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

February 28, 1997

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue, 11th Tower
Jacksonville, FL 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 review conducted at Florida Hospital Transitional Care Unit (Medicare provider number 10-5759), a skilled nursing facility located in Orlando, 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 January 1994 through December 31, 1995.

The ORT reviewers questioned $52,318 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 22 of the 24 beneficiaries in the sample. The disallowed cost consists of $35,513 for occupational, physical, speech, and respiratory therapy services; $1,068 of charges for psychological services; $10,620 for supply services; $1,964 for laboratory services; and $3,153 of charges for x-rays and other tests that were not medically necessary, undocumented or not covered by Medicare. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a focused review of all occupational therapies since the period of our review and the use of standing orders for all therapies be conducted by the FI 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 to the FI in this 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,

Rose Crum-Johnson
HCFA Regional Administrator - Reg IV

Charles Curtis
Regional Inspector General - Audit

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February 28, 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 Florida Hospital Transitional Care Unit (Medicare provider number 10-5759), a skilled nursing facility located in Orlando, 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 January 1994 through December 31, 1995.

The ORT reviewers questioned $52,318 in charges reported for 22 of the 24 beneficiaries in our study and we are recommending an adjustment of the above charges. In addition, we request that the State Agency initiate corrective action with this facility, especially related to the use of standing orders for Rehab therapies.

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 directed to the State agency in this 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,

Dale K Kendrick
for
Rose Crum-Johnson
HCFA Regional Administrator - Reg IV

Charles Curtis
Regional Inspector General - Audit

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I. EXECUTIVE SUMMARY

This report provides the results of our Operation Restore Trust (ORT) survey of Florida Hospital Transitional Care Unit (FHTCU), a skilled nursing facility (SNF) in Orlando, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Part A Fiscal Intermediary (Intermediary) and Part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. For these services to be allowable they must be:

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

A team consisting of a Florida State Agency for Health Care Administration (State Agency) nurse surveyor, a Regional Health Care Administration (HCFA) nurse consultant, and an Office of Inspector General (OIG) Office of Audit Services auditor conducted an unannounced focused survey at FHTCU. The members of the team evaluated the services for 24 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994.

We found $52,318 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 22 of the 24 beneficiaries in the sample. The disallowed cost consists of $35,513 for occupational, physical, speech and respiratory therapy services, $1,068 of charges for psychological services, $10,620 for supply services, $1,964 for laboratory services and $3,153 of charges for x-rays and other tests that were not medically necessary, undocumented or not covered by Medicare.

In addition, we noted that a charge of $26,907 for one of the 24 beneficiaries, was for services related to an automobile accident, for which Medicare may be a secondary payor.

The therapy overcharges of $35,513 occurred because all patients received standing orders on admission for evaluation of need for Occupational(OT), Physical (PT), Speech (ST) and Respiratory therapy (RT) services. The SNF rarely documented the need for OT. Every evaluation conducted by the OT therapist included the same goals: transfer on and off the commode, transfer in and out of the shower, energy conservation and the use of adaptive devices. It was difficult to determine from the progress notes how much progress the residents were making toward their goals. It was also not

clear why residents only met their goals at the time of discharge. Not one resident met his or her goal before discharge.

The SNF routinely ordered psychological services (PyT) on every resident entering the facility. Also, the SNF routinely ordered group therapy for the family on admission. They did not document the physician's decision for PyT on admission in the medical records.

Review of the medical records for the 24 beneficiaries revealed a lack of evidence in nursing or therapy notes to show that they had rendered services to the beneficiary.

The FHTCU submitted charges to the Intermediary that were for not covered services or represented items considered routine and covered by the daily room and board rate. This cost category contained many charges for special beds for weighing the patients, and air sack beds for residents with pressure sores.

We are recommending that the Intermediary make an adjustment of $52,318 for questioned charges and further investigate $26,907 for charges reported by the SNF on its FY 1994 cost report for services of one beneficiary that were related to an automobile accident.

REGION IV OPERATION RESTORE TRUST PILOT

FOCUSED REVIEW OF A SKILLED NURSING FACILITY

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:

- o home health,
- o nursing homes,
- o hospice, and
- o 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, ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified through investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) has identified certain SNFs 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 statistical data 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. BDMS generated a listing of SNFs with high reimbursement amounts per day and per stay. The listing of SNFs was manually scanned and 14 were judgementally selected based on total highest reimbursement.

In addition to these 14 SNFs, we requested the two principal fiscal intermediaries in Florida (AETNA and Blue Cross) to each identify 3 SNFs for inclusion in this project based upon their data, complaints, and experience with SNF providers.

