

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NORWALK HOSPITAL DID NOT
COMPLY WITH MEDICARE
INPATIENT REHABILITATION
FACILITY DOCUMENTATION
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Gloria L. Jarmon
Deputy Inspector General**

**February 2013
A-01-11-00531**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

An inpatient rehabilitation facility (IRF) provides rehabilitation for patients who require a hospital level of care to improve their ability to function. Effective for discharges on or after January 1, 2010, documentation requirements specified in 42 CFR § 412.622(a)(4) and (5) must be met to ensure that the IRF care is reasonable and necessary under the Social Security Act, § 1862(a)(1)(A). These requirements state that the patient's medical record at the IRF must include (1) a comprehensive preadmission screening, (2) a postadmission rehabilitation physician evaluation, and (3) an individualized overall plan of care developed by a rehabilitation physician. The documentation must also demonstrate that the patient requires an interdisciplinary team approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician.

The documentation requirements ensure that the IRF coverage requirements specified in 42 CFR § 412.622(a)(3) are met. The coverage requirements specify that at the time of admission, the IRF must have a reasonable expectation that the patient needs multiple intensive therapies, including physical or occupational therapy; is able to actively participate and demonstrate measurable functional improvement; and requires supervision by a rehabilitation physician to assess the patient and modify the course of treatment as needed to maximize the benefit from the rehabilitation process.

Norwalk Hospital (the Hospital) is a 328-bed not-for-profit acute care community teaching hospital located in Norwalk, Connecticut, that operates a 25-bed IRF unit. Based on the Centers for Medicare & Medicaid Services' (CMS) National Claims History data, Medicare paid the Hospital \$8,136,686 for 325 IRF claims for services provided to beneficiaries during calendar year 2010. Our audit covered these 325 claims.

OBJECTIVE

Our objective was to determine whether the Hospital billed IRF claims that complied with Medicare documentation requirements.

SUMMARY OF FINDINGS

For 98 of the 100 claims that we sampled, the Hospital billed IRF claims that did not comply with Medicare documentation requirements. Specifically, for these 98 claims, the Hospital's medical records did not include sufficient documentation to support any of the following required elements:

- documentation that a comprehensive preadmission screening occurred within the 48 hours immediately preceding the admission,
- documentation that a rehabilitation physician performed a postadmission evaluation within the first 24 hours of the IRF admission,

- documentation that a rehabilitation physician developed and documented an individualized overall plan of care within 4 days of the IRF admission, and
- documentation that interdisciplinary team meetings met all Federal requirements.

The Hospital's procedures did not ensure that IRF services were documented according to Medicare requirements.

The Hospital improperly received \$2,738,379 in Medicare payments associated with 98 of the 100 claims that we sampled. Based on our sample results, we estimate that Medicare overpaid the Hospital an additional \$5,236,378 for the 225 IRF claims that were not included in our sample.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$2,738,379 for 98 IRF claims in our sample that did not comply with Medicare requirements;
- work with CMS to resolve the 225 IRF claims that were not included in our sample, with potential overpayments estimated at \$5,236,378;
- identify IRF claims in subsequent years that did not meet Medicare documentation requirements and refund any associated overpayments; and
- develop and implement procedures to ensure that it bills Medicare only for IRF services that comply with Medicare documentation requirements.

