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

December 13, 1996

A-04-96-01136

Ms. Terri Ginnetti, Benefits Integrity Unit
Aetna Life Insurance, Co.
25400 US 19 North
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 Savanna Cay Manor (Medicare provider number 10-5579), a skilled nursing facility located in Port St. Lucie, 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 $354,537 in charges reported for the 20 sample beneficiaries in our study. This amount is comprised of $349,835 related to Physical, Occupational, and Speech therapy services rendered; $16,064 of unallowable RT services; $684 in unallowable pharmacy charges; $4,702 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 physician orders for these 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 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

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December 13, 1996

A-04-96-01136

Mr. Marshall Kelly, Director
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 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 review conducted at Savanna Cay Manor (Medicare provider number 10-5579), a skilled nursing facility located in Port St. Lucie, 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,

Clarence Boone
HCFA Regional Administrator

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 Savanna Cay Manor, a Skilled Nursing Facility (SNF) in Port St. Lucie, 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 based on applicable Federal regulations and implementing instructions under the Medicare guidelines. 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;
- reasonable in amount, frequency, and duration; and
- fully supported by the patient medical records.

We reviewed the medical records of twenty beneficiaries at the SNF covering charges made for the period January 1, 1994 to December 31, 1994. We found $354,537 in charges reported by the SNF and private contractors that did not meet the Medicare reimbursement guidelines as stated above. The disallowed costs consists of $349,835 in therapy charges that relate to Fiscal Intermediary issues and $4,702 in physician, psychiatric, and other services that relate to Carrier issues.

The therapy overcharges of $349,835 occurred because the SNF prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services, and without prior authorization of a physician. The amount is comprised of $153,478 for occupational therapy, $109,520 for speech therapy, $65,500 for physical therapy, $16,064 for respiratory therapy, and $4,589 for routine therapy services that we determined were not reasonable or medically necessary, and a $684 pharmacy charge for which there was no supporting documentation. We are recommending that the FI make an adjustment of $349,835 for the charges reported by the SNF in it's FY 1994 cost report and conduct a focused review of therapy services provided by this SNF during FY 94-95. We are also recommending that the State Agency take corrective action to ensure that the above problems identified do not continue.

We found $4,702 in charges submitted directly to the Part B carrier which did not meet Medicare guidelines. These services were provided under agreement with private contractors and billed as other services, physician services, and psychiatric services received by 14 of the 20 beneficiaries. The private contractor's treatments of SNF patients were not documented in some cases, and determined to not be medically necessary in others. We found that only brief notes by the therapist

were included in the records and there was little evidence that a plan of care was developed. Furthermore, 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 recommending that the carrier recoup the $4,702 of unallowable charges identified during our survey. We are also recommending that the Carrier conduct a focused review of these other services and recoup additional payments made to these contractors for these unallowable services at Savanna Cay Manor Rehabilitation Center.

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:

- home health
- nursing homes
- hospice
- durable medical equipment (DME).

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 the Health Care Financing Administration (HCFA), the Office of Inspector General (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 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 of the facilities with high reimbursement amounts per day and per stay were generated by BDMS. The final listing of SNF providers was manually scanned and 14 SNFs with the highest reimbursement were selected for review.

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.

II. SCOPE OF REVIEW

The survey was conducted by a team comprising a Nurse surveyor from the Florida State Agency for Health Care Administration (State Agency), a Nurse consultant from HCFA, and an Auditor from the OIG office of Audit Services. This HCFA's 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.

Under the authority of Section 1861 (o)(6)(7) of the Social Security Act, the pilot survey was conducted at Savanna Cay Manor, a SNF with 120 beds, 119 of which are Medicare certified. It was selected for the survey based upon aberrant BDMS data for high cost per stay, and the high cost per day. Savanna Cay Manor is owned and operated by the Beverly Nursing Home Corporation.

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 20 beneficiaries in our sample, for whom Savanna Cay Manor billed Medicare $905,653 during the period January 1, 1994 through December 31, 1994. The facility's Medicare fiscal period is January 1 through December 31. Savanna Cay Manor charged $2,415,796 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 20 beneficiaries in our sample during their stay at Savanna Cay Manor between January 1994 and December 1994. This approach was adopted because many providers, other than Savanna Cay Manor bill separately for services to the SNF patients, e.g., podiatrist, 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.

