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** ★ ★ ★

December 13, 1996

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

A-04-96-01130

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 National Health Corporation (Medicare provider number 10-5772), a skilled nursing facility located in St. Petersburg, 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 1, 1994 through December 31, 1994.

The ORT reviewers questioned $32,239 in charges reported for the 7 sample beneficiaries in our study. This amount is comprised of $29,310 related to Physical, Occupational, and Speech therapy services rendered; $100.00 of unallowable RT services; $1,690 for unnecessary ambulance service charges for one beneficiary; and $1,139 for inappropriate enteral nutrients provided for one beneficiary. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a focused review of physical therapy 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 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,

Clarence Boone
HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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** ★ ★ ★

December 13, 1996

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

A-04-96-01130

Dear Mr. Kelly;

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at National Health Corporation (Medicare provider number 10-5772), a skilled nursing facility located in St. Petersburg, 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 1, 1994 through December 31, 1994.

The ORT reviewers questioned $32,239 in charges reported for the 7 sample beneficiaries in our study. This amount is comprised of $29,310 related to Physical, Occupational, and Speech therapy services rendered; $100.00 of unallowable RT services; $1,690 for unnecessary ambulance service charges for one beneficiary; and $1,139 for inappropriate enteral nutrients provided for one beneficiary. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a focused review of physical therapy 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 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,

Clarence Boone
HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust survey of National Health Corporation of St. Petersburg (NHC), a Skilled Nursing Facility (SNF) in St. Petersburg, Florida. 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. 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.

A team comprising a Florida State Agency for Health Care Administration (State agency) nurse-suveyor, 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 this SNF. The members of the team evaluated the services for 7 aberrant Medicare beneficiaries which resulted in questioned costs of $32,239. The details of our findings follow:

The SNF reported questionable charges of $29,410 in its Medicare cost report in 5 of the 7 cases. This amount consists of $26,375 for physical therapy, $1,935 for occupational therapy, $1,000 for speech therapy, and $100 for respiratory therapy services we determined were not reasonable, medically necessary, or properly documented in the medical records. We are recommending an adjustment of $29,410 for the charges reported by the SNF in its FY 1994 cost report. We are also recommending the FI do an in-depth review of all physical therapy services for FY 94-95 and that the State Agency take corrective action to ensure that this problem does not continue.

In addition to the services billed through the SNF cost report, we found two additional significant problem areas involving billings submitted directly to the Part B carrier. Ambulance service in the amount of $1,690 received by 1 of the 7 beneficiaries was not reasonable. The beneficiary was transported by ambulance to a wound care center and it was determined the wound could have been treated at the SNF.

We also found inappropriate enteral food items in the amount of $1,139 charged for 1 of the 7 beneficiaries. Enteral nutrients provided during a stay that is covered under Medicare part A are classified as a routine food item and should be included in the Part A payment to the SNF. This service was determined to be routine, not an ancillary charge and was therefore disallowed. We are recommending the Medicare Part B Carrier recover the $2,829 of charges determined not to be

allowable and investigate other payments to this supplier.

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 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 more than 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, OIG, and the Administration on Aging. These components are focusing attention on program vulnerabilities identified through investigations and audits.

The HCFA's Bureau of Data Management Services 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 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 Bureau of Data Management Services 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 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.

III. SCOPE OF REVIEW

This survey was conducted by a team comprised of 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. According, 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.

Under the authority of Section 1861(o)(6)(7) of the Social Security Act, the pilot survey was conducted at NHC St. Petersburg, a SNF with 20 Medicare certified beds. NHC St. Petersburg was selected for the survey based upon its high cost per stay and the high costs per day. This SNF had identified as aberrant 7 Medicare eligible beneficiaries during the period of our survey.

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 7 beneficiaries in our review the SNF billed Medicare Part A $213,339 during the period January 1, 1994 through December 31, 1994, the facility's Medicare fiscal period. The SNF claimed $1,106,057 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 7 beneficiaries during their stay at the SNF between January 1994 and December 1994. 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.

The sample of 7 aberrant beneficiaries was selected from the BDMS data and those medical records were reviewed to determine the causes of the high incidence 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 which have contractual arrangement with the facility. The medical records of these beneficiaries were evaluated to determine if the services were: 1) medically necessary, 2) rendered, 3) documented in the medical records, 4) ordered by a physician, and 5) supported by the resident's condition and diagnosis.