NORWALK HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital agreed with our fourth recommendation and described steps that it has taken to review and improve the IRF unit's documentation protocols and procedures. The Hospital disagreed with the rest of our recommendations. After considering the Hospital's comments on our draft report, we maintain that all of our findings and recommendations are correct.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Inpatient Rehabilitation Facilities	1
Norwalk Hospital	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope	2
Methodology	2
FINDINGS AND RECOMMENDATIONS	3
PROGRAM REQUIREMENTS	4
DOCUMENTATION OF PREADMISSION SCREENING	5
Federal Requirements.....	5
Inadequate Documentation of Preadmission Screening.....	5
DOCUMENTATION OF POSTADMISSION REHABILITATION	
PHYSICIAN EVALUATION	6
Federal Requirements.....	6
Inadequate Documentation of Postadmission Rehabilitation	
Physician Evaluation	6
DOCUMENTATION OF INDIVIDUALIZED OVERALL PLAN OF CARE	7
Federal Requirements.....	7
Inadequate Documentation of Individualized Overall Plan of Care	7
DOCUMENTATION OF INTERDISCIPLINARY TEAM MEETINGS	8
Federal Requirements.....	8
Inadequate Documentation of Interdisciplinary Team Meetings	8
THE HOSPITAL’S PROCEDURES DID NOT ENSURE THAT	
DOCUMENTATION REQUIREMENTS WERE MET	9
OVERPAYMENT ESTIMATES	9
RECOMMENDATIONS	9

NORWALK HOSPITAL COMMENTS AND
OFFICE OF INSPECTOR GENERAL RESPONSE.....9
 Audit Was Unnecessary and Unprecedented10
 Documentation “Checklist” To Recommend Claims Denials Inconsistent With
 Coverage and Payment Requirements10
 Audit Approach Contained Other Limitations.....11
 Hospital’s Consultants Disagree With Findings12

APPENDIXES

- A: SAMPLING DESIGN AND METHODOLOGY
- B: SAMPLE RESULTS AND ESTIMATES
- C: EXAMPLES OF MEDICAL REVIEW DETERMINATIONS
- D: NORWALK HOSPITAL COMMENTS

INTRODUCTION

BACKGROUND

Inpatient Rehabilitation Facilities

An inpatient rehabilitation facility (IRF) provides rehabilitation for patients who require a hospital level of care to improve their ability to function. Effective for discharges on or after January 1, 2010, documentation requirements specified in 42 CFR § 412.622(a)(4) and (5) must be met to ensure that the IRF care is reasonable and necessary under the Social Security Act (the Act), § 1862(a)(1)(A). These requirements state that the patient's medical record at the IRF must include (1) a comprehensive preadmission screening, (2) a postadmission rehabilitation physician evaluation, and (3) an individualized overall plan of care developed by a rehabilitation physician. The documentation must also demonstrate that the patient requires an interdisciplinary team approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician.

The documentation requirements ensure that the IRF coverage requirements specified in 42 CFR § 412.622(a)(3) are met. The coverage requirements specify that at the time of admission, the IRF must have a reasonable expectation that the patient needs multiple intensive therapies, including physical or occupational therapy; is able to actively participate and demonstrate measurable functional improvement; and requires supervision by a rehabilitation physician to assess the patient and modify the course of treatment as needed to maximize the benefit from the rehabilitation process.

The Centers for Medicare & Medicaid Services (CMS) designed the 2010 IRF regulations to reflect current best practices in medicine for IRF care¹ and to emphasize the importance of rehabilitation physician² documentation quality in the management of complex inpatient rehabilitation services. The *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 1, section 110.1.1, reiterates the requirement in 42 CFR § 412.622(a)(4) that a determination be made through a careful preadmission screening within 48 hours immediately preceding the IRF admission and that "trial" IRF admissions, during which physicians admit patients for 3 to 10 days to assess whether they would benefit significantly from IRF treatment, are no longer considered reasonable and necessary.

During our calendar year (CY) 2010 audit period, CMS contracted with Part A Medicare Administrative Contractors (MAC) to process and pay claims submitted by IRFs. CMS also contracted with Quality Improvement Organizations (QIO) to protect the integrity of the Medicare trust fund by ensuring that Medicare pays only for services that are reasonable, medically necessary, and provided in the most appropriate settings.

¹ CMS National Provider Training Call Transcript, Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements, November 12, 2009, page 4.

² For the purposes of this report, "rehabilitation physician" is the IRF physician, with specialized training and experience in rehabilitation, in charge of the patient during the inpatient rehabilitation stay, as opposed to ancillary physicians, such as cardiologists, neurologists, internal medicine specialists, and others who assist the rehabilitation physician at the IRF.