A sample of 20 aberrant beneficiaries was selected from the BDMS data and the medical records reviewed to determine the cause(s) of the 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 which have contractual arrangement with the facility. The medical records of these patients 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

The review of the 20 beneficiaries included in our survey consisted of a retrospective analysis of their payment history for rehabilitative services under Medicare part A and services provided under part B while residents in the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 20 beneficiaries resulted in questioned costs of $354,537. The details of our findings are presented below:

UNALLOWABLE CHARGES	
Occupational Therapy	$153,478
Speech Therapy	109,520
Physical Therapy	65,500
Respiratory Therapy	16,064
Routine Therapy	4,589
Pharmacy Services	684
Total	$349,835

FISCAL INTERMEDIARY ISSUES

Our review disclosed that $349,835 in charges reported by the facility in FY 1994 for the 20 beneficiaries included in our sample did not meet Medicare reimbursement guidelines. The amount questioned includes $153,478 for occupational therapy, $109,520 for speech therapy, $65,500 for physical therapy, $16,064 for respiratory therapy, $4,589 for routine therapy services, and a $684 pharmacy charge which we believe was not reasonable or medically necessary. We are recommending an adjustment of $349,835 to the charges reported by the facility.

FINDING #1

Occupational Therapy Services

We questioned $153,478 of occupational therapy (OT) services provided to 18 of the 20 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 an individual's illness or injury (42 CFR 409.31) 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 beneficiaries' level of functioning. In addition, the total amount of units billed by the facility to the Medicare program exceeded the amount supported in the patient medical files. In some cases residents who were very ill died immediately after reaching their maximum potential of occupational therapy treatment.

RECOMMENDATION:

We recommend that the Fiscal Intermediary:

- adjust the $153,478 of charges related to these specific OT services.
- conduct a focused review of all OT services provided at Savanna Cay Manor from 1/1/94 to the present.

We recommend the State Agency take corrective action 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.
- OT services are only provided as appropriate for each beneficiary.

FINDING #2

Speech Therapy Services

We questioned $109,520 of speech therapy (ST) services provided to 16 of the 20 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 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 (42 CFR 409.31). 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 to these 16 beneficiaries did not meet one or more of the above criteria. This occurred because the facility's initial screening of residents failed to provide a comprehensive assessment of their mental and physical capabilities. There was no evidence of involvement by the physician or utilization of the resident assessment protocols during the assessment. In addition, the total amount of units billed by the facility to the Medicare program exceeded the amount supported in the patient medical files.

RECOMMENDATION:

We recommend that the Fiscal Intermediary:

- adjust the $109,520 of charges related to these specific ST services.

- conduct a focused review of all ST services provided at Savanna Cay Manor from 1/1/94 to the present.

We recommend the State Agency should take corrective action 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.

- speech therapy services are provided as appropriate for each beneficiary.

- documentation in medical records includes specific physician orders for speech services and the use of Resident Assessment Protocols (RAPs) during the initial evaluation for services.

FINDING #3

Physical Therapy Services

We questioned $65,500 of physical therapy (PT) services provided to 16 of the 20 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 (42CFR 409.31). 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 to the beneficiaries were questioned 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 no evidence of involvement by the physician or utilization of the resident assessment protocols during the assessment. In addition, the total amount of units billed by the facility to the Medicare program exceeded the amount supported in the patient medical files.

RECOMMENDATION:

We recommend that the Fiscal Intermediary:

- adjust the $65,500 of charges related to those PT services.
- conduct a focused review of all PT services provided at Savanna Cay Manor from 1/1/94 to the present.

We recommend the State Agency take corrective action 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.
- documentation in the medical records includes physician orders for physical therapy services.
- physical therapy utilizes the Resident Assessment Protocols (RAPs) during the initial evaluation phase.

FINDING #4

Respiratory Therapy Services

We questioned $16,064 for respiratory services provided to 5 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. Medicare reimbursement for respiratory therapy services are allowable only if they are provided by a hospital with which the SNF has a transfer agreement or by a nurse on the staff of the SNF (42 CFR 409.27). We reviewed the medical records for five beneficiaries and found no bases for which these patients needed respiratory therapy. In addition, there was little evidence of involvement by the physician or utilization of the resident assessment protocols during the assessment.

