DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

August 17, 2006

Report Number: A-06-06-00047

Mr. Roberto A. Martinez, MS., LNFA
Administrator
Regent Care Center, Laredo
7001 McPherson Road
Laredo, Texas 78401

Dear Mr. Martinez:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Skilled Services at Regent Care Center of Laredo, Texas." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-06-00047 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SKILLED SERVICES AT REGENT CARE CENTER OF LAREDO, TEXAS

Daniel R. Levinson
Inspector General

August 2006
A-06-06-00047

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Prior to 1998, Medicare paid the costs of individual services provided to skilled nursing facility (SNF) patients using a retrospective reimbursement system. This system was vulnerable to abusive billing schemes because Medicare reimbursed SNFs for their actual costs, thus giving them a strong incentive to provide unnecessary and overpriced services to increase their Medicare payments. Our prior audit work[1] confirmed that some SNFs provided overpriced and unnecessary infusion therapy services that may have harmed patients.[2]

Currently, Medicare pays SNFs a daily rate to cover skilled services (e.g., infusion therapy, rehabilitation therapy, nursing) provided to Medicare patients during each day of a covered SNF stay; it does not base payments on the cost of individual services. For billing purposes, SNFs complete an assessment form called a Minimum Data Set (MDS) that places a patient in a specific payment group, known as a Resource Utilization Group (RUG), based on the patient's care and resource needs.

Although Medicare pays SNFs a daily rate based on each assigned RUG, it requires SNFs to record the charge for each service, such as infusion therapy, on each Medicare claim and to summarize the related charges in their annual cost reports. The Centers for Medicare & Medicaid Services (CMS) uses this information for various rate-setting and payment-refinement activities.

SNFs periodically assess patients' clinical progress. If a patient's condition changes substantially, the SNF may adjust the patient's MDS and reassign the patient a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim may have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

OBJECTIVE

Our objective was to determine whether Regent Care Center (Regent) of Laredo, Texas, provided patients with skilled services, particularly infusion therapy services, that were medically necessary and adequately supported by medical documentation.

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[1]We issued "Infusion Therapy Services Provided in Skilled Nursing Facilities" (A-06-99-00058) on December 13, 1999.

[2]In infusion therapy, medication is administered intermittently or continuously into a vein. Intravenous administration is the fastest way to deliver fluids throughout the body.

SUMMARY OF FINDINGS

For the period July 1 through December 31, 2002, Regent submitted 50 claims, each of which included charges for infusion therapy services.[3] Because SNFs are reimbursed based on the RUGs that appear on claims and not on the services provided by the SNF, medical reviewers performed a complete medical review of all skilled services provided to patients to determine whether RUGs were correctly assigned on all 50 claims. In addition, medical reviewers identified whether the infusion therapy services were medically necessary and adequately documented. The results of the skilled services and infusion therapy reviews are provided below.

Medical Review of All Skilled Services

A complete medical review of all skilled services on the 50 claims showed that Regent was properly reimbursed for 6 claims. However, of the 44 remaining claims, medical reviewers made the following recommendations:

- Thirty-eight claims should either be denied or partially denied because skilled services were not medically necessary at (1) the intense level provided in an SNF[4] and/or (2) the RUG level claimed. These errors occurred because Regent did not have a full understanding of SNF medical necessity requirements.

- Six claims should be denied because they were not supported by adequate documentation. These errors occurred because Regent did not follow controls in place to ensure that it supported all Medicare claims with sufficient medical documentation.

Because of these errors, Medicare overpaid Regent $136,292 for services that did not meet Medicare requirements.

Medical Review of Infusion Therapy Services

A review of infusion therapy services on the 50 claims showed that:

- Twenty-one claims included charges for infusion therapy services that were medically necessary and adequately documented. However, 2 of the 21 claims included infusion therapy services that could have been rendered in a nonskilled setting. These errors occurred because Regent did not have a full understanding of SNF medical necessity requirements.