Norwalk Hospital

Norwalk Hospital (the Hospital) is a 328-bed not-for-profit acute care community teaching hospital located in Norwalk, Connecticut, that operates a 25-bed IRF unit. Medicare paid the Hospital \$8,136,686 for 325 IRF claims for services provided to beneficiaries during CY 2010.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital billed IRF claims that complied with Medicare documentation requirements.

Scope

Our audit covered the 325 IRF claims with CY 2010 discharge dates, for which the Hospital received total Medicare payments of \$8,136,686.

We limited our review of the Hospital's internal controls to its procedures for documenting IRF services and submitting Medicare claims.

We conducted our fieldwork at the Connecticut QIO and at the Hospital from September 2011 through April 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed with CMS officials the 2010 revisions to the Medicare regulations for documenting IRF care;
- extracted paid claim data from CMS's National Claims History file to identify the 325 IRF claims covered by our review;
- selected a stratified random sample of 100 claims, for which Medicare paid the Hospital \$2,777,896, including \$462,362 in outlier payments³ (see Appendix A for our sampling design and methodology);

³ An outlier payment is a payment in addition to the basic prospective payment system payment for cases involving extraordinarily high costs.

- reviewed data from CMS’s Common Working File for the 100 sampled claims to (1) validate claim information extracted from the National Claims History file and (2) determine whether any of the selected claims had been canceled or adjusted;
- obtained the services of Qualidigm, the Connecticut QIO, to review all medical records associated with the 100 sampled claims to determine whether the documentation supported the IRF level of care;
- obtained the services of National Government Services, the Hospital’s MAC, to confirm the accuracy of the Connecticut QIO’s determination by conducting an independent medical review on a subset of the sampled claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated overpayments associated with claims that did not comply with Medicare documentation requirements;
- used our sample results to estimate the total value of overpayments in our sampling frame (see Appendix B for our sample results and estimates); and
- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

The Hospital frequently billed IRF claims that did not comply with Medicare documentation requirements. For 98 of the 100 claims that we sampled, the Hospital billed IRF claims that did not comply with Medicare documentation requirements. Specifically, for these 98 claims, the Hospital’s medical records did not include sufficient documentation to support any of the following required elements:

- documentation that a comprehensive preadmission screening occurred within the 48 hours immediately preceding the admission,
- documentation that a rehabilitation physician performed a postadmission evaluation within the first 24 hours of the IRF admission,

- documentation that a rehabilitation physician developed and documented an individualized overall plan of care within 4 days of the IRF admission, and
- documentation that interdisciplinary team meetings met all Federal requirements.

See Appendix C for examples of medical review determinations.

The Hospital's procedures did not ensure that IRF services were documented according to Medicare requirements.

The Hospital improperly received \$2,738,379 in Medicare payments associated with 98 of the 100 claims that we sampled. Based on our sample results, we estimate that Medicare overpaid the Hospital an additional \$5,236,378 for the 225 IRF claims that were not included in our sample.

PROGRAM REQUIREMENTS

Pursuant to the Act, § 1862(a)(1)(A), no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member. Effective for discharges on or after January 1, 2010, documentation requirements specified in 42 CFR § 412.622(a)(4) and (5) must be met to ensure that IRF care is reasonable and necessary under the Act (74 Fed. Reg. 39762, 39788 (August 7, 2009)). These requirements state that the patient's medical record at the IRF must include (1) a comprehensive preadmission screening, (2) a postadmission rehabilitation physician evaluation, and (3) an individualized overall plan of care developed by a rehabilitation physician. The documentation must also demonstrate that the patient requires an interdisciplinary team approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician.

