DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JAN 5 2000

Memorandum

Date:

From: Regional Inspector General
for Audit Services, Region IV

Subject: Review of World Gym Physical Therapy Center Outpatient Rehabilitation Facility Program (CIN: A-04-98-01 191)

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

This final report provides you with the results of our review of World Gym Physical Therapy Center's (the Provider) Outpatient Rehabilitation Facility Program. Medicare covers outpatient rehabilitation services to eligible beneficiaries for services that are reasonable and necessary to treat an individual's illness with an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

EXECUTIVE SUMMARY

The objective of our review was to determine whether the Outpatient Rehabilitation services claimed by the provider during the Fiscal Year (FY) ended December 31, 1997 met the Medicare eligibility and reimbursement criteria.

SUMMARY OF FINDINGS

We reviewed a statistical sample of 100 claims containing 2,075 units of service that were provided to 82 Medicare beneficiaries during FY 1997. Ninety-two claims representing 1,966 units of service did not meet the Medicare eligibility and reimbursement requirements:

- 55 claims containing 1,270 units of service were considered unallowable by medical review personnel because the services were provided without proper certification or order.
- 28 claims containing 597 units of service were disallowed by medical review personnel because the supporting documentation did not support the need or medical necessity of the services.
- 9 claims containing 99 units of service were considered unallowable by medical review personnel because they were either not documented or the supporting documentation was considered inadequate.

The Provider claimed gross charges totaling $873,763. Based on the results of our review, we estimate that $5 18,479 did not meet the Medicare eligibility and reimbursement requirements and. therefore, constituted an overpayment.

This overpayment occurred because the provider did not conduct monitoring activities to ensure that the beneficiaries admitted to the program met the eligibility criteria. In addition, the provider did not implement controls to ensure that the services were properly authorized by a physician and documented in the beneficiaries' folders.

RECOMMENDATIONS

We are recommending the Health Care Financing Administration (HCFA) direct the FI to:

- recover the $5 18,479 in overpayments for 1997; and
- ensure that the provider establishes controls to ensure that beneficiaries are eligible for Outpatient Rehabilitation services, and that the services are properly authorized and documented.

World Gym, through it's attorney Mark A. Coel, PA, has responded to our draft report. This response, and our comments are summarized on page 6 of this report. The response, in it's entirety, is included as Appendix B of this report.

BACKGROUND

The provider is a Medicare-certified Outpatient Rehabilitation Facility with its principal place of business in Miami, Florida. Fiscal Year 1997 is the provider's first year of operation.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the Outpatient Rehabilitation benefits program. The intermediary for The Provider is First Coast in Jacksonville, Florida. The FI is responsible for:

- processing claims;
- making interim payments;
- providing consultative services to assist Outpatient Rehabilitation Facilities to maintain necessary fiscal records and otherwise qualify as providers;

- performing liaison activities between HCFA and Outpatient Rehabilitation Facilities; and
- conducting audits of cost reports submitted by Outpatient Rehabilitation Facilities,

Regulations

Outpatient Rehabilitation Facilities provide physical therapy, occupational therapy, and speech pathology services. To be eligible for coverage, the patient must be under the care of a physician and the services must be rendered in accordance with an established treatment plan.

Conditions for Medicare coverage of Outpatient Rehabilitation Facility services are outlined in Section 270 through 273 of the HCFA Outpatient Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered ***only*** by (or under the supervision of) a skilled therapist.

Medicare guidelines require Outpatient Rehabilitation Facilities to demonstrate that the services were: (1) required by the patient; (2) furnished under a treatment plan that has been reviewed by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving Outpatient Rehabilitation services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record.

Medicare regulations require that a patient be discharged once the treatment goals have been met. Maintenance therapy is not appropriate or allowable in an Outpatient Rehabilitation Facility setting. In addition, Medicare does not reimburse for services related to the overall good and welfare of patients, such as general fitness exercises or diversionary activities.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective was to determine whether the Outpatient Rehabilitation services claimed by the provider during FY 1997 met the Medicare eligibility and reimbursement requirements.

Scope and Methodology

We obtained the Provider Statistical and Reimbursement data from the FI to establish the universe of claims submitted by the provider. From a universe of 1 ,019 claims, we selected a

statistical sample of 100 claims. For details on our sampling methodology and the results of our sample see Appendix A.

To determine whether the beneficiary was eligible to receive Outpatient Rehabilitation services and whether the services were reasonable and necessary we:

- interviewed the beneficiary, a family member, or a close acquaintance;
- requested supporting medical records documentation maintained by the provider; and
- requested the Intermediary's medical review personnel to review each record.

The review was performed at the provider's place of business, the Miami Field Office and the FI's office in Jacksonville, Florida. The interviews were conducted at the beneficiaries' residences. The field work was conducted from August 1998 through September 1998.