- Twenty-nine claims incorrectly included charges for infusion therapy services that Regent did not render. On 28 of these claims, charges for infusion therapy services should have been reported as pharmacy charges.[5] These errors occurred because Regent

[3] Of these 50 claims, 33 contained at least one rehabilitation RUG.
[4] In these situations, services could have been provided in a nonskilled setting.
[5] We could not locate an invoice for the remaining claim and, therefore, could not determine whether charges for infusion therapy services should have been reported as pharmacy charges.

did not have adequate controls in place to ensure that it properly coded each service on the claims.

Though these errors did not result in overpayments, SNFs should accurately record charges for services on Medicare claims because CMS uses this information for various rate-setting and payment-refinement activities.

RECOMMENDATIONS

We recommend that Regent:

- refund to the Medicare program $136,292 in overpayments,
- provide training to its staff to ensure that it fully understands and complies with SNF medical necessity requirements so that future claims comply with these requirements,
- ensure that its staff follows controls in place so that all Medicare claims are supported with adequate medical documentation,
- reclassify the improperly reported pharmacy services and submit a revised Medicare cost report, and
- establish adequate controls to ensure that claims are properly coded.

REGENT'S COMMENTS

In its comments to our draft report, Regent agreed with our recommendations. Collectively, the full text of Regent's comments is included at Appendixes B and C.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Skilled nursing facilities (SNFs) provide daily services that include infusion therapy; speech, occupational, and physical therapies; and transfusions. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals and be for a condition previously treated at a hospital.

Medicare's Prospective Payment System for Skilled Nursing Facilities

Prior to 1998, Medicare paid the cost of individual services provided to SNF patients using a retrospective reimbursement system. This system was vulnerable to abusive billing schemes because Medicare reimbursed SNFs for their actual costs, thus giving them a strong incentive to provide unnecessary and overpriced services to increase their Medicare payments. Our prior audit work[1] confirmed that some SNFs provided overpriced and unnecessary infusion therapy services that may have harmed patients.[2]

The Balanced Budget Act of 1997 mandated the implementation of a prospective payment system that pays SNFs a daily rate to cover skilled services (e.g., infusion therapy, rehabilitation therapy, nursing) provided to a patient during each day of a covered SNF stay. Therefore, Medicare no longer bases payments on the cost of individual services. For billing purposes, SNFs complete a Minimum Data Set (MDS) assessment form that classifies a patient into a specific payment group, known as a Resource Utilization Group (RUG), based on the patient's care and resource needs.

Federal regulations require SNFs to complete MDSs on the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of patients' stays, and whenever a patient's medical condition substantially changes. The 5-day MDS includes the patient's initial recommended treatment and the corresponding RUG. SNFs periodically assess patients' progress. If a patient's condition changes substantially, the SNF may adjust the patient's MDS and reassign the patient a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim may have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

Skilled Nursing Facilities Must Record Individual Services on Medicare Claims

Although Medicare pays SNFs a daily rate based on each assigned RUG, Medicare requires SNFs to record the charges for all services on each Medicare claim. SNFs assign these costs to

[1] We issued "Infusion Therapy Services Provided in Skilled Nursing Facilities" (A-06-99-00058) on December 13, 1999.

[2] In infusion therapy, medication is administered intermittently or continuously into a vein. Intravenous administration is the fastest way to deliver fluids throughout the body.

revenue codes, each representing a specific service, such as infusion therapy, nursing care, or physical therapy. SNFs use the revenue code data to prepare their annual cost reports.

The accuracy of the cost reports is critical. The Centers for Medicare & Medicaid Services (CMS) uses this information for various rate-setting and payment-refinement activities that include updating price indexes for revising Medicare payment rates, projecting future Medicare expenditures, and determining adequate deductibles and premiums. In addition, the Government Accountability Office, the Office of Management and Budget, and other Federal agencies depend on accurate cost report information when conducting audits and evaluating SNFs.