The documentation requirements are intended to ensure that the IRF coverage requirements specified in 42 CFR § 412.622(a)(3) are met (42 CFR § 412.622(a)(4)). The coverage requirements in section 412.622(a)(3) specify that at the time of admission the IRF must have a reasonable expectation that the patient meets all of the following requirements: (1) requires the active and ongoing intervention of multiple therapies, including physical or occupational therapy; (2) is sufficiently stable and able to actively participate and demonstrate measurable functional improvement in an intensive rehabilitation therapy program; and (3) requires supervision by a rehabilitation physician to assess the patient medically and functionally and to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

Section 110.2 of the Manual states that for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the postadmission physician evaluation described in section 110.1.2, and the overall plan of care described in section 110.1.3) must demonstrate that IRF admission is reasonable and necessary.

DOCUMENTATION OF PREADMISSION SCREENING

Federal Requirements

Pursuant to 42 CFR § 412.622(a)(4), at the time of admission, the patient's medical record at the IRF must contain documentation of a comprehensive preadmission screening performed within the 48 hours immediately preceding the IRF admission. The screening includes a detailed review of the patient's condition and medical history, serves as the basis for the initial determination of whether the patient meets the requirements for an IRF admission, and is used to inform a rehabilitation physician, who reviews and documents concurrence with the findings and results of the screening.

According to the Manual, chapter 1, section 110.1.1, IRFs must justify the IRF admission by documenting in the patient's medical record⁴ the results of a preadmission screening that was conducted within the 48 hours immediately preceding the admission.⁵ The preadmission documentation must be detailed, comprehensive, and indicate the following: the patient's prior level of function (prior to the event causing the need for intensive rehabilitation therapy), the expected level of improvement, the expected length of time to achieve the level of improvement, an evaluation of the risk for clinical complications, the conditions that caused the need for rehabilitation, the therapies needed, the expected frequency and duration of IRF treatment, the anticipated discharge destination, and any anticipated postdischarge treatments. The medical record must include evidence of the rehabilitation physician's review and concurrence with the findings of the preadmission screening after the screening is completed and prior to the IRF admission.

Inadequate Documentation of Preadmission Screening

For 98 claims, the preadmission screening documentation did not justify the IRF level of care. The documentation did not sufficiently describe the patient's prior level of function (prior to the event causing the need for intensive rehabilitation therapy), the expected level of improvement, the expected length of time to achieve the level of improvement, an evaluation of the risk for clinical complications, the conditions that caused the need for rehabilitation, the therapies needed, the expected frequency and duration of IRF treatment, the anticipated discharge destination, and any anticipated postdischarge treatments.

⁴ Reiterating the requirement in 42 CFR § 412.622(a)(4)(i), the Manual, section 110.1.1, requires "all preadmission screening documentation (including documentation transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) be retained in the patient's medical record at the IRF." Information housed only in the acute care hospital's medical record that is not in some way included in or copied over to the IRF medical record may not be used to demonstrate the IRF's compliance with the requirements in 42 CFR § 412.622(a)(3), (4), and (5) or the Manual, chapter 1, section 110.

⁵ Pursuant to 42 CFR § 412.622(a)(4)(A), "a preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted ... to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record."

In addition, the patients' medical records included only brief handwritten narratives about the history of present illness, with lists of comorbid conditions; names of specific insurance coverage; and checkoff boxes identifying the ordered therapies and general functional characteristics, such as levels of prognosis, mental status, ambulation, endurance, and motivation. This preadmission screening information was insufficient to document, in accordance with the requirements in 42 CFR § 412.622(a)(4)(i) and section 110.1.1 of the Manual, a comprehensive assessment and the specific reasons for the inpatient rehabilitation admission.

For 73 of the 98 claims with preadmission screening documentation that did not justify, in accordance with CMS's requirements, that IRF care was reasonable and necessary, the referring physician indicated the date of the signature but not the time. Therefore, we were unable to determine whether (1) the referring physicians performed the screenings within 48 hours of admission or (2) the rehabilitation physicians had reviewed and concurred with the findings of the preadmission screenings before the admissions. For an additional 17 of the 98 claims, preadmission screenings were either not documented or lacked signatures, dates, and times of when the screenings were performed or approved.

