DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

APR 22 1997

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

CIN: A-04-96-01149

Mr. Edward Hanchey
Vice President of Provider Reimbursement
Blue Cross of Texas
1020 South Sherman, 2nd Floor
Richardson, Texas 75081

Dear Mr. Hanchey:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility (SNF) review conducted at Presbyterian Hospital (Medicare provider number 455938), a SNF located in Dallas, Texas. 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 1995 through March 1996.

The ORT reviewers questioned $198,663 of the $1,006,495 in charges for 40 beneficiaries in our sample. This amount is comprised of $100,549 for unallowable services, $51,802 for services which were not reasonable or medically necessary and $46,312 for services for which the SNF could not produce adequate supporting documentation. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a detailed review of all rehabilitative therapies and physician orders for these therapies be conducted by the Fiscal Intermediary and State Agency in order to recoup overpayments made to the SNF and to implement corrective action by the facility.

Following your review of this report, please prepare and submit to Health Care Financing Administration action official listed below, a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within 30 days from the date of this letter.

If you have any questions, please call Roy Wainscott at (404) 331-2446. To facilitate identification, please refer to Common Identification Number (CIN) A-04-96-01149 in all correspondence relating to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

AUDIT OF PRESBYTERIAN HOSPITAL SKILLED NURSING FACILITY DALLAS, TEXAS

JUNE GIBBS BROWN
Inspector General

APRIL 1997
A-04-96-01149

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I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust (ORT) audit of the Presbyterian Hospital, Skilled Nursing Facility (SNF) in Dallas, Texas. The objective of the review was to determine whether charges billed to the Medicare Fiscal Intermediary (Intermediary) were allowable.

We determined that $198,663 in charges reported by the SNF were unallowable because the SNF did not have an effective system of administrative internal controls.

For the charges to be allowable, they must be for services:

- 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 unannounced audit was conducted by a team comprised of two Office of Inspector General (OIG), Office of Audit Services auditors, a Health Care Financing Administration (HCFA) nurse-consultant from Region IV and four nurse consultants from Region VI HCFA.

The team determined the allowability of amounts charged for services provided to a sample of 40 beneficiaries during the period January 1995 through March 1996. Based on the audit results, we questioned $198,663 of $1,006,495 in Medicare charges reported by the SNF. The charges did not meet Medicare reimbursement guidelines stated above for the 40 beneficiaries in our sample. The amount questioned consists of $100,549 for services which were specifically unallowable, $51,802 for services which were not reasonable or medically necessary, and $46,312 of charges for which the SNF could not produce adequate supporting documentation. (See Appendix A)

We are recommending that the Intermediary:

- remove $198,663 of charges from the SNF's Medicare Cost Report; and
- direct the provider to implement a Corporate Compliance Policy which includes effective internal controls that ensure future compliance with pre-admission, level-of-care, billing, and supporting documentation criteria.

II. BACKGROUND

The President and the Secretary of the Department of Health and Human Services initiated 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 abuse and fraud:

- o home health agencies
- o nursing homes
- o durable medical equipment

Departmental records further disclosed the States of California, Florida, Illinois, New York and Texas 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, the ORT project 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.

The HCFA's Bureau of Data Management and Strategies (BDMS) has identified certain SNFs in the targeted ORT States 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 Calendar Year 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. The BDMS generated a listing of the facilities with high reimbursement amounts per day and per stay. The final listing of SNF providers were manually scanned and the SNF with the highest reimbursement within each of the five targeted States was selected for review. In Texas, Presbyterian Hospital of Dallas, a SNF, was chosen for audit.

III. SCOPE OF REVIEW

The audit was conducted by a team comprised of four nurse-consultants from the Region VI HCFA, a nurse-consultant from the HCFA Region IV, and two auditors from the OIG Office of Audit Services. Individual team members are listed in Appendix B.

Presbyterian Hospital, a SNF in Dallas, Texas, was selected for audit based upon its high therapy costs, average length of stay by residents, cost per stay, and cost per day.

The objective of the review was to identify, and quantify charges associated with, unnecessary care (over-utilization) and to identify any abusive practices. We determined the allowability of SNF reported charges for the following services:

- o Room and Board
- o Physical Therapy
- o Occupation Therapy
- o Speech Therapy
- o Respiratory Therapy
- o X-rays
- o Drugs
- o Laboratory Services

We reviewed documentation relating to Medicare-funded services provided to 40 residents of the facility during the January 1995 through March 1996 audit period. Our review included an analysis of charges made to Medicare for services provided to the beneficiaries at the facility. We also reviewed the financial agreements related to the Medicare reimbursement of these services.

The HCFA nurses identified services which were (1) not reasonable or necessary, (2) not supported in the medical records, or (3) unallowable. The auditors quantified the charges associated with the questioned services. Field work was performed in Dallas, Texas and Atlanta, Georgia from November 4, 1996 through March 28, 1997.

The audit was performed in accordance with generally accepted government auditing standards. The internal control review was limited to testing the adequacy of the SNF's documentation supporting billed charges.

IV. FINDINGS AND RECOMMENDATIONS

Our review disclosed that $198,663 of $1,006,495 in reported Medicare charges for the 40 beneficiaries in our sample did not meet Medicare reimbursement guidelines established by HCFA. Because the SNF had not established an effective system of administrative internal controls; charges were reported for services that were specifically unallowable ($100,549), not medically necessary ($51,802), and were undocumented ($46,312).

