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★ ★ ★ **OPERATION RESTORE TRUST** ★ ★ ★

September 25, 1996

Mr. Marshall Kelly, Director
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Dear Mr. Kelly:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility (SNF) review conducted at Palm Gardens of Pinellas (Medicare provider number 105733), a SNF located in Largo, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from November 1, 1994 through December 31, 1995.

The ORT reviewers questioned $47,229 in charges reported for the 28 sample beneficiaries in our study. This amount is comprised of $32,420 related to Physical, Occupational, and Speech therapy services rendered; $10,180 of unallowable respiratory therapy services; $270 in unallowable pharmacy charges; $310 in inappropriate physician payments; $441 in undocumented X-ray charges; and $3,598 in inappropriate psychiatric services. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a focused review of all rehab therapies and the use of standing orders for these therapies be conducted by the Fiscal Intermediary and State agency in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within 30 days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely yours,

Clarence J. Boone for
Clarence J. Boone
Regional Administrator
Health Care Financing
Administration, Region IV

Charles J. Curtis
Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

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★ ★ ★ **OPERATION RESTORE TRUST** ★ ★ ★

September 25, 1996

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue, 11th Tower
Jacksonville, Florida 32231

Dear Mr. Lord:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility (SNF) review conducted at Palm Gardens of Pinellas (Medicare provider number 105733), a SNF located in Largo, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from November 1, 1994 through December 31, 1995.

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Sincerely yours,

Clarence J. Boone
Regional Administrator
Health Care Financing
Administration, Region IV

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

The purpose of this report is to provide the results of the Operation Restore Trust survey/review of Palm Garden of Pinellas Skilled Nursing Facility (SNF) in Largo, Florida. A team comprised of a Florida State Agency Nurse-Surveyor, a Regional Health Care Financing Administration Nurse Consultant, and an auditor from the Office of Inspector General, Office of Audit Services conducted an unannounced focused survey/review at this SNF. The reviewers evaluated the services/charges for 28 sample Medicare beneficiaries and made the following findings:

In summary, we questioned $42,870 in charges reported by the SNF in its Medicare Cost Reports in these 28 cases plus $4,349 in charges submitted by other providers directly to the Part B carrier, for a total of $47,219 in inappropriate payments. The SNF amount is comprised of $32,420 of physical, occupational and speech therapy services we determined were not reasonable or medically necessary; $10,180 of respiratory therapy services provided by a contractor other than a hospital with which the SNF had a transfer agreement; and a $270 pharmacy charge for which there was no supporting documentation. We are recommending an adjustment of $42,870 for the charges reported by the SNF.

In addition to the services billed through the SNF we found two additional and significant problem areas involving billings submitted directly to the Part B carrier. Psychiatry service received by 6 of the 28 beneficiaries included in our sample (and totaling $3,598) was provided under an agreement with a private contractor. The individuals received an evaluation , which included testing with interpretation of results, and multiple visits with individuals and/or family members. Only brief notes by a therapist were included in the records and there was little evidence that a plan of care was developed. Additionally, our review of the Resident Assessment Instrument did not indicate that the mood or behavior exhibited by the beneficiaries required this level of care. We are instructing the carrier to conduct a focused review and recoup all payments made to this contractor for psychiatric services at Palm Gardens, and other locations.

We also found inappropriate laboratory services charged to 5 of the 28 beneficiaries included in our sample. The individuals either had questionable laboratory studies performed or had been charged for multiple tests when a single test was ordered. We are directing the carrier fraud unit to investigate the payments made to this laboratory and to take appropriate corrective actions, including referral to the OIG - Office of Investigation.

II. BACKGROUND

The Secretary of the Department of Health and Human Services and the President initiated Project Operation Restore Trust (ORT). This innovative, collaborative project was designed to address growing concerns over rising health care costs. A review of Departmental records indicate that over the last 10 years, the following segments of the health care industry have experienced a surge in health care fraud:

(1) home health,
(2) nursing homes,
(3) hospice, and
(4) durable medical equipment.