DOCUMENTATION OF POSTADMISSION REHABILITATION PHYSICIAN EVALUATION

Federal Requirements

Pursuant to 42 CFR § 412.622(a)(4), the patient's medical record at the IRF must document a postadmission rehabilitation physician evaluation that meets all of the following requirements: completed within 24 hours of the patient's admission to the IRF, documents the patient's status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care.

According to the Manual, chapter 1, section 110.1.2, the postadmission evaluation must also (1) identify any relevant changes that may have occurred since the preadmission screening; (2) include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities; and (3) support the medical necessity of the IRF admission.

Inadequate Documentation of Postadmission Rehabilitation Physician Evaluation

For 98 claims, the medical records did not document that the postadmission rehabilitation physician evaluations met all of the requirements. Specifically:

- For 88 claims, the medical records did not document that the rehabilitation physicians performed, within the first 24 hours of IRF admission, a history and physical examination. The medical records for these claims included rehabilitation physician progress notes that presented only a brief review of the patients' medical and functional status. These notes did not include additional required information, such as a comparison

with the information noted in the preadmission screening documentation and an identification of any relevant changes that may have occurred since the preadmission screening. As a result, there was insufficient documentation to establish, in accordance with CMS's requirements, that IRF care was reasonable and necessary.

- For 10 claims, the rehabilitation physicians completed history and physical examinations within the first 24 hours of admission but did not include additional required information, such as a comparison with the information noted in the preadmission screening documentation and an identification of any relevant changes that may have occurred since the preadmission screening. As a result, there was insufficient documentation to establish, in accordance with CMS's requirements, that IRF care was reasonable and necessary.

In addition, 22 of the 98 claims would have met the admitting history and physical examination requirement if the dates and times of the examinations had been documented to have occurred within 24 hours of the IRF admissions.

DOCUMENTATION OF INDIVIDUALIZED OVERALL PLAN OF CARE

Federal Requirements

Pursuant to 42 CFR § 412.622(a)(4), the patient's IRF medical record must contain an individualized overall plan of care that is developed by the rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission.

Further, guidance from the Manual, chapter 1, section 110.1.3, states that it is the sole responsibility of a rehabilitation physician to integrate information that is required in the overall plan of care, including an estimated length of stay, and to document it in the patient's IRF medical record. This integration includes information from the preadmission screening, postadmission physician evaluation, and other information from the assessments of all therapy disciplines and clinicians involved in treating the patient. The overall plan of care must detail the patient's medical prognosis, anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The overall plan of care must include the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.

Inadequate Documentation of Individualized Overall Plan of Care

For 98 claims, the medical records did not contain properly documented overall plans of care developed by rehabilitation physicians. Although IRF personnel prepared and documented assessments usually within 4 days of the IRF admission, rehabilitation physicians did not develop and integrate this information into individualized overall plans of care and document them in the medical records. Therefore, there was no plan of care documentation by the

rehabilitation physicians for any of the required elements, including medical prognosis, anticipated interventions, functional outcomes, and estimated lengths of stay.

DOCUMENTATION OF INTERDISCIPLINARY TEAM MEETINGS

Federal Requirements

Pursuant to 42 CFR § 412.622(a)(5) and the Manual, chapter 1, section 110.2.5, for an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care, as evidenced by documentation retained in the patient's medical record of interdisciplinary team meetings that meet all of the following requirements: (1) led by a rehabilitation physician; (2) consisting of a registered nurse, a social worker or case manager, and a licensed or certified therapist from each therapy discipline involved in treating the patient; (3) occurring at least once per week throughout the stay to implement appropriate treatment services and review progress toward goals; and (4) documenting the results and findings of the team meetings and the rehabilitation physician's concurrence with those results and findings.

The Manual, chapter 1, section 110.2.5, reiterates these requirements and also requires that documentation of each team meeting include the names and professional designations of the participants.