Medicare Program Safeguard Contractors

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, in part, to strengthen CMS's ability to deter fraud and abuse in the Medicare program. In accordance with this legislation, CMS created program safeguard contractors to perform medical reviews, cost report audits, data analysis, provider education, and fraud detection and prevention. Under a contract with CMS, TriCenturion performs fraud and abuse safeguard functions for the Medicare Part A workload in Texas. TriCenturion performed the medical review for this audit.

Regent Care Center

Located in Laredo, Texas, Regent Care Center (Regent) is a nursing home with a Medicare-certified skilled nursing unit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Regent provided patients with skilled services, particularly infusion therapy services, that were medically necessary and adequately supported by medical documentation.

Scope

We selected Regent for our review because it had claimed charges for infusion therapy services that were among the highest of all Texas SNFs for dates of service from July 1 through December 31, 2002. During this period, Regent submitted 50 claims that totaled $189,176 and contained infusion therapy services.

We limited our review of internal controls to gaining an understanding of Regent's policies and procedures for (1) assessing patient care needs and completing their MDSs, (2) maintaining medical records, and (3) coding infusion therapy charges on Medicare claims. We performed our fieldwork at Regent Care Center in Laredo, Texas.

Methodology

To accomplish our objective, we:

- reviewed the applicable laws, regulations, and guidance concerning the Medicare payment process for SNFs;

- interviewed Regent officials and reviewed Regent's policies and procedures for (1) assessing patient care needs and completing their MDSs, (2) maintaining medical records, and (3) coding infusion therapy charges on Medicare claims;

- obtained Regent's medical records for the 50 claims;

- compared infusion therapy invoice amounts to infusion therapy charges on Medicare claims;

- forwarded the medical records for the claims to TriCenturion's medical reviewers to determine whether the claimed services were medically necessary and supported by adequate documentation; and

- obtained the medical review results on the sample claims and verified the overpayment amounts calculated by Mutual of Omaha, Regent's fiscal intermediary.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

For the period July 1 through December 31, 2002, Regent submitted 50 claims, each of which included charges for infusion therapy services.[3] Because SNFs are reimbursed based on RUGs that appear on claims and not on the services provided by the SNF, the medical reviewers also performed a complete medical review of all skilled services provided to patients to determine whether RUGs were correctly assigned on all 50 claims. In addition, medical reviewers identified whether these infusion therapy services were medically necessary and adequately documented. The results of the skilled services and infusion therapy reviews are provided below.

Medical Review of All Skilled Services

A complete medical review of all skilled services on the 50 claims showed that Regent was properly reimbursed for 6 claims. However, of the 44 remaining claims, medical reviewers made the following recommendations:

[3] Of these 50 claims, 33 contained at least one rehabilitation RUG.

- Thirty-eight claims should either be denied or partially denied because skilled services were not medically necessary at (1) the intense level provided in an SNF[4] and/or (2) the RUG level claimed. These errors occurred because Regent did not have a full understanding of SNF medical necessity requirements.

- Six claims should be denied because they were not supported by adequate documentation. These errors occurred because Regent did not follow controls in place to ensure that it supported all Medicare claims with sufficient medical documentation.

Appendix A contains a more detailed breakdown of the medical reviewers' findings on the 50 claims.

Because of these errors, Medicare overpaid Regent $136,292 for services that did not meet Medicare requirements.

Medical Review of Infusion Therapy Services

A review of infusion therapy services on the 50 claims showed that:

- Twenty-one claims included charges for infusion therapy services that were medically necessary and adequately documented. However, 2 of the 21 claims included infusion therapy services that could have been rendered in a nonskilled setting. These errors occurred because Regent did not have a full understanding of SNF medical necessity requirements.

- Twenty-nine claims incorrectly included charges for infusion therapy services that Regent did not render. On 28 of these claims, the charges for infusion therapy services should have been reported as pharmacy charges.[5] These errors occurred because Regent did not have adequate controls in place to ensure that it properly coded each service on the claims.

