DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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

APR 08 1997

CIN: A-04-96-01150

Mr. John Hagerty
Deputy Director Field Services
California Department of Health Services
License and Certification
1800 3rd Street, Suite 210
P. O. Box 942732
Sacramento, California 94234

Dear Mr. Hagerty:

The enclosed report and recommendation for adjustment of charges provides the results of the Operation Restore Trust (ORT) Audit of the Flagship Convalescent Center (Medicare Provider number 05-5121), a skilled nursing facility located in Newport Beach, California. The primary objective of the audit 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, 1995 through March 31, 1996.

The ORT team questioned $287,664 of the $1,474,634 in Medicare charges reported for the 40 sample beneficiaries in our audit. This amount is consisted of $253,202 which were not reasonable or necessary, $30,713 of charges which were not properly documented, and $3,649 for services which were not covered. 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 Fiscal Intermediary and the State agency in order to recoup overpayments made to this skilled nursing facility and to implement corrective action by the facility.

Following your review of the report, please prepare and submit to the Health Care Financing Administration (HCFA) official listed below, a plan of corrective licensure or certification related actions. The actions would include, but not be limited to, addressing the HCFA certification guidelines relating to medically unnecessary, undocumented, and unallowable services. This plan should be submitted within 30 days of receipt of this letter.

If there are any questions regarding this report, please call Roy Wainscott at 404-331-2446, extension 106. To facilitate identification, please refer to Common Identification Number (CIN) A-04-96-01150 in all correspondence relating to this report.

Sincerely yours,

for Gerald R. Dinkel

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

Enclosure

Health Care Financing Administration
Action Official

Allison Blake
Associate regional Administrator for Medicare
75 Hawthorne Street
San Francisco, California 94105

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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

APR 08 1997

CIN: A-04-96-01150

Ms. Patty Aguilera
Mutual of Omaha
Program Integrity Manager
P. O. Box 1602
Omaha, Nebraska 68101

Dear Ms. Aguilera:

The enclosed report and recommendation for adjustment of charges provides the results of the Operation Restore Trust (ORT) Audit of the Flagship Convalescent Center (Medicare Provider number 05-5121), a skilled nursing facility (SNF) located in Newport Beach, California. The primary objective of the audit 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, 1995 through March 31, 1996.

The ORT team questioned $287,664 of the $1,474,634 in Medicare charges reported for the 40 sample beneficiaries in our audit. This amount is comprised of $256,305 related to Physical, Occupational, and Speech therapy services rendered; $11,226 in Respiratory therapy services, $700 of unallowable Room and Board, and $19,433 in unallowable pharmacy, X-ray, and laboratory charges. 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 Fiscal Intermediary and the State agency in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

Following your review of the report, please prepare and submit to the Office of Inspector General, Office of Audit Services Atlanta Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within 30 days of receipt of this letter.

If there are any questions regarding this report, please call Roy Wainscott at 404-331-2446, extension 106. To facilitate identification of this report, please refer to Common Identification Number (CIN) A-04-96-01150 in all correspondence relating to this report.

Sincerely yours,

for/ Gerard R. Bentivenga
Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Health Care Financing Administration
Action Official

Ms. Allison Blake
Associate Regional Administrator
for Medicare
75 Hawthorne Street
San Francisco, California 94105

Enclosure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF FLAGSHIP CONVALESCENT CENTER SKILLED NURSING FACILITY NEWPORT BEACH, CALIFORNIA

JUNE GIBBS BROWN
Inspector General

APRIL 1997
A-04-96-01150

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust (ORT) audit of the Flagship Convalescent Center Skilled Nursing Facility (SNF) at Newport Beach, California. The objective of the review was to determine whether charges billed to the Medicare Fiscal Intermediary (Intermediary) were allowable.

We determined that $287,564 of charges were unallowable because the SNF did not have an effective system of administrative internal controls.

For the 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 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 and two California Department of Health Services (State agency) nurse-surveyors.

The team determined the allowability of amounts charged for services provided to a sample of 40 beneficiaries during the period of January 1995 through March 1996. Based on the audit results, we questioned $287,564 of $1,474,634 in Medicare charges reported by the SNF. The charges did not meet Medicare reimbursement guidelines stated above for 37 of 40 beneficiaries in our sample. The amount questioned consist of $253,202 for services which were not reasonable or medically necessary, $30,713 of charges for which the SNF could not produce adequate supporting documentation, and $3,649 for services which were not covered. (See Appendix A)

We are recommending that the Intermediary:

- recover $287,564 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 annually receive approximately 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 California, the Flagship Convalescent Center at Newport Beach was the SNF chosen for audit.

III. SCOPE OF REVIEW

The audit was conducted by a team comprised of two nurse surveyors from the State agency, a nurse consultant from the Regional HCFA, and two auditors from the OIG Office of Audit Services. Individual team members are listed in Appendix B.