Inadequate Documentation of Interdisciplinary Team Meetings

For 98 claims, medical record documentation was not sufficient to support the occurrence of interdisciplinary team meetings and did not contain all required elements. The rehabilitation physicians made only brief mention of team meetings in certain progress notes, which describe the daily status of the patients, and did not address additional requirements. For example, one rehabilitation physician's only reference to team meetings came at the end of progress notes where he stated, "continue acute rehab as discussed at the team meeting today, including physical therapy, occupational therapy, speech therapy, registered nurse, and case management."

Documentation retained in the patients' medical record of interdisciplinary team meetings did not identify:

- the results, findings, and decisions made at the meetings;
- the concurrence of the rehabilitation physician with the results, findings, and decisions; and
- the names and professional designations of the participants.

THE HOSPITAL'S PROCEDURES DID NOT ENSURE THAT DOCUMENTATION REQUIREMENTS WERE MET

The Hospital's procedures did not ensure that IRF services were documented according to Medicare requirements. Specifically, medical record documentation practices were not adapted to comply with all of the 2010 documentation requirements. As a result, medical reviewers could not determine whether an IRF level of care was reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act.

OVERPAYMENT ESTIMATES

The Hospital billed \$2,738,379 during CY 2010 for 98 IRF claims that did not comply with Medicare documentation requirements. Based on our sample results, we estimate that Medicare overpaid the Hospital an additional \$5,236,378 for the 225 IRF claims that were not included in our sample.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$2,738,379 for 98 IRF claims in our sample that did not comply with Medicare requirements;
- work with CMS to resolve the 225 IRF claims that were not included in our sample, with potential overpayments estimated at \$5,236,378;
- identify IRF claims in subsequent years that did not meet Medicare documentation requirements and refund any associated overpayments; and
- develop and implement procedures to ensure that it bills Medicare only for IRF services that comply with Medicare documentation requirements.

NORWALK HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital agreed with our fourth recommendation and described steps that it has taken to review and improve the IRF unit's documentation protocols and procedures. The Hospital disagreed with the rest of our recommendations. The Hospital's comments regarding these recommendations are summarized below and are included in their entirety as Appendix D.

After considering the Hospital's comments on our draft report, we maintain that all of our findings and recommendations are correct.

Audit Was Unnecessary and Unprecedented

Norwalk Hospital Comments

The Hospital noted that our audit marked the first time that we have targeted a specific hospital for compliance with the revised Medicare documentation requirements, which took effect on January 1, 2010. The Hospital stated that we should have conducted a wider review of compliance across the industry for this initial review of compliance with these new requirements.

Office of Inspector General Response

We use data analysis to identify providers that bill claims that have a high risk of overpayments. We selected the Hospital for our initial review of IRF compliance with the revised documentation requirements because our data showed that the Hospital was among the highest in its region for number of claims with outlier payments for CY 2010. Medicare made \$991,617 in outlier payments for 92 IRF claims to the Hospital, which has a 25-bed IRF unit.

Documentation “Checklist” To Recommend Claims Denials Inconsistent With Coverage and Payment Requirements

Norwalk Hospital Comments

The Hospital stated that our methodology was flawed because we relied on a documentation checklist to recommend the disallowance of IRF claims rather than examining the medical necessity of IRF services that the Hospital provided. The Hospital suggested that a missing note or a failure to document within a prescribed time frame could eliminate payment for a case that otherwise was reasonable and necessary. The Hospital cited excerpts from the Manual, chapter 1, section 110, including:

- “Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary’s individual care needs.”
- “Medicare contractors must consider the documentation in a patient’s IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the postadmission physician evaluation, the overall plan of care, and the admission orders.”

The Hospital stated that these excerpts show that consideration of documentation is important, but it is not necessarily the exclusive means of assessing medical necessity. The Hospital concluded that because our review did not examine medical necessity, there is no basis for a recommendation that the Hospital refund overpayments to the Medicare program.

Office of Inspector General Response

We based our audit of these claims on 42 CFR § 412.622(a)(3), (4), and (5) and CMS’s interpretive guidance in the Manual, chapter 1, section 110. CMS established these specific

requirements for time and content to ensure that providers meet IRF coverage requirements. Based on these requirements, the Hospital's documentation was deficient on multiple levels.