Though these errors did not result in overpayments, SNFs should accurately record the charges for services on Medicare claims because CMS uses this information for various rate-setting and payment-refinement activities.

MEDICAL REVIEW OF ALL SKILLED SERVICES

Services Were Not Medically Necessary

Pursuant to Title XVIII of the Social Security Act, section 1862(a)(1)(A), no payment may be made under Part A or Part B of Medicare for items or services that are not reasonable and

[4] In these situations, services could have been provided in a nonskilled setting.
[5] We could not locate an invoice for the remaining claim and, therefore, could not determine whether charges for infusion therapy services should have been reported as pharmacy charges.

necessary for the diagnosis or treatment of an illness or injury, or for improving the functioning of a malformed body member.

Pursuant to 42 CFR § 409.31(b), Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily; (2) the beneficiary needs care for a condition previously treated in a hospital or critical access hospital; and (3) the skilled services, as a practical matter, can be provided only in an SNF on an inpatient basis.

Pursuant to 42 CFR § 424.20, SNFs must assign patients to the RUG category that represents the required level of care. Regulations (42 CFR § 413.343(b)) also require periodic assessments of the patients' conditions and adjustments to the MDSs when the patients' conditions change.

The "Medicare Part A Intermediary Manual," sections 3101.9, 3101.10A, and 3132.3, also requires that, for rehabilitation therapy to be considered reasonable and necessary, the therapy must be provided to patients who are expected to improve significantly in a reasonable and generally predictable period.

The medical reviewers recommended that RUGS on 38 of the 50 claims reviewed should be denied or downcoded. For these 38 claims, which included 66 RUGs, the medical reviewers determined that 5 RUGs were medically necessary and supported by adequate documentation. For the remaining 61 RUGs, the reviewers recommended that:

- 45 RUGs be denied because all of the services were not medically necessary at the intense level provided in an SNF and

- 16 RUGs be downcoded because some of the services were not medically necessary at the RUG level claimed.

The reviewers cited multiple reasons for recommending either to deny or downcode the claims. The following two examples illustrate these reasons.

- A 75-year-old patient with a history of dementia was admitted to a hospital with fever, tachycardia, and hypertension. She received infusion therapy at the hospital and was discharged to Regent, where she received care that included both rehabilitation therapy and infusion therapy. The patient depended on staff for all of her care and mobility and required 24-hour nursing supervision for her chronically debilitated condition. The medical reviewers stated that her condition could not be expected to improve significantly within a reasonable and generally predictable period. Given her deteriorated mental and physical status, she could not participate meaningfully or obtain any long-term benefit from skilled rehabilitation therapy. The medical reviewers determined that she did not require skilled rehabilitation therapy and recommended that one of the rehabilitation RUGs on the claim be downcoded to an extensive services RUG, and the remaining rehabilitation RUG be denied.

- A 76-year-old patient with Parkinson's disease and Alzheimer's disease was hospitalized with acute bronchitis and pneumonia. Once his condition stabilized, he transferred to Regent for skilled rehabilitation therapy. However, according to the medical reviewers, his condition did not warrant care that could be provided only in an SNF setting. Moreover, the Regent admission orders did not specify the patient's level of care. Finally, the medical reviewers concluded that it was unrealistic to expect the patient to attain long-term benefit from skilled rehabilitation therapy. Therefore, the reviewers recommended that the rehabilitation RUGs be denied.

Regent completed patients' MDSs based on physician orders, evaluations, and hospital discharge summaries. In addition, Regent staff met weekly to discuss each patient's status. However, based on the medical reviewers' determinations and interviews with nursing home officials, Regent did not have a full understanding of the SNF medical necessity requirements, as stated above. As a result, Medicare overpaid Regent $108,363 for services that were not medically necessary.

Claims Were Not Supported by Adequate Documentation

Pursuant to Title XVIII of the Social Security Act, section 1819(b)(6)(C), SNFs must maintain clinical records, including MDSs and written plans of care, that adequately support the need for services provided to all SNF patients. Furthermore, 42 CFR § 483.40 requires that the physician approve orders for SNF care in writing.

