DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
61 Forsyth Street, Room 3T41
Atlanta, GA 30303-8909

Memorandum

Date: DEC 30 1999

From: Regional Inspector General
for Audit Services, Region IV

Subject: Review of Outpatient Therapy Services at Life Care Centers of America Skilled Nursing Facilities in Tennessee (CIN: A-04-97-02143)

To: Rose Crum-Johnson, Regional Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, "*Review of Outpatient Therapy Services at Life Care Centers of America Skilled Nursing Facilities in Tennessee.*" The objective of our review was to determine whether Medicare Part B outpatient physical, occupational, and speech therapy services paid to Tennessee skilled nursing facilities (SNF) owned and operated by the Life Care Centers of America (Life Care) were in accordance with Medicare reimbursement requirements.

For the 12-month period ended June 30, 1997, we estimate that Life Care's Tennessee SNFs were paid approximately $1.6 million for Part B outpatient therapy services that did not meet Medicare reimbursement requirements. A statistical sample of therapy services revealed that 59 of the 105 therapy services in our sample were not reasonable and necessary, or lacked adequate medical documentation to support the services claimed. The services were not reasonable and necessary because: (1) the level of services rendered did not require a qualified therapist; (2) the beneficiary's condition was not expected to improve materially in a reasonable time; and (3) the amount, frequency, and duration of services were excessive. In addition, the medical records were not specific, adequate and complete to support the services claimed.

We believe that Life Care claimed inappropriate services because it did not ensure that the therapy services were billed in accordance with Medicare's reimbursement requirements. Based on the results of our review, we recommend that the Health Care Financing Administration (HCFA) instruct Life Care's fiscal intermediary (FI) to:

- remove $1,638,025 of charges from the Medicare cost reports of Tennessee SNFs owned and operated by Life Care.

- have Life Care implement a formal plan to establish effective reimbursement procedures so that only allowable services are claimed by Life Care's Tennessee SNFs. The HCFA should monitor the FI's oversight of Life Care's progress in establishing adequate reimbursement procedures and submitting claims that comply with Medicare's requirements.

- implement a higher level of medical review on Life Care's Tennessee SNFs. If high rates of unallowable services continue, the FI should suspend Medicare payments to Life

Care's Tennessee SNFs until their error rates improve.

In responding to our draft report, HCFA agreed with our recommendations. A copy of HCFA's response is included in its entirety as an attachment to this report.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions or need clarification on the report, please call me or have your staff contact Linda Ritter, Audit Manager, Office of Audit Services at 404-562-7760.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-97-02143 in all correspondence relating to this report.

Charles J. Curtis

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT THERAPY SERVICES AT LIFE CARE CENTERS OF AMERICA SKILLED NURSING FACILITIES IN TENNESSEE

JUNE GIBBS BROWN
Inspector General

DECEMBER 1999
A-04-97-02143

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Subject: Review of Outpatient Therapy Services at Life Care Centers of America Skilled Nursing Facilities in Tennessee (CIN: A-04-97-02143)

To: Rose Crum-Johnson, Regional Administrator
Health Care Financing Administration

This final report provides you with the results of our review of outpatient therapy services provided in Life Care Centers of America (Life Care) skilled nursing facilities (SNF) in Tennessee.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of this audit was to determine whether Medicare Part B outpatient physical, occupational and speech therapy services paid to Tennessee SNFs owned and operated by Life Care were in accordance with Medicare reimbursement requirements.

SUMMARY OF RESULTS

For the 12-month period ended June 30, 1997, we estimate that Life Care's Tennessee SNFs were paid approximately $1.6 million in Medicare Part B outpatient therapy services that did not meet Medicare requirements. Medicare requires that therapy services be reasonable and necessary, and be adequately supported with medical documentation. A statistical sample of therapy services revealed that 59 of the 105 therapy services in our sample were not reasonable and necessary or lacked adequate medical documentation to support the services claimed. The services were not reasonable and necessary because: (1) the level of services rendered did not require a qualified therapist; (2) the beneficiary's condition was not expected to improve materially in a reasonable time; and (3) the amount, frequency, and duration of services were excessive. In addition, the medical records were not specific, adequate and complete to support the services claimed. We believe that Life Care claimed inappropriate services because it did not ensure that the therapy services were billed in accordance with Medicare's reimbursement requirements.