The audit objective did not require an understanding or assessment of the internal control structure. Consequently, no evaluation of the internal control structure or internal controls was performed.

Our review was performed in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF MEDICAL REVIEW

Ninety-two claims containing 1,966 units of service were denied because they were not properly authorized, lacked medical necessity, or were not adequately documented.

Services Not Properly Authorized

Fifty-five claims containing 1,270 units of service were denied by medical review because services were not properly authorized. The beneficiaries were provided treatments without a physician establishing and certifying a plan for treatment. In most cases, the certification forms were not signed by a physician. In one particular case, the certification was not obtained for an order of treatment dated approximately 2 ½ months after the patient started receiving therapies.

Services Not Medically Necessary

Twenty-eight claims containing 597 units of service were denied because medical review determined that the services were not reasonable and medically necessary for the patients'

conditions. The medical review revealed minimal or no documentation to support the medical necessity of the services. The documentation was not specific regarding the medical history pertinent to the beneficiaries' conditions. In many instances, it failed to note the beneficiaries' past medical history or specific episode requiring outpatient rehabilitation therapy. Treatment plans were not individualized to the beneficiaries specific needs nor were the corresponding rehabilitative goals measured. In some cases, the therapies continued after the patient reached their rehabilitative goals. The medical reviewers noted beneficiaries were elderly individuals, most bed ridden, who had no specific illnesses for which the therapies were rendered. The conditions of the elderly individuals were not expected to improve significantly in a predictable period of time.

Inadequate Documentation

Nine claims containing 99 units of service were denied because the medical reviewers determined the documentation supporting the services was either missing or inadequate to support the services billed. Many medical records lacked documentation to support that the services were rendered or the documentation was inadequate to support the patient's potential benefit from therapies.

The provider did not have any controls in place to ensure that beneficiaries met the Medicare eligibility criteria for Outpatient Rehabilitation services, or that the services were properly authorized by a physician and documented in the beneficiaries' medical records.

The majority of the beneficiaries resided in adult congregate living facilities or skilled nursing facilities. Many beneficiaries did not know the provider who ordered the therapies, nor how they enrolled for the therapies.

We found that the provider was very aggressive in enrolling Assisted Living Facility residents without proper screening to determine eligibility requirements for Outpatient Rehabilitation services.

Based on the results of our review of a statistical sample of 100 claims, we projected the provider was paid at least $5 18,479' for services that did not meet the Medicare eligibility and reimbursement requirements.

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[1] This amount represents the lower limit of the 90% confidence interval. The point estimate of our sample was $600,734.

RECOMMENDATIONS

We are recommending HCFA direct the FI to:

- recover the $5 18,479 in overpayments for 1997; and

- ensure that the provider establishes controls to ensure that beneficiaries are eligible for Outpatient Rehabilitation services, and that the services are properly authorized and documented.

World Gym, through it's attorney Mark A. Coel, PA, has responded to our draft report. The response, in it's entirety, is included as Appendix B of this report. World Gym's response and our comments on the response follow:

World Gym's Response

World Gym's response can be summarized as:

- World Gym was selected for audit due to it's previous selection for 100% medical review by the Medicare Fiscal Intermediary (FI).

- World Gym believes it substantially complied with certifications of treatment and the documentation of services being medically necessary. World Gym also believes that the FI provided little or no guidance regarding both of these requirements.

- World Gym would like to conduct further discussions regarding our findings.

OIG Comment

- The 100% focused medical review was not part of the selection criteria for this provider. Regardless, the basis for selection for audit has no bearing on the results of the audit.

- In this audit, we utilized medical review personnel to determine whether services are properly authorized, medically necessary, and adequately documented. The medical review personnel used the HCFA and Medicare guidelines and regulations cited in our report as criteria in making their medical review decisions. These criteria are published in the Federal Register, reinforced by FI bulletins, and are available at HCFA's Internet web site.

- The World Gym was provided a copy of our draft report and an opportunity to respond accordingly. This fulfills our responsibilities to the auditee within Generally Accepted Government Auditing Standards and our own Policies and Procedures. World Gym maintains their rights to appeal our decisions to the FI and the courts.

Charles J. Curtis

SAMPLING METHODOLOGY AND RESULTS

OBJECTIVE

To determine whether Medicare payments to World Gym Physical Therapy Center during FY 1997 met the Medicare eligibility and reimbursement criteria.

POPULATION

We used the population of paid Outpatient Rehabilitation Facility claims for services rendered during the FY 1997. The population consisted of 1,019 claims with a total gross reimbursement of $868,700. The net reimbursement was $619,886.

The PS & R data provided by the FI containing the sampling frame was numbered sequentially. Although the frame contains 1,02 1 claims, we inadvertently gave only the first 1,0 19 claims a chance of being selected. Therefore, our sample population was 1,0 19 claims.