IV. FINDINGS AND RECOMMENDATIONS

Our evaluation of the services for 7 Medicare beneficiaries resulted in questioned costs of $32,239. The details of our findings are presented below:

INTERMEDIARY ISSUES

The SNF reported questionable charges of $29,410 in its Medicare cost report in 5 of the 7 cases. This amount is comprised of $26,375 for physical therapy, $1,935 for occupational therapy, $1,000 for speech therapy, and $100 for respiratory therapy services we determined were not reasonable, medically necessary or properly documented in the medical records. We are recommending an adjustment of $29,410 for the charges reported by the SNF in its FY 1994 cost report.

FINDING #1

Physical Therapy Services

We questioned $26,375 of physical therapy (PT) services provided to 4 of the 7 beneficiaries. 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 four beneficiaries were questionable because the services were not deemed effective treatment 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. In addition, the total amount of units billed by the facility to the Medicare program exceeded the amount supported in the patients' medical files.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $26,375 of charges related to those PT services.
- do an in-depth review of all physical therapy services from 1/1/94 to the present.

We are also recommending that the State Agency should take corrective action with this provider to ensure that:

- the provider conducts a comprehensive assessment of each resident's mental and physical capabilities at the time of admission to the facility and provides appropriate services.
- the provider assesses the adequacy of medical record documentation to support the medical necessity for physical therapy services

FINDING #2

Occupational Therapy Services

We questioned $1,935 of occupational therapy (OT) services provided 2 of the 7 beneficiaries. 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 individuals' illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury 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.

The OT services provided the two beneficiaries were questionable because the services were not deemed effective treatment 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.

RECOMMENDATION:

We recommend that the Fiscal Intermediary should:

- adjust the $1,935 of charges related to these specific OT services.

We recommend the State Agency take corrective action to ensure:

- the provider conducts a comprehensive assessment of each resident's mental and physical capabilities at the time of admission to the facility and provides this service as appropriate for each beneficiary.

FINDING #3

Speech Therapy Services

We questioned $1,000 of speech therapy (ST) services provided to one of the 7 beneficiaries. Speech 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
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 conditions 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 to the one beneficiary did not meet the medically necessary criteria because the patient was not considered an effective candidate for speech therapy based on the speech therapy evaluation.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $1,000 of charges related to those ST services.

We recommend the State Agency ensure that:

- the provider conducts a comprehensive assessment of each resident's mental and physical capabilities at the time of admission to the facility and provides this services only as appropriate.

FINDING #4

Respiratory Therapy Services

We questioned $100 for respiratory services provided to one of the 7 beneficiaries. In order to be covered under Medicare Part A, such services must be:

- prescribed by a physician and be performed by a qualified therapist;
- reasonable and necessary for the treatment of the individual's illness or injury; and
- under 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.

We determined that the SNF had a transfer agreement with Clearwater Community Hospital. However, we found no evidence of medical necessity or documentation in the medical records for respiratory services.

RECOMMENDATION:

We recommend that the Fiscal Intermediary should:

- adjust the $100 in charges for these Respiratory services.

We recommend the State Agency ensure that:

- the provider conducts a comprehensive assessment of each resident's respiratory needs and capabilities at the time of admission to the facility.

Carrier Issues

In addition to the services billed through the SNF cost report, we found two additional significant problem areas involving billings submitted directly to the Part B carrier involving ambulance services and enteral nutrients. These are detailed in findings 5 and 6.

FINDING #5

Ambulance Services

We questioned $1,690 in ambulance services charged to one of the 7 beneficiaries. CFR 410.40 outlines ambulance services and limitations. Medicare Part B pays for a round trip from a participating SNF to an outside supplier to obtain medically necessary diagnostic or therapeutic services which are not available at the SNF where the beneficiary is an inpatient. The beneficiary was transported to a wound care center and it was determined the wound care services could have been provided at the SNF.

RECOMMENDATION:

We recommend the carrier recover this $1,690 in unallowable ambulance charges and evaluate whether other payments to this provider should be investigated.

FINDING #6

Enteral Nutrients

We questioned $1,139 for enteral nutrients (i.e., Ensure) charged to one of the 7 beneficiaries. Enteral nutrients provided during a stay are covered under Medicare part A and classified as food. Food items should be included in the Part A payment to the SNF. This food item was determined to be routine, not an ancillary charge and was therefore disallowed.

RECOMMENDATION:

We recommend the DMERC recover the $1,139 of charges determined not to be allowable and evaluate whether other claims from this supplier should be investigated.

TEAM MEMBERS

Sheila Kanaly, RN, M. P. H., Nurse Consultant, Health Care Financing Administration

Katherine Burnside, Auditor, Office of Inspector General - Office of Audit.

Ann DaSilva, RN Specialist, Florida Agency for Health Care Administration