Departmental records further disclosed that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds paid to the above health care segments,. As a result, these States and the above health care segments were chosen as targets of the ORT 23-month pilot project.

Within the Department of Health and Human Services, Operation Restore Trust has been a joint effort by the Health Care Financing Administration, the Office of Inspector General, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified though investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) has identified certain Skilled Nursing Facilities in Florida as aberrant according to their billings. The method used to identify these providers was to evaluate the universe of SNF admissions in each state during CY 1994. Data for all SNF claims, was summarized first by beneficiary, and then by SNF. Key beneficiary statistics included total claims per beneficiary; allowed dollars per stay; line items or services per number of beneficiaries, average dollars and claims per stay, and average dollars per day. Listings were generated by BDMS of the facilities with high reimbursement amounts per day and per stay. The final listing of SNF providers was manually scanned and 14 were judgementally selected based on total highest reimbursement.

In addition to these 14 providers, we requested the two principal Fiscal Intermediaries in Florida (Aetna and Blue Cross) to each identify 3 SNF's for review in this project, based upon their data.

complaints, and experience with SNF providers. Palm Gardens of Pinellas was one of the facilities recommended for review by Blue Cross of Florida.

A team comprised of a Florida State Agency Nurse-Surveyor, a Regional Health Care Financing Administration Nurse Consultant, and an auditor from the Office of Inspector General, Office of Audit Services conducted an unannounced focused survey review at the Palm Gardens of Pinellas Nursing Facility in Largo, Florida.

The primary objective of the survey was to evaluate all services/charges to Medicare provided to the sample beneficiaries during the period June 1, 1994 through May 31, 1995. The facility's Medicare fiscal period is January 1 through December 31.

III. SCOPE OF REVIEW

Under the authority of Section 1861 (o) (6) (7) of the Social Security Act, the pilot survey was conducted at Palm Gardens of Pinellas located in Largo, Florida. This is a Skilled Nursing Facility with 120 certified beds -- 15 Medicare, 83 Medicaid, and 22 dually entitled.

The survey was conducted by a team comprised of a nurse surveyor from the Florida State Agency for Health Care Administration (State Agency), a nurse consultant from the Regional Health Care Financing Administration (HCFA), and an auditor from the Regional Office of Inspector General (OIG), Office of Audit Services auditor. This HCFA-directed survey was conducted using HCFA's review protocols rather than the OIG's policies and procedures. Accordingly, the OIG's work was in compliance with generally accepted government auditing standards only in relation to the quantification of the unallowable services identified by other members of the team.

Palm Gardens was selected for the survey based upon its high rankings in total charges and denied charges by its fiscal intermediary.

The primary objective of the survey was to identify unnecessary care provided to the 28 beneficiaries in our sample, for whom Palm Gardens billed Medicare Part A, Part B and Medicaid $962,795 during the period June 1, 1994 through May 31, 1995. The facility's Medicare fiscal period is January 1 through December 31. Palm Gardens' Medicare Part A reimbursement was $2,243,999 and $1,800,066 for fiscal years 1994 and 1995 respectively. We did not determine Medicare Part B or Medicaid reimbursement for this period.

The approach used was to identify all services being billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 28 beneficiaries in the sample during their stay between June 1994 and June 1995 at the SNF. This approach was adopted because many providers, other than the SNF, bill separately for services to the SNF patients, e.g. podiatrists, portable x-ray suppliers, therapy providers, and DME suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely, if ever, associated with each other or the SNF bills.

We selected a sample of 28 residents to review the medical record documentation to determine the cause(s) of the above high incidences of medical costs. We reviewed the entire medical charges of the residents, including the therapy and nursing progress notes, and the monthly therapy billing logs supplied to the facility by the therapy companies who have a contractual arrangement with the facility. The medical records of these patients were evaluated to determine: 1) that services provided were medically necessary 2) that services were, in fact, rendered, 3) that the services were documented in the medical records, 4) that services were ordered by a physician, and 5) that the resident's condition and diagnosis supported the need for therapies and other services.