Florida Hospital Transitional Care Unit was one of the 14 SNFs judgementally selected for review. It was selected for the survey based upon its high therapy costs, high average length of stay by the residents, high cost per stay, and high cost per day.

III. SCOPE OF REVIEW

The survey was conducted by a team comprising a nurse surveyor from the State Agency, a nurse consultant from HCFA , and an auditor from the 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.

The objective of the survey was to determine whether charges other than room and board, billed to the Intermediary and 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 24 beneficiaries in our sample, for whom FHTCU billed Medicare $913,071 during the period January 1, 1994 through December 31, 1994. The facility's Medicare fiscal period is January 1 through December 31. FHTCU charged $2,335,428 in its cost report for fiscal year 1994. 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 24 beneficiaries in our sample during their stay at FHTCU between January 1994 and December 1994. This approach was adopted because many providers, other than FHTCU 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's bills.

Using the team concept, the State Agency and HCFA nurses identified Medicare funded services which were either not reasonable or necessary, and the OIG auditor quantified the charges associated with the services. The beneficiaries' medical records and related documentation were reviewed to determine the medical necessity of charged services; specifically, were the services: (I) recorded in the medical records, (ii) ordered by a physician, (iii) rendered by qualified personnel, and (iv) appropriate considering the physicians' diagnosis and the residents' physical/mental condition. The SNF's accounting records and supporting documentation were reviewed to determine: (I) the bases for charges reported to Medicare, and (ii) the amount of charges associated with questioned services.

Field work was performed at the SNF's offices in Orlando, Florida during the period May 6 through May 10, 1996.

IV. FINDINGS AND RECOMMENDATIONS

The review of the 24 beneficiaries included in our survey consisted of a retrospective analysis of their payment history for rehabilitative services under Part A and services provided under Part B while residents of the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 24 beneficiaries resulted in disallowance of $52,318 in charges reported by FHTCU in its FY 1994 Medicare Cost Report. We found $52,318 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 22 of the 24 beneficiaries in the sample. The disallowed cost consists of $35,513 for occupational, physical, speech and respiratory therapy services, $1,068 of charges for psychological services, $10,620 for supply services, $1,964 for laboratory services and $3,153 of charges for x-rays and other tests which were not medically necessary, undocumented or not covered by Medicare.

In addition, we noted that charges of $26,907 for 1 of the 24 beneficiaries, were for services related to an automobile accident.

QUESTIONED CHARGES

	Billed	Questioned	Percentage
THERAPIES:			
Occupational	$ 81,184	$ 32,796	40%
Physical	96,218	1,051	1%
Speech	14,917	1,404	9%
Respiratory	13,582	262	2%
Subtotal	$205,901	$ 35,513	17%
Psychological	$ 9,311	1,068	11%
Supplies	73,558	10,620	14%
Laboratory	52,421	1,964	4%
X-rays & Other Tests	76,241	3,153	4%
Total	$417,432	$ 52,318	13%

OCCUPATIONAL, PHYSICAL, SPEECH, AND RESPIRATORY THERAPY SERVICES

We questioned $35,513 of occupational (OT), physical (PT), speech (ST) and respiratory (RT) provided 22 of the 24 beneficiaries included in our sample. Under paragraph 1861(h)(3) of the Social Security Act, these services are covered under Medicare Part A when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist. The Medicare Intermediary Manual at paragraph 3132 (MIM 3132) states that the ordered therapies provided in a SNF must be reasonable and necessary for the treatment of the beneficiary's illness or injury. The questioned charges did not meet the reimbursement criteria.

FINDING #1

Occupational Therapy Services

We questioned the medical necessity, documentation, and coverage of $32,796 for OT provided to 20 of 24 beneficiaries that FHTCU was reimbursed during the period of our review. 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. OT 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 with a reasonable period of time. We do not believe a basis existed for an expectation that the OT services provided would significantly improve the four residents' level of functioning.

Our review of the residents' records showed the OT services were not medically necessary. Additionally, patient care conferences were billed under the therapies, did not involve face to face contact with the patients and are not a covered service.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $32,796 from OT charges reported by the SNF on its FY 1994 cost report.
- Conduct a focused review of all OT services provided at FHTCU from January 1, 1994 to the present.

We recommend that the State Agency should:

- Ensure through a Corrective Action Plan that O.T. services are appropriately ordered by the physician, documented, and provided to patients who have been accurately assessed with a medical need or indication for such services.