The medical reviewers recommended denying 6 of the 50 claims reviewed because the services were not supported with valid physicians' orders that would have qualified the patients for skilled care.[6] For these 6 claims, which included 11 RUGs, the medical reviewers recommended that all of the RUGs be denied.

Regent did not follow the controls in place for maintaining the complete medical documentation needed to support the claims. Specifically, a Regent official stated that, although the facility had established procedures to ensure that patients' medical records were complete, these procedures were not always followed. For instance, the official had instructed the staff to file medical documentation daily and to conduct periodic, random chart audits to ensure that the documentation was complete. However, the official stated that the staff routinely filed medical records on a weekly or monthly basis and did not conduct periodic chart audits. As a result, Medicare overpaid Regent $27,929 for services that were not supported by adequate documentation.

MEDICAL REVIEW OF INFUSION THERAPY SERVICES

According to the CMS "Skilled Nursing Facility Manual," chapter 5, section 515.3(B), SNFs are required to use the proper revenue codes to report individual services on Medicare claims.

[6] Although the medical reviewers denied only 6 claims for inadequate documentation, they also noted some documentation deficiencies on 26 other claims that were denied primarily for lack of medical necessity. However, in all of those cases, the reviewers were able to base their determinations on the available documentation.

Of the 50 claims reviewed for infusion therapy services:

- Twenty-one claims included charges for infusion therapy services that were medically necessary and adequately documented.[7] However, 2 of the 21 claims included infusion therapy services that could have been rendered in a nonskilled setting. Based on the medical reviews and interviews with nursing home officials, Regent did not have a full understanding of the SNF medical necessity requirements.

- Twenty-nine claims incorrectly included charges for infusion therapy services that Regent did not render. On 28 of these claims, the charges for infusion therapy services should have been reported as pharmacy charges.[8] These errors occurred because Regent did not have adequate controls in place to ensure that it properly coded each service on the claims. A Regent official had trained an employee to code skilled services correctly but had failed to review the employee's work. As a result, Regent improperly reported pharmacy charges as infusion therapy charges on Medicare claims.[9]

Though these errors did not result in overpayments, SNFs should accurately record charges for services on Medicare claims because CMS uses this information for various rate-setting and payment-refinement activities.

CONCLUSION

From July 1 through December 31, 2002, Regent:

- received $136,292 for Medicare claims that were either medically unnecessary or inadequately documented; and

- reported on its Medicare cost report inflated infusion therapy charges that could affect future SNF rate-setting and payment-refinement activities.

RECOMMENDATIONS

We recommend that Regent:

- refund to the Medicare program $136,292 in overpayments,

- provide training to its staff to ensure that it fully understands and complies with SNF medical necessity requirements,

[7] In addition, Regent incorrectly reported pharmacy charges as infusion therapy charges for 4 of these 21 claims. Further, we could not locate invoices for 8 of these 21 claims and, therefore, could not determine whether these eight claims were proper.

[8] We could not locate an invoice for the remaining claim and, therefore, could not determine whether charges for infusion therapy services should have been reported as pharmacy charges.

[9] All claims with coding errors included dates of service during September 2002.

- ensure that its staff follows controls in place so that all Medicare claims are supported with adequate medical documentation,

- reclassify the improperly reported pharmacy services and submit a revised Medicare cost report, and

- establish adequate controls to ensure that claims are properly coded.

REGENT'S COMMENTS

In its comments to our draft report, Regent agreed with our recommendations. Regent responded that since FY 2004, its staff had participated in various Medicare-specific training sessions on clinical, financial, and documentation issues. Additionally, Regent also stated that it had (1) implemented systems to ensure that proper documentation procedures are followed and that patient-specific treatments are administered in accordance with Medicare requirements and (2) installed controls to ensure that claims are properly coded.

