follow Medicare requirements or FI guidance. Absolute had written policies and procedures that, if followed, would have precluded the errors the medical reviewers identified.

However, Absolute did not adhere to its policies and procedures for ensuring that plans of care contained all required elements, for documenting that plans of care were reviewed at least every 60 days, or for documenting that services were actually provided.

MEDICARE REQUIREMENTS AND FISCAL INTERMEDIARY GUIDANCE

Federal regulations contain the Medicare requirements for claiming CORF services. In addition, FI guidance specifies that CORF services must be furnished under an approved plan of care, that the plan of care must be reviewed at least every 60 days, and that the services must be documented in patient records.

Medicare Requirements

Approved Plan of Care — Medicare regulations state: "The services must be furnished under a written plan of treatment that (i) Is established and signed by the physician before treatment is begun; and (ii) Prescribes the type, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals" (42 CFR § 410.105(c) (1)).

Review of Plan of Care — Medicare regulations state: "The plan must be reviewed at least every 60 days by a facility physician who, when appropriate, consults with the professional personnel providing the services" (42 CFR § 410.105(c) (2)).

Medicare Requirements and Fiscal Intermediary Guidance

Adequate Documentation — Medicare regulations state: ". . . The clinical record contains sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately . . ." (42 CFR § 485.721(b)). Florida LMRP 97003 states in part that the progress notes must contain necessary and sufficient information, which indicates that the services were actually provided and were reasonable and necessary to treat the patient's condition.

SERVICES PROVIDED BY ABSOLUTE DID NOT MEET MEDICARE REQUIREMENTS

The medical reviewers determined that 20 out of the 100 sampled claims contained 246 CORF therapy services that did not meet Medicare reimbursement requirements for CORF services:

- For 179 therapy services, the scope of services provided did not comply with the written plan of treatment. For example, the written plan of treatment for a patient prescribed treatment sessions 3 times per week for 6 weeks. However, Absolute provided six more treatments than were prescribed. As a result, Absolute received $4,217 in unallowable payments.

- For 45 therapy services, the plans of care were not reviewed every 60 days. For example, although a sampled claim contained a signed and dated certification, there was no documentation that a facility physician reviewed the plan of care at least every 60 days. As a result, Absolute received $1,158 in unallowable payments.

- For 22 therapy services, the services provided did not meet documentation standards. For example, the documentation supplied for one claim indicated that 4 units of procedure code 97530 (therapeutic activities to improve functional performance – 15 minutes) were performed (there was no billing for this service), but the provider billed 4 units of procedure code 97535 (self-care/activities of daily living). However, no documentation supported that this service was performed. As a result, Absolute received $553 in unallowable payments.

POLICIES AND PROCEDURES NEED IMPROVEMENT

Medical reviewers determined that Absolute did not always follow Medicare requirements or FI guidance. Absolute had written policies and procedures that, if followed, would have precluded the errors identified by the medical reviewers.

Absolute did not adhere to its policies and procedures for ensuring plans of care contain all required elements, documenting that plans of care were reviewed at least every 60 days, and documenting that services were actually provided.

OVERPAID COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY CLAIMS

Absolute received $5,928 in unallowable payments for therapy services associated with these 20 claims because they contained 246 services that did not meet Medicare reimbursement requirements. By projecting the results of our random sample to the entire population, we estimate that Absolute received $414,712 in payments for unallowable services from January 1, 2002, through December 31, 2002. (See Appendix A.)

RECOMMENDATIONS

We recommend that Absolute:

- refund to the Medicare program the $414,712 in payments for services Absolute billed from January 1, 2002, through December 31, 2002, that did not meet Medicare reimbursement requirements;

- follow its policies and procedures for ensuring plans of care contain all required elements, for documenting that plans of care were reviewed at least every 60 days, and for documenting that services were actually provided; and

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APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE:

Our objective was to determine whether payments to Absolute Therapy, Inc. (Absolute) for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

POPULATION:

The population consisted of 14,157 paid claims for comprehensive outpatient rehabilitation facility (CORF) services provided in calendar year 2002, representing $6,614,212 in therapy benefits the FI paid to Absolute. Five claims were $3,000 or greater and 14,152 claims were under $3,000.

SAMPLING UNIT:

The sampling unit is a paid CORF claim for a Medicare beneficiary. A paid claim consists of multiple units of therapy services claimed by the provider for the period covered by the claim.

SAMPLING DESIGN:

The sample was stratified. All claims $3,000 or greater were included in a separate stratum for 100 percent review. We then selected an unrestricted random sample of paid claims with values less than $3,000.

SAMPLE SIZE:

We randomly selected 95 paid claims that were less than $3,000. We reviewed all five paid claims that were $3,000 or greater. The total sample size was 100, which contained 2,668 CORF therapy services.

ESTIMATION METHODOLOGY:

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Variable Appraisal Program for stratified samples, we projected the excessive overpayments to Absolute resulting from erroneous claims. RAT-STATS uses the difference estimator.

APPENDIX B

STATISTICAL SAMPLE INFORMATION

Sample Results

Stratum	Sample Size	Value of Sample	Number of Non-Zero Errors	Value of Errors
1<$3,000	95	$45,940	19	$5,035
2≥$3,000	5	$17,683	1	$ 893
Total:	100	$63,623	20	$5,928

Variable Projections

Point Estimate:		$750,976
90 Percent Confidence Interval		
	Lower Limit	$414,712
	Upper Limit	$1,087,239

APPENDIX C

Willenbrecht Consulting, Inc.
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Middleburg, Florida 32068
(904) 282-0851 Cell (904) 571-0967 Fax (904) 291-9354
KarenY1@msn.com

July 6, 2006
Department of Health and Human Services
Office of Inspector General
61 Forsyth Street S.W., Suite 3T41
Atlanta Georgia 30303

Re: Absolute Therapy Report Number A-04-04-02010

Dear Ms. Lori Pilcher,

Thank you for the opportunity to provide your office with our comments regarding the review of the above facility. Ms. Lourdes Schilling has asked me as Facility Representative to respond to your letter.

We disagree with some of the findings, as reported on the Claim Summary Form.

- For example, the denials that were based on lack of a date of the physician's signature, or a lack of a physician's signature—the faxed date could and should be utilized as justification of a timely certification for those missing the date. Each of these patients had a prescription referring them for skilled therapy, therefore evidencing physician involvement in the patient's care. 42CFR424.11 (d) (3) (Reference §1835 (a) of the Act) states "Payment should not be denied for a covered service under an appropriate certified plan that is only certified late. It is payable regardless of the date it was certified".

- Those claims denied for failure to "comply with the written plan of treatment". Chapter 15 Section 220.1.2 of the Medicare Benefits Manual (Ref 42CFR410.61) states "Plan should be modified for significant changes in conditions—those that change long term goals". "Insignificant changes ------deletion of achieved goals, or specific interventions" "Insignificant changes –decrease in frequency/duration." "Procedures and modalities are not goals and may be modified without a change in plan".

- The claims denied because an error was made –4 units of 97530 were performed, but 4 units of 97535 were billed. Services were rendered to this patient and documented, however a simple billing error was made. This error occurred in one claim; it was not prevalent throughout the review.

We feel that the services rendered were medically necessary and reasonable. We do expect that our facility, with its numerous therapists would make some mistakes, as a perfect medical record does not exist. However, we did not expect such a hypercritical review of our documentation.

Sincerely,

Karen Willenbrecht, RN
Facility Representative

CC: Lourdes Schilling
Mark Starinsky