IV. FINDINGS AND RECOMMENDATIONS

We questioned $42,870 in charges reported by the SNF in its Medicare Cost Reports in these 28 cases. The amount is comprised of $32,420 of physical, occupational, and speech therapy services we determined were not reasonable or medically necessary; $10,180 of respiratory therapy services provided by a contractor other than a hospital with which the SNF had a transfer agreement; and a $270 pharmacy charge for which there was no supporting documentation. We are recommending an adjustment of $42,870 for the charges reported by the SNF.

In addition to the services billed through the SNF we found two additional and significant problem areas involving billings submitted directly to the Part B carrier. Psychiatry service received by 6 of the 28 beneficiaries included in our sample was provided under an agreement with a private contractor. The individuals received an evaluation, which included testing with interpretation of results, and multiple visits with individuals and/or family members. Only brief notes by a therapist were included in the records and there was little evidence that a plan of care was developed. Additionally, our review of the resident assessment instrument did not indicate that the mood or behavior exhibited by the beneficiaries required this level of care. We are instructing the carrier to conduct a focused review and recoup all payments made to this contractor for psychiatric services at Palm Gardens and other locations.

We also found inappropriate laboratory services charged to 5 of the 28 beneficiaries included in our sample. The individuals either had questionable laboratory studies performed or had been charged for multiple tests when a single test was ordered. We are directing the carrier fraud unit to investigate the payments made to this laboratory and to take appropriate corrective actions.

FINDING #1

Physical Therapy Services

We questioned $8,569 of physical therapy (PT) services provided 3 of the 28 beneficiaries included in our sample. In order to be covered under Medicare Part A, PT services must relate directly and specifically to an active written treatment regimen, established by the physician or by the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (MIM 3101.8). To be considered reasonable and necessary, the following conditions must be met:

- The services must be considered a specific and effective treatment for the patient's condition.
- There must be an expectation that the patient's condition will improve significantly

in a reasonable period of time based on the assessment made by the physician

- The amount, frequency, and duration of the services must be reasonable

The PT services provided the three beneficiaries were questioned by the ORT reviewers because the services were not deemed effective treatments for their condition or based on an expectation that their condition would improve materially in a reasonable period of time. This occurred because the facility s initial screening of the residents failed to provide a comprehensive assessment of their mental and physical capabilities. There was little evidence of involvement by the physician or utilization of the Resident Assessment Protocols during the assessment.

RECOMMENDATION:

The Fiscal Intermediary:

- should adjust the $8,569 of charges related to those Physical Therapy services

- direct the provider to conduct a comprehensive assessment of each resident's mental and physical capabilities, upon their admission.

FINDING #2

Occupational Therapy Services

We questioned $13,213 of occupational therapy (OT) services provided 7 of the 28 beneficiaries included in our sample. In order to be covered under Medicare Part A, such services must be prescribed by a physician, be performed by a qualified therapist, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time.

We determined that no basis existed for an expectation that the OT services provided would significantly improve these seven beneficiaries' level of functioning. This occurred because the facility's initial screening of the residents failed to provide a comprehensive assessment of their mental and physical capabilities. There was little evidence of involvement by the physician or utilization of the Resident Assessment Protocols during the assessment.

RECOMMENDATION

The Fiscal Intermediary should:

- adjust the $13,213 of charges related to these specific OT services.
- direct the provider to conduct a comprehensive assessment of each resident's mental and physical capabilities at the time of his admission to the facility.
- Conduct a focused review investigation of all OT services provided at Palm Gardens since January 1, 1994.

FINDING #3

Speech Therapy Services

We questioned $10,638 of speech therapy (ST) services provided 4 of the 28 beneficiaries included in our sample. Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must be related directly and specifically to a written treatment regimen established by the physician (or speech pathologist providing the services). The services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:

- The services must be considered a specific and effective treatment for the patient's condition.
- The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist.
- There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.
- The amount, frequency, and duration of the services must be reasonable.