Collectively, the full text of Regent's comments is included at Appendixes B and C.

APPENDIXES

MEDICAL REVIEW DETERMINATIONS FOR THE 50 CLAIMS

A single claim can have multiple Resource Utilization Groups (RUGs) that cover different periods and pay different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently and make individual decisions on each one. The table below summarizes the medical review determinations for the 50 claims, including the total number of RUGs for each determination category and a breakdown of the number of RUGs denied, downcoded, and allowed.

Table 1: Summary of Resource Utilization Groups for the 50 Claims

			Recommendations		
Medical Determination	**No. of Claims**	**Total No. of Rugs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
Claims Allowed	6	7	-	-	7
Medically Unnecessary	38	66	45	16	5
Lack of Supporting Documentation	6	11	11	-	-
Total	**50**	**84**	**56**	**16**	**12**

Table 2: Detail of RUGs for the 50 Claims

The table below lists detailed information for the 50 claims reviewed and the medical reviewers' recommendations for each claim.

			Recommendations		
Claim No.	**Error Category**	**Total No. of RUGs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
1	M	2	1	1	
2	M	2		2	
3	M	2		2	
4	M	2	1	1	
5	M	1		1	
6	M	1	1		
7	D	3	3		
8	M	1	1		
9	M	1	1		
10		1			1
11	D	1	1		
12	M	1	1		
13	M	1	1		
14	M	1	1		
15	M	1	1		

Claim No.	Error Category	Total No. of RUGs	No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
16		2			2
17	M	2		1	1
18	M	2	2		
19	M	1	1		
20	M	2	1		1
21	M	2	1	1	
22		1			1
23	M	3		2	1
24	M	3	1	1	1
25	M	1	1		
26	D	3	3		
27	M	3	3		
28	M	3	3		
29	M	2		2	
30	M	1		1	
31	M	2	2		
32	M	2	2		
33	M	1	1		
34	M	2	2		
35	M	2		1	1
36	D	2	2		
37	M	1	1		
38	M	2	2		
39	M	2	2		
40		1			1
41		1			1
42	D	1	1		
43	M	2	2		
44	M	2	2		
45		1			1
46	M	1	1		
47	M	1	1		
48	D	1	1		
49	M	2	2		
50	M	3	3		
Total		**84**	**56**	**16**	**12**

Error Categories
M = Medically unnecessary
D = Lack of supporting documentation

Regent Care Center
Laredo

July 19, 2006

Department of Health and Human Services
Office of the Inspector General
Attention: Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Sir or Madam:

Please find attached various agendas/outlines of Medicare specific training sessions held with Regent Care Nursing staff commencing since FY 2004. These assist in insuring that past and current staff has been adequately trained in all facets dealing with Medicare clinical, financial and documentation issues.

Systems have also been put into place in order to safeguard and insure that proper documentation procedures are being followed and that adequate descriptions dealing with patient specific treatments have been administered with appropriate documentation in order to comply with all Medicare requirements.

Controls have been put into place to ensure all claims are properly coded with the company regional account manager also reviewing these reports at months' end closing.

A revised cost report will be forwarded from the Regent Care corporate office.

Sincerely,

R. A. Martinez

Roberto A. Martinez, MS., LNFA
Administrator

7001 McPherson Road • Laredo, Texas 78041 • 956.723.7001 • Fax 956.725.5611

REGENT CARE
SEMINAR AGENDAS 2004 - 2006

Medicare PPS for SNFs:
An Overview of Critical Issues for Upper Level Management
March 23, 2004

Medicare Basics

- Pre-Admission
- Day of Admission
- Post-Admission
- Part A Coverage Guidelines
- Definition of Daily Skilled Care
- RUG-III Classification System
- Medicare Assessment Schedule
- MDS Coding Issues
- Billing Concerns
- Consolidated Billing

Focus Areas for Upper Management

- Common Problems Resulting in Incorrect Revenue
- Pivotal Role of Nurses and Therapists on Medicare Payment
- Importance of Adequate Oversight Over Medicare Processes

