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

February 6, 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 Bon Secours-Venice Hospital (Medicare provider number 10-5753), a skilled nursing facility located in Venice, 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 $87,105 in charges reported for the 32 sample beneficiaries in our study. This amount is comprised of $10,182 related to Occupation and Physical therapy services determined to be medically unnecessary; $73,873 in inappropriate payments for supplies and equipment; and $3,050 of drug, laboratory, and Part B services which were not documented. Therefore, we are recommending an adjustment of the above charges and for the FI to perform a focused review to identify and recoup overpayments made to this SNF, for periods since our review period.

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,

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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

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 Bon Secours-Venice Hospital (Medicare provider number 10-5753), a skilled nursing facility located in Venice, 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 $87,105 in charges reported for the 32 sample beneficiaries in our study and we are recommending an adjustment of these charges. In addition, we request that the State Agency implement corrective action by the facility to ensure that services, supplies, and equipment are properly provided to its residents.

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,

Patricia L. Talley
Patricia Talley
Acting HCFA Regional Administrator

Charles J. Curtis
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 Bon Secours-Venice Hospital's Transitional Care Unit (Venice), a skilled nursing facility (SNF) in Venice, 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:

- 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.

A team comprising 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 Bon Secours. The members of the team evaluated the services for 32 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994. This period coincided with the SNF's Medicare Fiscal Year 1994 (FY 1994).

We found $87,105 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 32 of the 32 beneficiaries in the sample. The disallowed costs consists of $10,182 of occupational and physical therapy services which were not reasonable or medically necessary or undocumented, $73,873 of charges for supplies and equipment which were inappropriately billed and $3,050 of drug, laboratory and Part B services which were not documented.

The therapy overcharges of $10,182 occurred because the SNF prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services. We are recommending that the Intermediary make an adjustment of $87,105 from the charges reported by the SNF on its FY 1994 cost report and identify and recoup overpayments for periods since our review, and for the State Agency to ensure via a corrective action plan (CAP) that this facility provided all supplies and equipment medically needed by its patients.

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 judgmentally 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.

Bon Secours-Venice Hospital's Transitional Care Unit was one of the 14 SNFs judmentally 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 32 beneficiaries in our sample, for whom Venice billed Medicare $171,355 during the period January 1, 1994 through December 31, 1994, the facility's Medicare fiscal 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 Venice between January 1994 and December 1994. This approach was adopted because many providers, other than Venice 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 Venice, Florida during the period July 8 through July 12, 1996.

IV. FINDINGS AND RECOMMENDATIONS

The review of the 32 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 32 beneficiaries resulted in disallowance of $87,105 in charges reported by Venice in its FY 1994 Medicare Cost Report. The disallowed costs consists of $10,182 of occupational and physical therapy services which were not reasonable or medically necessary or undocumented, $73,873 of charges for supplies and equipment which were inappropriately billed, and $3,050 of drug, laboratory, and Part B services which were not documented. We are recommending that the Intermediary adjust the questioned charges and conduct focused reviews of therapy services reported by the SNF.

QUESTIONED CHARGES

	Billed	Questioned	Percentage
THERAPIES:			
Occupational	$26,354	$ 5,341	20%
Physical	60,633	4.841	8%
Subtotal	$86,987	$ 10,182	11%
Supplies & Equipment	$79,772	$ 73,873	92%
Drug, Lab & Part B	4,596	3,050	66%
Total	$171,355	$ 87,105	

OCCUPATIONAL & PHYSICAL THERAPY SERVICES

We questioned $10,182 of occupational (OT)and physical (PT) provided 23 of the 32 aberrant 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 $5,341 of OT provided to 16 of 32 beneficiaries. This cost includes $4,013 which was not medically necessary and $1,328 which was not documented. 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. The following information provides the bases for this conclusion.

- Therapy goal was to increase endurance and strengthen muscles. The resident's disease and medication prevented the attainment of this goal.
- Therapy not medically necessary due to cognitive deficits and non-compliance of the resident.
- Therapy duplicated administered PT and it could have been accomplished by the facility's nursing staff.
- Therapy was not medically necessary due to decline in resident's medical conditions and cognitive status.

The therapeutic services provided the above residents should have been accomplished by the facility's nursing staff.

RECOMMENDATIONS

We recommend that the Intermediary should:

- Adjust the $5,341 from OT charges reported by the SNF on its FY 1994 cost report.
- Conduct a focused review of all OT services provided at Venice since the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that OT services are appropriately provided to patients with medical needs for these services.

FINDING # 2

Physical Therapy Services

We questioned the medical necessity of $4,841 of PT provided to 21 of 32 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 following information provides the bases for our questioning the PT services.

- Therapy was continued after resident was discharged to restorative nursing care.
- Therapy was continued after resident's cognitive status became very limited. The medical records show she became non-verbal and non-self initiating in daily living skills.
- The side effect of medication being taken by one resident included muscle weakness, loss of muscle mass and osteoporosis. The PT evaluation did not indicate that the therapists were aware of the resident's bone cancer, his use of steroid drugs, and the side effects of the drugs.
- Therapy primarily consisted of bandage wraps and measurements.
- Therapy was continued after resident attained established goals.

The routine therapeutic services provided the above residents should have been accomplished by the facility's nursing staff.

RECOMMENDATION

We recommend that the Intermediary adjust the $4,841 from PT charges reported by the SNF on its FY 1994 cost report.

FINDING #3

Supplies & Equipment

We questioned $73,873 of supplies and equipment charged to 29 of the 32 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.

RECOMMENDATIONS

We recommend that the Intermediary should:

- Adjust the $73,873 from equipment charges reported to the SNF on its FY 1994 cost report.
- Conduct a focused review of all supplies & equipment provided at Venice for the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that supplies and equipment are properly provided to all residents.

FINDING #4

Drug, Laboratory & Part B Services

We questioned $3,050 of drug, laboratory, and Part B services charged to 29 of the 32 beneficiaries included in our sample because of lack of adequate documentation to support the charges.

RECOMMENDATION

We recommend that the Intermediary adjust the $3,050 from drug, laboratory and Part B services charges reported by the SNF on its FY 1994 cost report.