FINDING # 2

Physical Therapy Services

We questioned the medical necessity, documentation, and coverage of $1,051 for PT provided to 12 of 24 beneficiaries that FHTCU was reimbursed during the period of our review. 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 be the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (M.M. 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.

Our review of the medical records for PT for the 24 beneficiaries revealed a lack of evidence in nursing or therapy notes to show that services had been rendered to the beneficiary. Additionally, patient care conferences were billed under the therapies, did not involve face to face contact with the patients and are not a covered service.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $1,051 from PT charges reported by the SNF on its FY 1994 cost report.

We recommend that the State Agency should:

- Review medical records for documentation that physical therapy services provided were rendered.

FINDING #3

Speech Therapy Services

We questioned the medical necessity, documentation, and coverage of $1,404 for ST provided to 4 of 24 beneficiaries that FHTCU was reimbursed during the period of our review. 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.

Our review of the residents' records showed the ST services were not medically necessary. Additionally, review of the medical records for the 24 beneficiaries revealed a lack of evidence in nursing or therapy notes to show that services had been rendered to the beneficiary. Also, patient care conferences were billed under the therapies, did not involve face to face contact with the patients and are not a covered service.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $1,404 from ST charges reported by the SNF on its FY 1994 cost report.

We recommend that the State Agency should:

- Review medical documentation that speech therapy services provided were rendered.

FINDING #4

Respiratory Therapy Services

We questioned the medical necessity, documentation, and coverage of $262 for RT provided to 2 of 24 beneficiaries that FHTCU was reimbursed during the period of our review. These services are reimbursable under Medicare Part A if furnished by a transfer hospital or by a nurse on the staff of the skilled nursing facility. The services are considered medically necessary and reasonable if they meet the following criteria.

- Consistent with the nature and severity of the individuals's complaints and diagnosis,
- Reasonable in terms of modality, amount, frequency, and duration of the treatments, and
- Generally accepted by the professional community as being safe and effective treatment for the purpose used.

Our review of the residents' records showed the RT services were not medically necessary.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $262 from RT charges reported by the SNF on its FY 1994 cost report.

FINDING #5

Psychological Services

We questioned $1,068 of other services charged to 4 of the 24 beneficiaries included in our sample. It was the practice of FHTCU that all patients received standing orders on admission for evaluation of need for PyT services. The medical records were silent as to the physician's rationale for the need to evaluate and treat for PyT services. 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. In addition, the records revealed that the physician's orders were often not signed timely, and frequently were signed after the evaluation of the resident had been accomplished and services were initiated. Also, review of the medical records for the 24 beneficiaries revealed a lack of evidence in nursing or therapy notes to show that services had been rendered to the beneficiary.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $1,068 from PyT services charged to the SNF on its FY 1994 cost report.

We recommend that the State Agency should:

- Ensure psychological services are rendered only after assessment of the need for such services and that appropriate physician orders are documented prior to the initiation of such services.

FINDING #6

Supplies

We questioned $10,620 of other services charged to 5 of the 24 beneficiaries included in our sample. Federal regulations 42 CFR 409.25 state that supplies, appliances, and equipment are covered as extended care services only if they are ordinarily furnished by the skilled nursing facility for the care and treatment of inpatients. We considered that these items should have been included in the room and board charge.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the $10,620 from supply charges reported by the SNF on its FY 1994 cost report.

FINDING #7

Laboratory Services

We questioned $1,964 of laboratory services charged to 4 of the 24 beneficiaries included in our sample. These charges were found to be either not medically necessary, not documented or not covered by Medicare.

RECOMMENDATION

We recommend that the Intermediary adjust the $1,964 from laboratory charges reported by the SNF on its FY 1994 cost report.

FINDING #8

X-rays and Other Tests

We questioned $3,153 of x-rays and other tests charged to 5 of the 24 beneficiaries included in our sample.

RECOMMENDATION

We recommend that the Intermediary adjust the $3,153 from x-rays and other tests reported by the SNF on its FY 1994 cost report.

FINDING #9

Medicare Secondary Payor Case

The SNF charged $26,907 for services related to an automobile accident.

RECOMMENDATION

We recommend that the Intermediary should further review the services provided to the beneficiary at FHTCU during the period of our review to determine if Medicare was credited for any recoveries from the auto insurance company.

TEAM MEMBERS

Veronica Stephens-Echols, RN, Health Care Financing Administration

Robert Julian, Auditor, Office of Inspector General - Audit Services

Margaret Bonnell, RN Specialist, Florida Agency for Health Care Administration