The IRF regulations unambiguously conditioned the reasonableness and necessity of an IRF admission on the inclusion of specified forms of documentation in the patient record. In addition to the excerpts from the Manual that the Hospital noted, the Manual also states that "IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR § 412.622(a)(3), (4), and (5) as interpreted in this section."

Lastly, we disagree with the Hospital's assertion that because we did not examine medical necessity, there is no basis for a recommendation that the Hospital refund overpayments to the Medicare program. IRF compliance with the documentation requirements is necessary to determine whether a provider had met the coverage requirements for reasonable and necessary IRF care.

Audit Approach Contained Other Limitations

Norwalk Hospital Comments

The Hospital stated that we did not review its preadmission screening process and that we refused to consider and use the acute care records that were part of the IRF patient chart. The Hospital suggested that we should have incorporated these readily available records when making our findings and recommendations.

Office of Inspector General Response

We maintain that the Hospital did not provide comprehensive evidence in the IRF medical records of the results of a preadmission screening process. The Manual emphasizes the importance of the content of the preadmission screening document: "The focus of the review of preadmission screening information will be on its completeness, accuracy, and extent to which it supports the appropriateness of the IRF admission decision, not how the process is organized" (chapter 1, section 110.1.1).

Contrary to the Hospital's assertion, we considered the acute care records in our determination of overall findings even though it was unclear whether these records were (1) part of the permanent IRF charts, (2) represented in any electronic format designating its inclusion in IRF documentation, and (3) available to clinicians during the IRF stays.⁶ We reviewed these records even though CMS has stated in the regulations, in the Manual, and in the training clarifications online that a provider must retain the required preadmission screening documentation in the patient's medical record at the IRF. CMS officials informed us that any documents pertaining to the admission or care of a patient in the IRF must be a permanent part of the medical record at

⁶ On December 5, 2011, we asked the Hospital whether the IRF medical records (including preadmission screening documentation) that it provided to us were complete. On December 14, 2011, the Hospital responded that all history and physicals were included in the records provided, and the "Level of Care Assessments" were the preadmission screening documents. During February 2012, the Hospital provided us with additional acute care records.

the IRF. They also stated that records housed only in the acute care record that are not included or copied over to the IRF medical record may not be used to demonstrate compliance with Medicare requirements. Further, CMS officials stated that Medicare reviewers may not go back to the acute care record to find relevant information on the IRF admission or care.

In considering these acute care records, for 40 of the 100 sample claims, we found documentation of acute care rehabilitation physician consultations that were performed within 48 hours of IRF admission. However, only 10 of the 40 claims complied with the Medicare requirement that the IRF rehabilitation physician approve the IRF admission prior to the admission. Because approvals were not time stamped for 30 claims, we could not determine whether these approvals were made prior to the IRF admission. For 8 of the 10 claims, acute care rehabilitation physician consultations were not accompanied by the other required documentation for Medicare IRF coverage. The remaining two claims demonstrated overall compliance with the documentation requirements for Medicare IRF coverage.

Hospital's Consultants Disagree With Findings

Norwalk Hospital Comments

The Hospital stated that it engaged FTI Consulting, Inc. (FTI), to review Medicare claims in our sample and provide professional and expert opinion on whether the records in those cases supported the claims as reasonable and necessary. According to the Hospital, FTI has determined that for a significant number of the sample cases, the patients needed the IRF level of services.

Office of Inspector General Response

As stated in our report, the Connecticut QIO and National Government Services, the Hospital's MAC, assisted us in determining whether the Hospital complied with Medicare documentation requirements. Further, CMS officials concurred with our application of the IRF documentation requirements. Our medical review experts agreed that the Hospital's documentation was deficient for the key required elements and did not comply with Medicare requirements.

APPENDIXES

APPENDIX A: SAMPLING DESIGN AND METHODOLOGY

POPULATION

The population consisted of Norwalk Hospital (the Hospital) inpatient rehabilitation facility (IRF) claims for discharges in calendar year 2010.