RECOMMENDATIONS

We recommend that the Health Care Financing Administration (HCFA) instruct the fiscal intermediary (FI) to:

- remove $1,638,025 of charges from the Medicare cost reports of Tennessee SNFs owned and operated by Life Care.

- have Life Care implement a formal plan to establish effective reimbursement procedures so that only allowable services are claimed by Life Care's Tennessee SNFs. The HCFA should monitor the FI's oversight of Life Care's progress in establishing adequate reimbursement procedures and submitting claims that comply with Medicare's requirements.

- implement a higher level of medical review on Life Care's Tennessee SNFs. If high rates of unallowable claims continue, the FI should suspend Medicare payments to Life Care's Tennessee SNFs until their error rates improve.

In responding to our draft report, HCFA agreed with our recommendations. A copy of HCFA's response is included in its entirety as an attachment to this report.

BACKGROUND

Life Care is one of the largest nursing and retirement center companies in the nation. The Corporate headquarters are in Cleveland, Tennessee. Life Care, founded in 1976, operates over 200 nursing facilities in 28 states and employs approximately 2,400 therapists. Over 180 of these facilities are SNFs which provide skilled nursing and rehabilitation services.

The SNFs provide therapy services (which can include physical, speech, and occupational therapy) to Medicare beneficiaries. The services must be furnished under a written plan of treatment established by a physician. The plan must state the type, amount, frequency, and duration of the therapy services to be furnished, and indicate the diagnosis and anticipated goals.

Therapy services are paid by either Medicare Part A or Part B with coinsurance payments by beneficiaries where appropriate. Part A pays the full cost of covered services for the first 20 days. For the next 80 days, therapy services are paid by Part A and a coinsurance amount paid by the beneficiary. After the 100-day period, Part B pays for required services after an annual deductible and coinsurance are paid by the beneficiary.

This review was a collaborative initiative comprised of auditors from the Office of Inspector General (OIG), Office of Audit Services, and medical review personnel from Riverbend Government Benefits Administrators, the FI for all Life Care facilities nationwide.

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of this audit was to determine whether Medicare Part B outpatient physical, occupational and speech therapy services paid to Tennessee SNFs owned and operated by Life Care were in accordance with Medicare reimbursement requirements.

To achieve the objective, a stratified statistical sample of 105 therapy services was selected from therapy claims during the period July 1, 1996 through June 30, 1997 for beneficiaries who received Part B outpatient therapy services. The 105 therapy services consisted of 35 services each in physical, occupational and speech therapy.

For each of the 105 therapy services, we obtained supporting medical records maintained by the SNFs, and requested the FI's medical review personnel to evaluate whether the therapy services met Medicare's reimbursement requirements. The medical reviewers evaluated the supporting documentation for the services, including the written plan of care for each beneficiary and other information in the beneficiary's medical record. The auditors quantified the charges associated with the questioned therapy services. A review of internal controls was not performed because the objective of our review was accomplished through substantive testing. Details on our sampling methodology and projection are presented in the appendix.

The review was performed primarily at the FI in Chattanooga, Tennessee, and at the HCFA and OIG Regional Offices in Atlanta during the period of September 30, 1997 through August 30, 1999. We requested, from the FI, all Part B therapy services provided in the 11 facilities in Tennessee owned and operated by Life Care for the period of July 1, 1996 through June 30, 1997.

The audit was performed in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

For the 12-month period ended June 30, 1997, we estimate that Life Care's Tennessee SNFs were paid approximately $1.6 million in Medicare Part B outpatient therapy services that did not meet Medicare requirements. Medicare requires that therapy services be reasonable and necessary, and adequately supported with medical documentation. The medical reviewers determined that 59 of the 105 therapy services in the statistical sample did not meet Medicare requirements:

- Forty-four of the 59 services were **not reasonable and necessary** because:
  - 18 services were **not** of such a level of complexity and sophistication that they could be **performed only by a qualified therapist;**
  - 19 services were provided when there was **no expectation the beneficiary would improve** in a reasonable and predictable amount of time; and
  - seven services were provided where the **amount, frequency and duration of the services were not reasonable.**
- Fifteen of the 59 services **lacked adequate documentation** to support the services claimed. The patient's medical documentation was not specific, adequate, and complete.