SAMPLE UNIT

The sample unit was a paid Outpatient Rehabilitation claim for a Medicare beneficiary. A paid claim includes multiple units of Outpatient Rehabilitation services claimed by the provider for the period of time covered by the claim.

SAMPLE DESIGN

An unrestricted random sample of paid claims was used.

SAMPLE SIZE

The sample size was 100 claims.

ESTIMATION METHODOLOGY

Using the RAT-STATS Variable Appraisal Program, we projected the amount of Medicare reimbursement for Outpatient Rehabilitation claims for the provider that did not meet the Medicare eligibility and reimbursement requirements.

RESULTS OF SAMPLE

Sample Size	Value of Sample	Number of Errors	Value of Errors	Units of Service	Units in Error
100	$62,223.30	92	$58,953.30	2,075	1,966

VARIABLE PROJECTIONS

Point Estimate: $600,734

At the 90% Confidence Level:

Lower Limit: $518,479

Upper Limit: $682,990

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Re: CIN A-04-98-01 191

Dear Mr. Curtis:

This letter is in response to your letter dated October 20, 1999 and the draft audit report attached thereto.

Before addressing the specifics of the draft audit report, I believe it is important to outline, for the record, some of the events which led up to and followed World Gym being placed on 100% focused medical review and which apparently resulted in this matter being referred to your office.

As is customary with cost reimbursed providers, particularly in the early stages of operations, World Gym received a number of ADRs from Blue Cross and Blue Shield of Florida ("BC/BS") for and with respect to claims submitted in 1997. Throughout 1997 and into the early part of 1998, World Gym worked diligently to respond to BC/BS's requests. In one instance, it appeared that ADRs provided to BC/BS had been lost or misplaced by BC/BS. When World Gym attempted to follow up with BC/BS as to documentation World Gym previously provided, BC/BS was unable to provide information to World Gym as to ADRs which were received and which were pending review. In

other instances, the documentation that World Gym provided to BC/BS was reviewed several months after receipt or simply ignored.

Despite World Gym's repeated attempts to determine from BC/BS what it needed to provide in response to BC/BS's request for additional documents and to otherwise comply with the review process, World Gym was arbitrarily placed on 100% focused review based on BC/BS's determination that World Gym was not timely responding to BC/BS's requests for additional documentation.

After being placed on 100% review, World Gym repeatedly attempted to obtain from BC/BS feedback as to the ADR process and information and guidance that would enable World Gym to increase its claim approval rate and to thus have the focused review reconsidered. As you know, the focused review process is designed to provide a forum whereby Medicare, through its intermediaries, seeks to educate providers as to the proper procedures for claims processing and record keeping. World Gym received little if any insight from BC/BS as to the deficiencies BC/BS perceived in connection with World Gym's plans of treatment and other records and how these deficiencies could be corrected. Numerous requests were made for a face to face meeting with the Utilization Audit Supervisors to discuss the details of BC/BS's concerns and proposals for corrective action. These requests were either ignored, rebuffed or never followed-up with World Gym.

Nevertheless, and despite the lack of any meaningful guidance from BC/BS, World Gym worked diligently on its own throughout its operations to correct the would-be short comings in its documentation. When the difficulties with BC/BS first began, World Gym retained the services of a registered nurse to assist it in improving its records and in developing a corrective action plan with respect to its operations and record keeping.

With respect to the specifics of the draft audit report, I offer you the following:

1. We believe that with respect to the plans of treatment and the authorization of service, there was substantial compliance with respect to certifications of treatment. While in some cases, plans of treatment were signed, but not dated, arguably, the plans were signed simultaneously with the date(s) noted on the certification or recertification forms. Once again, however, World Gym received no guidance from BC/BS with regard to this matter as part of the ADR process.

2. We believe that the documentation for the vast majority of the claims substantiates the medical necessity of the services provided and otherwise supported the services provided. Once again, however, World Gym received little if any guidance from BC/BS with respect to the issues associated with its documentation.

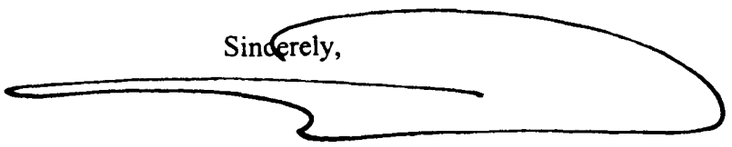
Based on the foregoing, we obviously take difference with your calculation of the alleged overpayment. With respect to the suggestion concerning a corrective action plan and the

establishment of controls, as you are probably aware, World Gym has ceased doing business as the result of the actions taken by BC/BS and the audit which followed.

I would very much appreciate you or Mr. Bustillo contacting me so that we can arrange a meeting so that we can address the specific issues concerning the records and perhaps reach an acceptable resolution before the audit report is finalized.

I look forward to hearing from you.

Sincerely,



Mark A. Coel

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