Brickell Federal Building
909 SE 1st Avenue, Suite 732
Miami, Florida 33131
(305) 536-6540 FAX (305) 536-6787

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

101 Marietta Tower, Suite 701
Atlanta, Georgia 30323
(404) 331-2329 FAX (404) 331-0104

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

February 6, 1997

Ms. Terri Ginnetti, Benefits Integrity Unit
Aetna Life Insurance, Co.
25400 US 19 N., Suite 135
Clearwater, FL 34623-2193

Dear Ms. Ginnetti:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Stratford Court (Medicare provider number 10-5851), a skilled nursing facility located in Boca Raton, 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 $161,774 in charges reported for the 29 sample beneficiaries in our study. This amount comprises $141,878 related to Physical, Occupation, and Speech therapy services that were determined to be medically unnecessary and $19,896 in undocumented rehab services. Therefore, we are recommending an adjustment of the above charges. In addition, we request that the FI conduct a focused review of all rehab therapies (and the use of standing orders) at this facility since the period of our review 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 recommendation made in the report. This plan should be submitted within thirty days of receipt of this letter.

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

Sincerely,

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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February 6, 1997

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

Dear Mr. Kelley:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Stratford Court (Medicare provider number 10-5851), a skilled nursing facility located in Boca Raton, 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 $161,774 in charges reported for the 29 sample beneficiaries in our study related to services that did not meet Medicare reimbursement requirements or were not supported by the medical records. We are recommending an adjustment of the above charges. In addition, we request that the State Agency require corrective action by this facility to discontinue the use of standing orders to initiate therapy services and ensure that all rehabilitative services are properly ordered, provided, and documented.

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

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

Sincerely,

Patricia L. Talley
Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust (ORT) survey of Stratford Court Skilled Nursing Facility (Stratford) in Boca Raton, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Fiscal Intermediary (Intermediary) and Part B Carrier (Carrier) were allowable. For these services to be allowable they must be:

- considered a specific and effective treatment for the patient's condition;
- prescribed under the assumption that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician; and
- reasonable in amount, frequency, and duration.
- fully supported by the patients medical records.

A team comprising a Florida State Agency for Health Care Administration (State Agency) Nurse Surveyor, a Regional Health Care Financing Administration (HCFA) Nurse Consultant, and an Office of Inspector General (OIG), Office of Audit Services Auditor conducted an unannounced focused survey at Stratford. The members of the team evaluated the services for a sample of 30 Medicare beneficiaries with aberrant charges, the details of the review follow:

Twenty-nine of the thirty beneficiaries in the sample received services that did not meet Medicare reimbursement requirements stated above or were not supported by the medical records. This occurred because Stratford prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services, and without the prior authorization of a physician. We determined that the 29 beneficiaries received $161,774 in unallowable or unsupported services during the period November 1, 1994 to December 31, 1995. We are recommending an adjustment of $161,774. We are also recommending that the Intermediary identify and recoup all overpayments made to Stratford for unnecessary and unsupported therapy services. In addition, we are recommending that the Intermediary and the State Agency direct Stratford to cease the practice of prescribing therapy services to all residents upon admission and re-admission without specific medical indications for such services, and without the proper authorization of a physician.

In addition to the findings disclosed above, we noted the following problems: therapies for Medicaid residents did not start until the payment source was confirmed; there was considerable overlap in the physical and occupational therapy services for activities of daily living, however, evidence of loss or diminished skills in this area was not documented; individual therapists' daily hours billed exceeded 32 units (32 units would be 8 hours); and residents receiving multiple, simultaneous therapies, received therapy services which exceeded 32 units. We also noted that Stratford was billing for outpatient Part B therapies for residents of the apartment complex adjacent to the facility who were not residents of the facility. If overhead cost associated with these billings is included in the cost report, it could result in an overcharge to Medicare.

II. BACKGROUND

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

- home health
- nursing homes
- hospice
- 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.

Under the authority of Section (o)(6)(7) of Social Security Act, the pilot survey was conducted at Stratford Court, a SNF with 60 Medicare certified beds. Stratford was selected for the survey as one of the facilities recommended by Aetna.

The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Fiscal Intermediary (FI) and part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. Primarily, we wanted to determine whether unnecessary care was provided to the 30 beneficiaries in our sample, for whom Stratford Court billed Medicare $1,760,541 during the period November 1, 1994 through December 31, 1994. The facility's fiscal year is January 1, through December 31.

In addition to these 14 providers, we requested the 2 principal fiscal intermediaries in Florida (Aetna and Blue Cross) to each identify 3 SNFs for review in this project, based upon their data, complaints, and experience with SNF providers. Stratford was one of the facilities recommended for review by Aetna.