THERAPY SERVICES NOT REASONABLE AND NECESSARY

The Medicare regulation which defines reasonable and necessary is found in 42 Code of Federal Regulation 409.44(c)(2). In order for therapy services to be covered by Medicare, the services must relate specifically to a written plan of treatment established by a physician. Also the services must be considered a specific, safe, and effective treatment for the beneficiary's condition. Finally, the services must be reasonable and necessary to the treatment of the illness or injury. Specifically:

- the services must be of such a level of complexity and sophistication that they can safely and effectively be performed only by a qualified therapist;
- there must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) amount of time based on the physician's assessment of the beneficiary; and
- the amount, frequency, and duration of the services must be reasonable.

Level of Services Did Not Require Qualified Therapist

The medical reviewers found that 18 therapy services did not require a qualified therapist because the patient was not impaired to a degree that warranted skilled therapy. For example, seven of the services involved assisting the patient in determining food preferences and encouraging the patient to eat. Other services were to assist the patient with walking practice, or to only change the patient's wound dressings. These services did not require the skills of a qualified therapist, but could have been performed by the SNF's nursing staff. The medical reviewer noted that three of the services for encouraging the patient to eat were "*blatantly not skilled.*" Some examples follow:

- An 87 year old beneficiary received 11 visits of speech therapy. The beneficiary had been diagnosed with dementia. The speech therapy services consisted of: educating the patient on nutritional needs, working with dietary staff to find palatable foods to the patient's liking, reminding and praising the patient for eating efforts, and communicating eating progress to other staff and family. The medical reviewer stated that these services do not require the skills of a therapist. The unallowable charges billed to Medicare were $2,565.

- A 92 year old beneficiary with a primary diagnosis of dementia received 9 visits of speech therapy. The services were to provide an atmosphere conducive to pleasant dining and to provide cues for feeding. The medical reviewer noted that the services do not require the skills of a therapist. The unallowable charges billed to Medicare were $2,223.

- An 86 year old beneficiary with a primary diagnosis of Alzheimer's disease received 7 visits of speech therapy. The services were to determine foods appetizing to the patient and encourage the patient to eat. The medical reviewer noted that these services did not require the skills of a therapist and could have been provided by dietary personnel. The unallowable charges billed to Medicare were $1,767.

No Expectation the Beneficiary Will Improve

Nineteen therapy services did not meet Medicare requirements because the beneficiary's condition could not be expected to improve materially in a reasonable amount of time. The unallowable services were provided to beneficiaries who made minimal or no progress. These included services where no improvement was noted in the beneficiary's condition for the duration of therapy. The medical conditions of these beneficiaries varied, but included those with cognitive impairments (such as dementia) that prevented any progress.

The medical reviewer found that seven beneficiaries received therapy services when the services provided should have been under a maintenance program handled by a nurse or other SNF personnel instead of a qualified therapist. The SNF Manual describes a maintenance program as repetitive services required to maintain function, and the skill of a qualified therapist is not required. Some examples are:

- An 84 year old beneficiary received one evaluation and 8 treatment visits of occupational therapy only 1 week after a medical assessment stated, "...is in a semi-comatose state, is unable to communicate and is not aware of needs." The medical reviewer noted that the beneficiary previously received therapy for the same condition and should have been on a maintenance program. The medical records also noted there was no improvement in the beneficiary's condition. The unallowable charges billed to Medicare were $3,650.

- An 87 year old beneficiary received 12 treatment visits of speech therapy. The medical reviewer noted that there was no expectation of improvement due to severe cognitive impairments. Medical records completed prior to therapy described severely impaired cognitive skills for daily decision making, and difficulty hearing and understanding. The unallowable charges billed to Medicare were $3,135.

- An 88 year old beneficiary received 27 treatment visits of physical therapy. The medical reviewer noted that the beneficiary had previously received about 9 months of physical therapy, with no significant progress. Therefore, the medical reviewer determined that the services were unallowable because the beneficiary's condition was not improving. The unallowable charges billed to Medicare were $4,230.