Medicare A to Z: Beyond the Basics
March 23, 2004

Admission Steps/Data Crucial to Billing

- Entitlement Verification
- Medicare Secondary Payer (MSP) Screening
- Hospital Data
- Coverage Decision
- Advance Deposit Regulations

Notices of Non-coverage

- Part A
- Part B
- Medicare + Choice

Coverage Guidelines and Benefit Periods

- Part A Coverage Criteria
- 3-Day Hospital Stay
- 30-Day Transfer Rule
- Physician Certifications
- Physician Delegation of Tasks
- Benefit Period Rules
- Updating Common Working File for End of Skilled Care
- Definition of "Daily" Skilled Care

ICD-9 Coding Importance

- Primary Diagnosis
- Secondary Diagnosis
- Impact on Billing

Medicare Assessment Scheduling

- Assessment Reference Date (ARD) Options
- Use of Grace Days
- Factors to Consider When Selecting ARDs
- ARD Impact Case Studies
- Off-Cycle Assessments
- Proper Assignment of Assessment Modifiers
- Discharge and Leaves of Absence
- Default Payments

Focus Areas for Clinicians Under PPS for SNFs
December 6 – 7, 2004

Importance of the Assessment Process
- Areas of MDS Impact
- Impact of the MDS on Medicare Payment

RUG-III Classification System
- 44 Case-mix Groups Defined

Medicare Assessment Scheduling
- Assessment Reference Date (ARD) Defined
- ARD Options
- Factors to Consider When Scheduling Medicare Assessments
- Off-cycle Assessments
- Discharges and Leaves of Absences
- Default Payments

MDS Coding Issues
- Section by Section Discussion of Coding Guidelines
- Activities of Daily Living (ADL) and Case Studies
- Expected Therapy Calculations and Case Studies

Coverage Guidelines and Benefit Periods
- Part A Coverage Criteria
- 3-Day Prior Qualifying Hospital Stay
- 30-Day Transfer Rule
- Physician Certifications
- Physician Delegation of Tasks
- Benefit Period Rules and Case Studies
- Updating the Common Working File (CWF) When Skilled Care Ends

Skilled Coverage Defined
- Direct Skilled Nursing
- Direct Rehabilitation Services
- Indirect Nursing Oversight and Supervision
- Definition of "Daily"

Importance of ICD-9 Codes on the UB92

- Primary Diagnosis
- Secondary Diagnosis
- V-codes

FINE-TUNING MEDICARE: KEY FOCUS AREAS FOR MANAGEMENT
August 19, 2004

Critical Admission/Billing Practices

- Accurate Determination of Payer Status
- Medicare Secondary Payer (MSP) Screening
- Verification of 3-Day Hospital Stay

Definition of Skilled Care

- Direct Skilled Nursing Care
- Direct Skilled Rehabilitation Services
- Indirect Nursing Management: Skilled Oversight and Supervision

Revenue Impact of Medicare Assessment Scheduling

- Assessment Reference Date (ARD) Options
- Financial Impact of ARD Selection
- Case Studies

MDD Coding Pitfalls

- Section G: Activities of Daily Living (ADLs)
- ADL Index
- Section P1b: Actual Therapy Days and Minutes

Focus Areas of Upper Management

- Common Problems Resulting in Incorrect Revenue Under PPS
- Importance of Nurse/Therapy Teamwork
- Importance of Accurate ADL Coding
- Daily Medicare Meeting: Agenda and Attendees
- Weekly Medicare Meeting: Agenda and Attendees
- Monthly Pre-Billing Medicare Meeting: Agenda and Attendees

Common MDS Coding Pitfalls

- Section G: Activities of Daily Living (ADLs)
- ADL Index

Consolidated Billing for the Medicare Team

- Exclusion Categories
- Use of SNF Help File to Determine Financial Liability
- Common Problems with Consolidated Billing