III. SCOPE OF REVIEW

This survey was conducted by a team comprising a Nurse Surveyor from the State Agency, a Nurse Consultant from the HCFA Miami Satellite Office, and an Auditor from OIG Office of Audit Services. 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.

Stratford is a SNF with 60 Medicare certified beds. It was selected for the survey because of its high therapy costs, a high average length of stay by the residents, the high cost per stay, and high cost per day.

The primary objective of the survey was to determine whether charges other than room and board billed to the Intermediary and Carrier, were allowable. For the 30 beneficiaries in the sample Stratford billed Medicare Part A, Part B and Medicaid $1,760,541 during the period November 1, 1994 through December 31, 1995. Our review covered $1,003,329 of these charges. The facility's Medicare fiscal period is January 1 through December 31. Stratford was reimbursed $183,585 and $1,430,100 in its Medicare Part A cost reports 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 billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 30 beneficiaries in our sample during their stay at Stratford between November 1994 and December 1995. This approach was adopted because many providers, other than Stratford, bill separately for services to the beneficiaries, e.g. podiatrists, portable x-ray suppliers, therapy providers, and durable medical equipment suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely cross-referenced with each other or with the SNF's claim.

We selected a sample of 30 aberrant beneficiaries to review the medical record documentation to determine the cause of the high incidence of medical costs. We reviewed the medical charts of the beneficiaries in the sample, including the therapy and nursing progress notes, and the monthly therapy billing logs supplied by the therapy companies which had contractual arrangements with Stratford. The medical records of these beneficiaries were evaluated to determine if services provided were: 1) medically necessary, 2) rendered, 3) documented in the medical records, 4) ordered by a treating physician, and 5) supported by the beneficiary's condition and diagnosis.

IV. FINDINGS AND RECOMMENDATIONS

Our review disclosed that 29 of the 30 beneficiaries included in the sample received services that did not meet Medicare reimbursement requirements or were not supported by the medical records. This occurred because Stratford prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services, and without the prior authorization of a physician. We determined that the 29 beneficiaries received $161,774 in unallowable or unsupported services during the period November 1, 1994 to December 31, 1995. We are recommending an adjustment of $161,774. We are also recommending that the Intermediary identify and recoup all overpayments made to Stratford for unnecessary and unsupported therapy services. In addition, we are recommending that the Intermediary and the State Agency direct Stratford to cease the practice of prescribing therapy services to all residents upon admission and re-admission without specific medical indications for such services, and without the proper authorization of a physician.

FINDING #1

Medical Necessity

Twelve of the thirty beneficiaries included in the sample received services that did not meet Medicare reimbursement requirements. We found that the 12 beneficiaries received unnecessary therapies, totaling $141,878.

It was the practice of Stratford to admit all residents with standard admission orders in which the following were directed: "Evaluate and treat as indicated: PT/OT/ST; Evaluate and treat as necessary: psychological, podiatry, dental, ophthalmological, audiology."

We also found that beneficiaries re-admitted to Stratford following a hospital stay, regardless of the hospital stay duration, were again evaluated on re-admission, and based on standard orders therapies were resumed. Some of these beneficiaries had previously been discharged from their various therapies as having reached "maximum potential."

The medical records were silent as to the physicians' rationale for the need to evaluate and treat for the entire range of therapies ordered in the Standard Admission Order.

These practices preclude the admitting or attending physician and the nursing staff from performing the individual assessment of need to determine each resident's rehabilitation potential. This practice also precludes an interdisciplinary team approach to the resident's care that ensures that diagnostic and treatment services by therapists are provided only when there are specific medical indications for such services.

In addition, the records revealed that the physicians' orders were often not signed timely, and frequently were signed after the evaluation of the resident had been accomplished, and therapies were initiated. The therapist called physicians with recommendations for therapy and secured telephone/clarification orders which were also not signed in a timely manner by the physician.

Based on the review of the medical records, we determined that Stratford billed for the following medically unnecessary units of therapy:

935 units of physical therapy @ $50 per 15-minute unit, totaling $46,750 or 11% of the $408,400 billed for physical therapy for the 30 beneficiaries in the sample.

(PART A, 425 units, $21,250 questioned of the $267,300 reviewed)
(PART B, 510 units, $25,500 questioned of the $141,100 reviewed)

537 units of occupational therapy @ $47 per 15-minute unit, totaling $25,239 or 9% of the $256,620 billed for occupational therapy for the 30 beneficiaries in the sample.

(PART A, 485 units, $22,795 questioned of the $188,799 reviewed)
(PART B, 52 units, $ 2,444 questioned of the $67,821 reviewed)

1,487 units of speech therapy @ $47 per 15-minute unit, totaling $69,889 or 24% of the $281,248 billed for speech therapy for the 30 beneficiaries in the sample.