Amount, Frequency and Duration of Services Unreasonable

Seven therapy services were unreasonable because either the amount, the frequency, or the duration of the services were excessive. Some examples of the unallowable therapy services are:

- An 86 year old beneficiary received one evaluation and 7 treatment visits of occupational therapy for positioning, activity tolerance/socialization, eating, family conferences and staff training. The medical reviewer determined that one evaluation of the patient and two visits of therapy should have been sufficient. The remaining five visits were considered unreasonable. Of the $3,604 billed to Medicare, the unallowable charges were $2,516.

- A 65 year old beneficiary received 12 treatment visits of occupational therapy due to the ill fit and discomfort from a hand splint. Splinting is the support of a body segment through application of an external device. The medical reviewer determined that 12 visits for splinting was excessive. The splinting process and care giver education could have been delivered within five visits. The unallowable charges billed to Medicare were $2,300.

SERVICES NOT ADEQUATELY DOCUMENTED

The SNF Manual Section 542 provides the requirements for documenting outpatient therapy claims. This section states that therapy services may be paid only if they meet all requirements established by the Medicare guidelines. Each bill for therapy services must include adequate medical documentation to justify payment. For the FI to make an informed medical review decision, the medical documentation should be specific, adequate and complete.

The documentation to support the need for therapy services includes the plan of treatment and the patient's medical history which should provide a brief description of the functional status of the beneficiary prior to the onset of the condition requiring therapy treatment. Other supporting documentation includes progress notes, a physician referral, initial evaluation, therapy logs, and service logs.

The medical reviewer found that 15 services were unallowable because the medical records lacked specific, adequate and complete information to support reimbursement. The medical records frequently contained conflicting information. The dates, amount, and type of therapy were not consistent in the medical records. The HCFA form used to bill Medicare often did not agree with the information provided on the therapy log (completed by the therapist to reflect the time and date the therapy was provided). The information on these forms did not agree with the plan of treatment, which describes the type, amount and frequency of therapy the beneficiary should receive.

The following are a few examples of therapy services where the medical records show conflicting or inadequate information:

- A 77 year old beneficiary received occupational therapy. The medical reviewer found that the therapy services recorded on the service log did not match the services billed to Medicare. The unallowable charges billed to Medicare were $825.

- A 70 year old beneficiary's medical records show conflicting documentation for physical therapy services. The physical therapist's notes show that the beneficiary received one evaluation visit and one treatment visit, but refused other treatment visits. However, the service log and Medicare billing form show one evaluation and five treatment visits, which were billed to Medicare. The unallowable charges were $270.

SUMMARY AND RECOMMENDATIONS

Therapy services provided by Life Care SNFs in Tennessee did not meet Medicare requirements because: there was no expectation the beneficiary would improve; required services were not of sufficient complexity to require a qualified therapist; the amount, duration, or frequency of services were excessive; and the medical documentation was not specific, adequate and complete to support the therapy services claimed. We believe that Life Care claimed unallowable services because it did not ensure that the services were billed in accordance with Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that HCFA instruct the FI to:

- remove $1,638,025 of charges from the Medicare cost reports of Tennessee SNFs owned and operated by Life Care.

- have Life Care implement a formal plan to establish effective reimbursement procedures so that only allowable services are claimed by Life Care's Tennessee SNFs. The HCFA should monitor the FI's oversight of Life Care's progress in establishing adequate reimbursement procedures and submitting claims that comply with Medicare's requirements.

- implement a higher level of medical review on Life Care's Tennessee SNFs. If high rates of unallowable claims continue, the FI should suspend Medicare payments to Life Care's Tennessee SNFs until their error rates improve.

In responding to our draft report, HCFA agreed with our recommendations. A copy of HCFA's response is included in its entirety as an attachment to this report.

SAMPLING METHODOLOGY

POPULATION

There were 2,453 outpatient physical, occupational, and speech therapy services during the 12-month period ending June 30, 1997. The FI provided us with a universe of claims history files from the Florida Shared System (FSS) for the period July 1, 1996 through June 30, 1997. As this data is part of the billing history files, it contained a full history of billing/ payment requests. The universe consists of paid therapy claims, claims submitted to the intermediary for payment and returned to the provider as unprocessable, claims rejected for non-medical reasons such as no entitlement to Medicare, and claims that were denied by medical review staff as not reasonable and necessary. If the selected sample item was other than a paid claim, it was not considered an error. Some items were displayed twice on the claims files even though they were paid only once. If one of these items was a sample item, we considered the first claim as the paid claim and the second as a non-error. In this way, we have assured that the sample projection did not inflate the error amount.

