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

December 13, 1996

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 Daytona Nursing Home (Medicare provider number 10-5665), a skilled nursing facility located in Daytona Beach, 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 $76,130 in charges reported for the 12 sampled beneficiaries in our study. This amount consists of $75,472 related to Physical Occupational, and Speech therapy services renders; $234 in unallowable pharmacy charges, $312 in inappropriate physician payments and $658 in other services billed to the Part B carrier. 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 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

A-04-96-01137

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★ ★ ★ **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

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 Daytona Nursing Home (Medicare provider number 10-5665), a skilled nursing facility located in Daytona Beach, 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 $76,130 in charges reported for the 12 sampled beneficiaries in our study. This amount consists of $75,472 related to Physical Occupational, and Speech therapy services renders; $234 in unallowable pharmacy charges, $312 in inappropriate physician payments and $658 in other services billed to the Part B carrier. 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 FI and State agency in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

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Sincerely,

Clarence Boone
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I. EXECUTIVE SUMMARY

This report provides the results of our Operation Restore Trust (ORT) survey of Daytona Nursing Home, a Skilled Nursing Facility (SNF) in South Daytona, 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.

The team reviewed the medical records of twelve beneficiaries at the SNF covering charges made for the period January 1, 1994 to December 31, 1994. We found $76,130 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 $75,472 in therapy charges that relate to Fiscal Intermediary issues and $658 in physician, psychiatric, and other services that relate to Carrier issues.

The therapy overcharges of $75,472 occurred because the SNF prescribed therapy services to all its residents upon admission and readmission without specific medical indications for such services, and without prior authorization of a physician. The amount is comprised of $49,769 for occupational therapy, $13,720 for speech therapy, and $11,749 for physical therapy services that we determined were not reasonable or medically necessary, and a $234 pharmacy charge for which there was no supporting documentation. We are recommending that the FI make an adjustment of $75,472 for the charges reported by the SNF in its cost report for fiscal year (FY) 1994. We are also recommending that the State Agency take corrective action to ensure that this problem does not continue.

We found $658 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 psychiatric services, physician services, and other services received by four of the 12 beneficiaries. The private contractor's treatment 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 a 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 $658 of unallowable charges identified during our survey. We are also recommending that the Carrier conduct a focused review and recoup all additional payments made to these contractors for those unallowable services at South Daytona Nursing Home.

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 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 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 SNFs for review in this project, based upon their data, complaints, and experience with SNF providers.

III. 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 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 survey was conducted at Daytona Nursing Home, a SNF with 65 Medicare certified beds. Daytona Nursing Home was selected for the survey based upon its high therapy costs, high cost per stay, and the high cost per day. Daytona Nursing Home 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 FI 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 12 aberrant beneficiaries in our sample, for whom Daytona Nursing Home billed Medicare $274,546 during the period January 1, 1994 through December 31. Daytona Nursing Home charged $578,749 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 crossover claims for each of the 12 beneficiaries in our sample during their stay at Daytona Nursing Home between January 1994 and December 1994. This approach was adopted because many providers, other than Daytona Nursing Home bill separately for services to the SNF patients, e.g., podiatrists, portable x-rays 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.

A sample of 12 aberrant beneficiaries was selected from the BDMS list and the medical records were 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 arrangements 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

UNALLOWABLE CHARGES	
Occupational Therapy	$49,769
Speech Therapy	13,720
Physical Therapy	11,749
Pharmacy Services	234
Total	$75,472

Our review of the 12 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 in the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 12 beneficiaries resulted in questionable costs of $76,130. The details of our findings are presented below.

FISCAL INTERMEDIARY ISSUES

Our review disclosed that $75,472 in charges reported by the facility in FY 1994 for the 12 beneficiaries included in our sample did not meet Medicare reimbursement guidelines. The amount questioned includes $49,769 for occupational therapy, $13,720 for speech therapy, $11,749 for physical therapy services, and a $234 pharmacy charge which we believe were not reasonable or medically necessary. We are recommending an adjustment of $75,472 to the charges reported by the facility.

FINDING #1

Occupational Therapy Services

We questioned $49,769 of occupational therapy (OT) services provided to 10 of the 12 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. OT designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury (42 CAR 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's medical files.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $49,769 of charges related to these specific OT services.

- conduct a focused review of all OT services provided at Daytona Nursing Home from 1/1/94 to the present.

We recommend that the State Agency should take corrective action with this facility 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 services appropriate for each beneficiary.

FINDING #2

Speech Therapy Services

We questioned $13,720 of speech therapy (ST) services provided to six of the 12 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 (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 six 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's medical files.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $13,720 of charges related to these specific ST services.
- conduct a focused review of all ST services provided at Daytona Nursing Home from 1/1/94 to the present

We recommend that 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 and ensure that services provided are appropriate for each beneficiary.

FINDING #3

Physical Therapy Services

We questioned $11,749 of physical therapy (PT) services provided to 10 of the 12 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 to the 10 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 residents failed to provide a comprehensive assessment of their mental and physical capabilities. There was no evidence of involvement by the physician or of utilization of the resident assessment protocols during the assessment.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $11,749 of charges related to those PT services.

- conduct a focused review of all PT services provided at Daytona Nursing Home for the period of our review.

We recommend that 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 and ensure that services provided are appropriate for each beneficiary.

FINDING #4

Pharmacy Services

We questioned $234 charged for pharmacy services not supported by the patient records for three beneficiaries in our sample.

RECOMMENDATION

We recommend that the Fiscal Intermediary should:

- adjust the $234 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: Psychological services, Physician services, and Other services. Our review of medical records for the 12 beneficiaries resulted in questioned costs of $658. The details of our findings are presented below.

COSTS FOR CONCERN	
Other Services	$319
Physician Services	312
Psychological Services	27
Total	$658

FINDING #5

Other Services

We questioned $319 related to other services. Based on our review of the residents' records, we could not determine the medical necessity for these charges.

RECOMMENDATION

We recommend that the Carrier should recoup payments of $319 for these undocumented services.

FINDING #6

Physician Services

We questioned $312 for physician services charged to 2 of the 12 beneficiaries included in our sample. Based on the records reviewed for residents requiring visits by outside physicians, it was determined that there were no doctors progress notes to support the services billed to the Medicare program. Therefore, these services were determined not to be medically necessary.

RECOMMENDATION

We recommend that the Carrier recoup payments of $312 for these undocumented physician visits.

FINDING #7

Psychological Services

We questioned $27 for psychological services charged to 1 of the 12 beneficiaries included in our sample. Based on our review of the records, we determined that the services were not medically necessary. There was no documentation in the resident's record to indicate the residents were evaluated and in need of such services.

RECOMMENDATION

We recommend that the Carrier recoup payments of $27 for these undocumented psychological services.

TEAM

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

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Andrew Funtel, Auditor, Office of the Inspector General, Office of Audit Services

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