(PART A, 1,023 units, $48,081 questioned of the $180,480 reviewed)
(PART B, 464 units, $21,808 questioned of the $100,768 reviewed)

RECOMMENDATIONS

We recommend that:

- The Intermediary and State Agency should direct the provider to: 1) cease the practice of using Standard Admission Orders that permit therapy staff to initiate admission evaluations for all therapies and institute therapies on residents prior to a documented physician's assessment and a signed physician's order; 2) ensure that physicians' orders are secured and signed in a timely manner and prior to residents undergoing evaluations for specialized services; 3) ensure that residents re-admitted to the facility following hospitalization, are assessed by the admitting physician as to the need for specialized services.

- The Intermediary should recover the $141,878 identified in our survey. We are also recommending that the Intermediary identify and recoup all overpayments made to

Stratford for unnecessary therapy services, since the period of our review.

FINDING #2

Non-Supported Therapy Units

Review of the medical records for the 30 beneficiaries revealed a lack of evidence in nursing or therapy notes to show that the therapist billing for therapy services had involvement with the beneficiary on the day indicated in the monthly billing documentation.

The following billed therapy units, totaling $19,896, were not supported by documentation in the medical records:

240 units of physical therapy @ $50 per 15-minute unit, totaling $12,000 or 2% of the $408,400 billed for physical therapy for the 30 beneficiaries in the sample.

(PART A, 127 units, $ 6,350 questioned of the $267,300 reviewed)
(PART B, 113 units, $ 5,650 questioned of the $141,100 reviewed)

74 units of occupational therapy @ $47 per 15-minute unit, totaling $3,478 or 1% of the $256,620 billed for occupational therapy for the 30 beneficiaries in the sample.

(PART A, 74 units, $ 3,478 questioned of the $188,799 reviewed)

94 units of speech therapy @ $47 per 15-minute unit, totaling $4,418 or 2% of the $281,248 billed for speech therapy for the 30 beneficiaries in the sample.

(PART A, 43 units, $ 2,021 questioned of the $180,480 reviewed)
(PART B, 51 units, $ 2,397 questioned of the $100,768 reviewed)

RECOMMENDATION

We recommend that:

- The Intermediary and State Agency should direct the provider to ensure that medical records of beneficiaries undergoing specialized therapy services are documented to show the specific service being provided. The records should document date and time of service, as well as the signature and professional credentials of the therapist.

- The Intermediary should recover the $19,896 for undocumented therapy services identified in the survey. We are also recommending that the Intermediary identify

and recoup all overpayments made to Stratford for undocumented therapy services since the period of our review.

OTHER MATTERS

Evaluations on Day of Admission

Evaluations for Medicaid residents were completed on the day of admission, but the therapies were not initiated until the payment source was confirmed.

RECOMMENDATION

We recommend that:

- The State Agency should direct the provider to ensure that all residents are provided the same quality of care. All residents undergoing evaluations for specialized services should have therapies initiated in a timely manner, regardless of payment source.

Overlap of Physical and Occupational Therapies

There was overlap of physical therapy and occupational therapy services for activities of daily living. Residents receiving physical therapy were also receiving occupational therapy, although loss or diminished skills in activities of daily living were not evident.

RECOMMENDATION

We recommend that:

- The Intermediary and State Agency should direct the provider to be alert for duplication of therapy services.

Billing

All therapies were logged and billed in 15 minute units. The records showed that Stratford included in the 15 minute unit, the therapist's time spent charting, care planning, teaching the regular nursing staff methods of continuing the therapies initiated, and meetings to discuss residents. Medicare was billed on the basis of visits but the dollar value for these visits was calculated on a 15 minute unit. The Intermediary indicated that a 15 minute unit, by the clock, was the recognized billing standard for the industry. The HCFA defines billable hours as the time that therapist spends with the patient.

Based on the HCFA definition that the 15 minute unit is a "by the clock" 15-minute, the following irregularities were noted:

individual therapists daily hours billed exceeded 32 units. 32 units would be 8 hours.

Residents receiving multiple, simultaneous therapies, received therapy services which exceeded 32 units.

In addition, physical therapy assistants billed for services at the same rate as physical therapists. Certified respiratory therapists were billing their services at the same rate as registered respiratory therapist. We also noted that Stratford was billing for outpatient Part B therapies for residents of the apartment complex adjacent to the facility who were not residents of the facility. If overhead cost associated with these billings is included in the cost report, it could result in an overcharge to Medicare.

RECOMMENDATION

We recommend that

- The Intermediary should direct the provider to cease the practice of billing for therapists's time spent in charting, care planning, teaching of nursing staff, and meetings to discuss residents, and ensure that therapists will document the residents' medical record when service is provided by another non-credentialed member of the therapy team. Billings of therapy units should be supported by documentation in the resident's medical record. In addition, Stratford should be directed to stop billing for services provided to residents of the adjacent complex who are not inpatients of the facility.