The ST services provided these four beneficiaries did not meet one or more of the above criteria. This occurred because the facility's initial screening of the residents failed to provide a comprehensive assessment of their mental and physical capabilities. There was little evidence of involvement by the physician or utilization of the Resident Assessment Protocols during the assessment.

RECOMMENDATION:

The Fiscal Intermediary should:

- adjust the $10,638 of charges related to these specific ST services.
- direct the provider to conduct a comprehensive assessment of each resident's mental and physical capabilities at the time of his admission to the facility.

FINDING # 4

Respiratory Therapy Services

We questioned $10,180 charged to Medicare for respiratory therapy services (RT) provided to 12 of the 28 beneficiaries included in our sample. The services were obtained under an agreement between the SNF and Health Services and Support Systems, Inc., an independent contractor.

The Federal regulations at 42 CFR 409.27 provide Medicare reimbursement for such services, only if they are provided by a hospital with which the SNF has a transfer agreement. Since the contractor was not a hospital, Medicare reimbursement was not allowable for the services. We attribute the facility's use of a Medicare-ineligible provider to an inadvertent oversight.

RECOMMENDATIONS:

The Fiscal Intermediary should adjust all RT charges at Palm Gardens since January 1, 1994.

FINDING #5

Pharmacy Services

We questioned $270 charged for pharmacy services relating to intravenous (IV) services provided to an individual in April, 1995. The beneficiary's records show his IV line was discontinued March 20, 1995. We attribute the charge to an inadvertent billing error.

RECOMMENDATION:

The Fiscal Intermediary should adjust the $270 in charges for these pharmacy services.

FINDING #6

Physician Visits

Documentation was not available to support $310 charged for physician visits to four residents of the facility. The Part B Medicare Program reimburses physicians for services rendered directly to the patient. However, charges for services rendered by means of a telephone call between physicians and beneficiaries and visits for the sole purpose of obtaining or renewing a prescription are not covered services.

RECOMMENDATION:

The Part B carrier should recoup payments for these undocumented physician visits

FINDING #7

X-Rays

Our review found $441 in x-ray charges provided to four residents that were not documented in the medical chart.

RECOMMENDATION:

The Part B carrier should recoup payments for these undocumented x-rays.

FINDING #8

Laboratory

Five residents had questionable lab. studies or either had charges for multiple test when a single test was ordered. These claims were submitted by the independent laboratory to the Part B carrier who made payments.

1. On March 3, January 1, and February 2, 1995 one beneficiary had charges for tissue and bacteria culture with commercial kit and identification of kit. There was no documentation that these tests were ordered.

2. No documentation in record of a CBC and SMA done on October 10, 1994 for one beneficiary.

3. Three beneficiaries had SMAC and/or CBC ordered, but charges were submitted also for Hepatic function, Cholesterol Test, Hemoglobin & Hematocrit, Iron and Amylase.

RECOMMENDATION:

The Part B carrier fraud unit should conduct an investigation of claims submitted by this independent laboratory and take appropriate corrective actions, including referral to the OIG-Office of Investigation.

Finding #9

Psychiatry Services

Psychiatry services received by 6 of the 28 beneficiaries included in our sample was provided under an agreement the SNF had with a private contractor. These individuals received an evaluation, which included testing with interpretation of results, and multiple visits with individuals and/or family members. Only brief notes by a therapist were included in the records and there was little evidence that a plan of care was developed. Additionally, our review of the Resident Assessment Instrument did not indicate that the mood or behavior exhibited by the beneficiaries required this level of care.

These psychiatry services were directly billed by the contractor to Medicare Part B. Our reviewers determined all to be medically unnecessary. The payments on our six sample patients totaled $3,598.00.

RECOMMENDATIONS:

The carrier should conduct a focused review/investigation of Medicare payments to this entity, and recoup all overpayments as well as evaluate other corrective actions.

TEAM

Linda Niswander, RN, Health Care Financing Administration Nurse Consultant

Bob Neilsen, Auditor, Office of the Inspector General, Office of Audit

Ann Da Silva, RN, Florida Agency for Health Care Administration