RECOMMENDATION:

We recommend that the Fiscal Intermediary:

- adjust the $16,064 of charges related to those respiratory services.
- conduct a focused review of all respiratory services provided at Savanna Cay Manor from 1/1/94 to present.

We recommend the State Agency take corrective action to ensure that:

- the provider to conduct a comprehensive assessment of each resident's mental and physical capabilities at the time of admission to the facility.
- documentation in medical records includes physician orders for Respiratory Therapy services and evidence of use of the Resident Assessment Protocols (RAPs) prior to the provision of this services.

FINDING #5

Routine Therapy Services

We questioned $4,589 for routine therapy services provided to 16 beneficiaries included in our sample. In order for these services 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. We do not believe that these charges related

to routine therapy services are allowable because these services can and should be done as part of the patient daily care included in room and board.

RECOMMENDATION:

We recommend that the Fiscal Intermediary:

- adjust the $4,589 of charges related to those routine therapy services.
- conduct a focused review of all routine therapy services provided at Savanna Cay Manor from 1/1/94 to the present.

We recommend the State Agency take corrective action to ensure that:

- documentation in medical records supports the use of routine physical therapy services separate from routine nursing services provided.

FINDING #6

Pharmacy Services

We questioned $684 charged for pharmacy services not related to medical necessity for four patients in our review sample. In addition, intravenous (IV) services claimed for an individual where the patient's record indicated that the services were not rendered.

RECOMMENDATION:

We recommend that the Fiscal Intermediary adjust the $684 in charges for these pharmacy services.

CARRIER ISSUES

In addition to services provided by the SNF, the survey also addressed the following Medicare Part B funded services furnished by providers other than the SNF: Physician services, Psychological services, and Other services. Our review of medical records for the 20 beneficiaries resulted in questioned costs of $4,702. The details of our findings are presented below.

UNALLOWABLE PART B CHARGES	
Physician Services	$2,500
Psychiatry services	2,093
Other Services	109
Total	$4,702

FINDING #7

Physician Services

We questioned $2,500 for physician services charged to 9 of the 20 beneficiaries included in our sample. Based on the records reviewed for resident's requiring visits by outside physicians, it was determined that the doctors notes were duplications of services provided by the attending physician's physical examination and physical therapist's evaluation. In addition, there were multiple charges for visits to the residents; however, progress notes documented by the doctor and the physical therapist contained the same information. There were also charges by the same doctor for psychiatry services for which there were no physician orders or medical justification. Therefore, these services were determined not to be medically necessary.

RECOMMENDATION:

We recommend that the Part B carrier recoup payments of $2,500 for these undocumented physician visits.

FINDING #8

Psychological Services

We questioned $2,093 for psychological services charged to 11 of the 20 beneficiaries included in our sample. Based on our review of the records, we determined that the services were not medically necessary. Although the attending physician ordered psychiatric evaluation and treatment, there was no evidence that the services provided by the doctor (a psychologist) resulted in individualized care and treatment. There was evidence that the physician placed at least one of the residents who was suffering from chronic pain in group therapy. There was no documentation in this resident's medical record which indicated that the patient was evaluated and that it was determined that group therapy would be the treatment of choice. In addition, there was no documented evidence of identified

problems which determined the goals for these 11 residents.

RECOMMENDATION:

We recommend that the Part B carrier recoup payments of $2,903 for these undocumented psychological services and conduct a focused review of all psychological services provided by this SNF from 1/1/94 to the present.

FINDING #9

Other Services

We questioned $109 related to other services. Based on our review of the residents' records, we could not determine the medical necessity for these charges. Therefore, the costs related to these services should be disallowed.

RECOMMENDATION:

We recommend that the Part B carrier recoup payments of $109 for these undocumented other services.

TEAM

Veronica Stephens-Echols, RN, Nurse Consultant, Health Care Financing Administration

Mary Jane Battaglia, RN Specialist, Florida Agency for Health Care Administration

Mervyn Carrington, Auditor, Office of Inspector General of Audit Services