The population of services is shown below:

Strata	Number of Services	Dollar Amount Of Services
Physical	1,188	$ 1,884,206
Occupational	725	1,352,716
Speech	540	1,025,667
Total	2,453	$ 4,262,589

SAMPLE DESIGN

The sample design is a stratified sample consisting of three strata: physical therapy services, occupational therapy services, and speech therapy services.

RESULTS OF SAMPLE

The results of our review are as follows:

Strata	Number of Services	Sample Size	Value of Sample	Number of Errors	Value of Errors
Physical	1,188	35	$ 64,171.00	19	$ 30,238.50
Occupational	725	35	69,590.00	21	33,760.00
Speech	540	35	54,622.50	19	29,202.50
	2,453	105	$188,383.50	59	$ 93,201.00

The point estimate of the sample was $2,176,248. The precision at the 90 percent confidence level was plus or minus $538,223.

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

REGION IV - ATLANTA
Health Care Financing Administration

Memorandum

Date: 12/17/99

From: Rose Crum-Johnson
Regional Administrator, Region IV
Health Care Financing Administration

Subject: Review of Outpatient Therapy Services at Life Care Centers of America Skilled Nursing Facilities in Tennessee (CIN: A-04-97-02143)

To: Chuck Curtis
Regional Inspector General for Audit Services, Region IV

The purpose of this memorandum is to provide you with our comments concerning the draft report entitled "Review of Outpatient Therapy Services at Life Care Centers of America Skilled Nursing Facilities in Tennessee." The objective of your review was to determine whether Medicare Part B outpatient physical, occupational, and speech therapy services paid to Tennessee skilled nursing facilities (SNF) owned and operated by the Life Care Centers of America (Life Care) were in accordance with Medicare reimbursement requirements.

We appreciate your staff conducting this review and allowing us to share information with your staff in the investigation of Life Care. We also have had concerns about Life Care's billing practices. Life Care was under a corrective action plan which they submitted to Riverbend Government Benefits Administrators (RGBA) and HCFA in 1994 due to the overutilization of therapy services by Life Care. We found in September 1997 that RGBA was not performing appropriate payment safeguard activities with Life Care facilities and required a Performance Improvement Plan from RGBA.

You made the following recommendations and we will provide you with our comments following the recommendation:

- Remove $1,639,025 of charges from the Medicare cost reports of Tennessee SNFs owned and operated by Life Care – We agree with this recommendation.

- Have Life Care implement a formal plan to establish effective reimbursement procedures so that only allowable services are claimed by Life Care's Tennessee SNFs. The HCFA should monitor Life Care's progress in establishing adequate reimbursement procedures and submitting claims that comply with Medicare's requirements – We will instruct RGBA to require a formal plan from Life Care as recommended and apply this plan to not only Life Care facilities in Tennessee, but Life Care facilities in all states where it operates. Our reason for suggesting this is because the last information we had was Life Care's corporate office in Cleveland, Tennessee was responsible for providing education about Medicare coverage requirements to all of its facilities. If this is still the case, we believe that these problems may exist in facilities in other states. Through our oversight of RGBA, we will monitor the intermediary in Life Care's establishment of adequate reimbursement procedures and appropriate billing of covered services to the Medicare program.

- Implement a higher level of medical review on Life Care's Tennessee SNFs. If high rates of unallowable services continue, the FI should suspend Medicare payments to Life Care's Tennessee SNFs until their error rates improve – We will ask RGBA to implement a higher medical review rate of Life Care's Tennessee SNFs and then determine the most aggressive corrective action they should take if denial rates are unacceptable. In addition to suspending payments to a Life Care facility, other corrective actions may be needed such as a Comprehensive Medical Review using statistical sampling for overpayment estimation or referral to RGBA's fraud unit.

Thank you for allowing us to comment on this report. If you have any questions, please contact Joy Morrison in the Program Integrity Branch, Division of Financial Management and Program Initiatives at (404) 562-7308.

Patricia A. Harris for
Rose Crum-Johnson

cc: Dale Kendrick