Medical Review

- Types of Medicare Denials
- Common Reasons for Denials
- Common Documentation Problems That Can Result in Denials
- Medical Review and Appeals Management

Management of Medicare Services

- Daily Medicare Meeting: Agenda and Attendees
- Weekly Medicare Meeting: Agenda and Attendees
- Monthly Pre-Billing Meeting: Agenda and Attendees

Medicare Update: How to Optimize Compliance and Revenue in a Changing Environment
December 8 – 9, 2005

Effectively Transitioning from 44-Group RUGs to 53-Group RUGs
- Purpose of RUG Refinements
- Changes Effective January 1, 2006
- New RUG Categories
- Case-mix Index Maximization

Critical MDS Focus Areas
- Section G: Activities of Daily Living (ADLs)
- Section K5a: IV Feeding and Fluids
- Section P1a: Special Treatments
- Medicare Assessment Scheduling

Transitional Billing Issues

Medicare Part A Coverage Guidelines and Benefit Periods
- 3-Day Qualifying Hospital Stay
- 30-Day Transfer Rule
- Physician Certifications

Beneficiary Notice Initiative
- New Expedited Determination Notices
- Relationship of New Notices to Existing Notices of Non-coverage

Other Issues
- Part B Therapy Caps
- Recovery Audit Contractors (RAC)
- Comprehensive Error Rate Testing Program (CERT)

Key Revenue Focus Areas
- Skilled Services for Nursing Management (Oversight and Supervision)
- Documentation

MDS Coding Relating to Therapy
- Section P1b: Actual Therapy Days and Minutes
- Section T1b: Expected Therapy Days and Minutes

Documentation to Support Medicare Coverage

- Basic Elements of Documentation
- Documenting to Support Daily Skilled Care
- Examples of Documentation for Common Diagnosis

ICD-9 Coding

- Primary Diagnosis
- Secondary Diagnosis
- Impact on Billing

Exceptions to the Part B Therapy Caps
May 17, 2006

Part B Therapy Financial Limitations (Caps)

Exceptions Process
- CMS Regulations
- Automatic Exception Criteria
- Manual Exception Request

Intermediary Instructions (Mutual of Omaha)
- General Information on the Caps Exceptions
- Submission of Manual Exceptions
- Handling of Cap Denials Before and After March 13, 2006

Notice of Exclusions from Medicare Benefits (NEMB Form 20007)
- Form Completion
- Circumstances Under Which the Form Should Be Issued

Documentation of Medical Necessity
- Local Coverage Determinations
- Local Medical Review Determinations
- Medicare Manual 100-02, Sections 220 and 230

Documentation Tool ("Justification Statement") for Use of KX Modifier

Case Studies (To Illustrate Use of the Justification Statement Tool)

Correct Coding Initiative (CCI) Edits
May 18, 2006

- **Purpose and Effective Date of CCI Edits for SNFs**
- **Websites for CCI Edit Information**
- **Mutually Exclusive Code Pairs**
- **Comprehensive Code Pairs**
- **Use of 59 Modifier**
- **CCI Edit Examples**
- **CCI Edit Tool for Therapy Codes**

Medicare Update: Key Compliance and Revenue Focus Areas
May 18, 2006

- **Refinements to the Case-mix System**
- **53-Group RUG Hierarchy**
- **Qualifiers for New Rehab Plus Extensive Categories**
- **Timely Assessment Reference Date (ARD) Selection**
- **ARD Selector Tool: Demonstration of Use and Case Studies**

Regent Care Center
Laredo

August 2, 2006

Mr. Jason Arrington
Office of the Inspector General

Dear Mr. Arrington:

As per your request, please be advised that we are not challenging the amount of monies to be recouped by Medicare. If any further questions should arise, I may be contacted at 956-723-7001 during normal working hours.

Sincerely,

R. A. Martinez

Roberto A. Martinez
Administrator

7001 McPherson Road • Laredo, Texas 78041 • 956.723.7001 • Fax 956.725.5011