UNALLOWABLE SERVICES

Our review disclosed that $100,549 in charges were claimed for services that were determined to be specifically unallowable pursuant to HCFA Skilled Nursing Facility Manual (SNFM) Sections; 230.2, 230.10 C.2, and 545.1 and HCFA Provider Reimbursement Manual Sections 2203.1 and 2203.2.

We reviewed the medical records for 40 beneficiaries to determine whether any services were specifically unallowable. Our review showed that, of the $1,006,495 in charges claimed for these beneficiaries, $100,549 were not allowable.

Durable Medical Equipment

We questioned $38,832 for durable medical equipment (DME) provided to 27 of the 40 beneficiaries included in our sample. These DME charges were for trapeze and beds which the nurses determined to be routine.

The Medicare Provider Reimbursement Manual, Part I section 2203.2 states that items which are utilized by patients, but which are reusable and expected to be available in an institution providing a SNF level of care ....and do not meet the criteria for ancillary services and charges for SNFs under section 2203.2 are considered routine. As such, they are not separately billable to Medicare.

Respiratory Therapy

We questioned $28,951 in Respiratory Therapy (RT) services which did not meet the Federal criteria for posthospital SNF care.

The RT is covered under the Medicare posthospital extended care benefit if furnished by a "transfer hospital" or by a nurse on the staff of the SNF (SNFM 230.10 C.2.). The beneficiaries were taken to the hospital for the RT and then returned to the SNF. Since the facility did not have a transfer agreement with the hospital, the RT charges are not allowable.

Private Room and Board

We questioned $26,169 for Private Room and Board provided to 32 of the 40 beneficiaries included in our sample. The SNFM 230.2 states that the Medicare program will pay for no more than the customary charge for a semi-private room, unless a private room is medically necessary. Because of this, we have questioned the excess of the private room rate charges over the semi-private room rate when a private room was not medically necessary.

Drugs

We questioned $6,597 related to drug charges provided to 30 of the 40 beneficiaries included in our sample. These drugs were charged as ancillary services instead of routine items to the Medicare program. To reduce the potential impact of unusual or inconsistent charging practices, certain items and services are always considered routine in a SNF for the purpose of Medicare cost apportionment. Non-legend (nonprescription) drugs are included as an example in the listing of such routine items (Paragraph 2203.1

of Part 1 to the HCFA Provider Manual). Some examples of routine drugs that were billed separately are Anacin, Tylenol, Fleets enema, and laxatives, etc...

Recommendation

We are recommending that the Intermediary:

- o remove the $100,549 in unallowable service charges from the SNF's Medicare Cost Report.

- o instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for non-covered services.

MEDICAL NECESSITY

Our review disclosed that the SNF claimed reimbursement for $51,802 of services that were determined to not be reasonable or necessary. The SNFM Sec.280.1 provides that items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

We reviewed the medical records for 40 beneficiaries to determine whether the services were reasonable and necessary. Our review showed that of the $1,006,495 in costs claimed for these beneficiaries, $51,802 was either not reasonable or necessary.

For example, we found:

- o An 82 year old man with end stage cardiomyopathy in atrial fibrillation and very weak, was given occupational therapy that was not medically necessary because it would not benefit the patient.

- o A beneficiary nursing assessment and background at admission showed that the patient could ambulate 100ft with minimal assistance. The goal of the physical therapy was to enable the patient to ambulate. Since the patient was able to ambulate upon admission, the therapy was not considered medically necessary.

In addition, had the SNF an effective system of administrative internal controls, it could have prevented claims being made for services which were not reasonable or necessary.

We recommend that the Intermediary:

- o remove the $51,802 of questioned charges from the SNF's Medicare cost report.

- o instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for services that are not reasonable or necessary.

UNDOCUMENTED COSTS

Our review showed that $46,312 of charges were claimed for reimbursement without the required supporting documentation. The SNFM Sec. 545.1. requires the SNF to maintain documentation necessary to support its reported charges; e.g., UB-92 billing statements and any other billing forms, supporting documents and forms, charge slips, daily patient census records and other business and accounting records applicable to specific claims.

We reviewed the medical records for 40 beneficiaries to determine whether there was supporting documentation for the services claimed. Our review showed that of the $1,006,495 in costs claimed for these beneficiaries, $46,312 was not supported as required by HCFA. Had the SNF had an effective system of administrative internal controls, it could have prevented claims being made for services which were not documented.

We are recommending that the Intermediary:

- o remove the $46,312 of questioned charges from the SNF's Medicare cost report.

- o instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for services not documented.

OPERATION RESTORE TRUST
REVIEW OF PRESBYTERIAN HOSPITAL
5750 PINELAND DRIVE
DALLAS, TEXAS
CIN: A-04-96-01149

RECOMMENDED ADJUSTMENT OF CHARGES

SERVICE	TOTAL QUESTIONED	UN-ALLOWABLE SERVICES	NOT MEDICALLY NECESSARY	UNSUP-PORTED SEVICES
ROOM & BOARD	$26,169	$26,169	$-0-	$-0-
PHYSICAL THERAPY	$33,948	$-0-	$23,384	$10,564
OCCUPATIONAL THERAPY	$44,785	$-0-	$21,401	$23,384
SPEECH THERAPY	$-0-	$-0-	$-0-	$-0-
DRUGS	$6,597	$6,597	$-0-	$-0-
MEDICAL EQUIPMENT	$38,832	$38,832	$-0-	$-0-
RESPIRATORY THERAPY	$28,951	$28,951	$-0-	$-0-
OTHER ANCILLARY CHARGES	$19,381	$-0-	$7,017	$12,364
TOTAL	$198,663	$100,549	$51,802	$46,312

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