The Flagship Convalescent Center at Newport Beach was selected for audit based upon its high therapy costs, high average length of stay by residents, high cost per stay, and high 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 Occupational Therapy
- o Speech Therapy
- o Respiratory Therapy
- o X-rays
- o Drugs
- o Laboratory Services

We reviewed documentation relating to Medicare-funded services provided 40 beneficiaries residing at 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 and State agency nurses identified services which were (i) not reasonable or medically necessary, (ii) not supported in the medical records, or (iii) provided residents who did not meet the pre-admission criteria for posthospital SNF care. The auditors quantified the charges associated with the questioned services. Field work was performed during the period December 3-18, 1996.

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 of billed charges.

IV. FINDINGS AND RECOMMENDATIONS

Our review disclosed that $287,564 of $1,474,634 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 not medically necessary ($253,202), were undocumented ($30,713), and unallowable ($3,649).

MEDICAL NECESSITY

Our review disclosed that the SNF claimed reimbursement for $253,202 of services that were determined to not be reasonable or necessary. The Skilled Nursing Facility Manual (SNFM) Section 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 $1,474,634 in costs claimed for these beneficiaries, $253,202 was not reasonable or necessary.

For example, we found:

- a beneficiary's physician's order specified the beneficiary received occupational therapy daily. However, the SNF billed for occupational therapy for the beneficiary twice daily.

- a beneficiary with advanced Parkinson's disease, was totally dependent for all activities, and had medical records which showed there was no progress after 2 weeks of physical therapy. The physician ordered that no further physical therapy be given due to the beneficiary's medical condition and poor prognosis for improvement. However, the SNF continued to bill for physical therapy based on a request from the beneficiary's family.

Had the SNF had 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:

- recover the $253,202 of questioned charges from the SNF's Medicare cost report.

- 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 SERVICES

Our review showed that $30,713 of charges were claimed for reimbursement without the required supporting documentation. The SNFM Section 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 $1,474,634 in costs claimed for these beneficiaries, $30,713 was not supported as required by HCFA. Our review showed that $28,775 of physical, occupational, speech and respiratory therapies were not documented in the beneficiaries' medical records. We also determined that $1,938 in other services, such as laboratory, drugs, and X-rays were claimed without supporting documentation.

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:

- recover the $30,713 of questioned charges from the SNF's Medicare cost report.

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

UNALLOWABLE SERVICES

Our review of one beneficiary's medical records showed that the beneficiary was transferred from a hospital's transitional care unit to the SNF to receive hospice care. The medical records also indicated that all of the beneficiary's charges billed related to his hospice, rather than skilled nursing care.

The regulations at 42 CFR 409.31(b)(3) state that admission to a SNF is contingent on the need for daily skilled services that could only be provided in a SNF on an inpatient basis. The regulations at 42 CFR 418.301 (a) through (f) provide for the Hospice program to be reimbursed for a beneficiaries needs relating to a terminal condition. This means that a beneficiary's admission to a SNF for hospice care can be proper, but the reimbursement for the services relating to the terminal condition are to be made through the hospice, rather than the SNF.

We questioned $1,058 in respiratory therapy, $1,000 in physical and occupational therapy, $700 in room and board charges, and $891 in drug charges relating to this beneficiary's 4-day SNF stay.

Had the SNF had an effective system of administrative internal controls, it could have prevented claims being made for unallowable services.

We are recommending that the Intermediary:

- recover the $3,649 in charges that did not meet the qualification for a covered SNF stay from the SNF's Medicare cost report.

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

APPENDIX A

REVIEW OF THE FLAGSHIP CONVALESCENT CENTER
NEWPORT BEACH, CALIFORNIA
CIN: A-04-96-01150

PROVIDER NUMBER # 055121
RECOMMENDED ADJUSTMENT OF CHARGES

SERVICE	TOTAL QUESTIONED	UNSUPPORTED	NOT MEDICALLY NECESSARY	UNALLOWABLE SERVICES
Room & Board	$700	$0	$0	$700
Physical Therapy	$73,475	$11,275	$62,050	$150
Occupational Therapy	$89,500	$8,350	$80,300	$850
Speech Therapy	$93,230	$9,150	$84,080	$0
Respiratory Therapy	$11,226	$0	$10,168	$1,058
Laboratory	$620	$620	$0	$0
Drugs	$15,769	$0	$14,878	$891
X-rays	$3,044	$1,318	$1,726	$0
TOTALS	$287,564	$30,713	$253,202	$3,649

APPENDIX B

AUDIT MANAGER:	Roy Wainscott OIG Office of Audit Services, Atlanta
SENIOR AUDITOR:	Andy Funtal OIG Office of Audit Services, Atlanta
AUDITOR-IN-CHARGE:	Robert Julian OIG Office of Audit Services, Atlanta
AUDIT STAFF:	Mervyn Carrington OIG Office of Audit Services, Tallahassee
NURSES:	Ann Schieding HCFA Nurse Consultant San Francisco, California
	Frances Del Rio State Survey Nurse Orange County District Office, Anaheim, California
	Theresa De Pue State Survey Nurse Orange County District Office, Anaheim, California