SAMPLING FRAME

We obtained a Microsoft Access table of 360 IRF claims and removed claims with zero paid amounts. The resulting table contained a sampling frame of 325 IRF claims with a total paid amount of \$8,136,685.49.

SAMPLE UNIT

The sample unit was an IRF claim.

SAMPLE DESIGN

Our sample design was a stratified random sample.

Stratum	IRF Claim Payment Range	Number of IRF Claims	Dollar Value of IRF Claim Payments
1	\$2,038.95 to \$58,924.67	318	\$7,562,676
2 (100% review)	Greater than \$58,924.67	7	574,010
Total		325	\$8,136,686

SAMPLE SIZE

We randomly selected 93 claims from stratum 1 and selected all 7 claims from stratum 2. Our total sample size was 100 IRF claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLED UNITS

We consecutively numbered the sample units in the frame from 1 to 318. After generating 93 random numbers for stratum 1, we selected 93 corresponding frame items. We selected all seven claims from stratum 2.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the dollar value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	IRF Claims in Error	Value of Overpayments
1	318	\$7,562,676	93	\$2,203,886	91	\$2,164,369
2	7	574,010	7	574,010	7	574,010
Total	325	\$8,136,686	100	\$2,777,896	98	\$2,738,379

Estimated Overpayments

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$7,974,757
Lower limit	7,488,994
Upper limit	8,460,520

APPENDIX C: EXAMPLES OF MEDICAL REVIEW DETERMINATIONS

The following examples of medical review determinations underscore the Hospital's noncompliance with the documentation requirements, pursuant to 42 CFR § 412.622(a)(3)(4)(5), for reasonable and necessary IRF care. The examples represent clinical scenarios that may have qualified as reasonable and necessary for IRF coverage if comprehensive planning for an ongoing coordinated and focused delivery of care had been documented as required for the preadmission screen, the postadmission evaluation, the overall plan of care, and an interdisciplinary approach to care.

EXAMPLE 1

Pursuant to the Manual, chapter 1, section 110.2.4, close rehabilitation physician involvement in the patient's care is required, including face-to-face visits to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. The requirement for IRF supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress in consideration of their medical conditions. The required rehabilitation physician visits must be documented in the patient's medical record at the IRF.

The Hospital was reimbursed \$73,335, including an outlier payment of \$37,469, for a 28-day IRF stay for a patient with a traumatic brain injury involving surgeries. The patient's medical record did not document that the rehabilitation physicians:

- defined goals and identified methods to attain measurable functional improvement for the patient at the onset of the admission and throughout the stay and
- integrated a medical and functional course of care for the patient, as the progress notes were brief and addressed mostly medical issues.

Because the medical record documentation did not include sufficient detail and justification supporting the patient's acute rehabilitation potential at the time of admission and throughout the stay, medical reviewers could not determine whether the IRF care was reasonable and necessary.

EXAMPLE 2

According to the Manual, chapter 1, section 110, "the IRF benefit is not to be used as an alternative to the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitation treatment provided, until the patient has completed the full course of treatment."

The Hospital was reimbursed \$93,105, including an outlier payment of \$55,562, for a 63-day IRF stay immediately preceded by a 3-day stay at the Hospital's acute inpatient unit for a patient

who was experiencing an evolving right middle cerebral artery stroke. The patient's medical record did not indicate that the rehabilitation physician:

- evaluated the patient's practical potential for cognitive rehabilitation prior to and at the time of admission, as the patient was admitted with delirium, somnolence, and aspiration, all clinical complications that limit the patient's ability to actively participate in and benefit from intensive inpatient rehabilitation, and
- integrated a medical and functional course of care for the patient, as the progress notes were brief and lacked evidence of communication with the interdisciplinary team.

Because the patient's medical record did not include sufficient detail and justification for the IRF admission, medical reviewers could not determine whether the IRF care was reasonable and necessary. However, medical reviewers could determine, based on detailed documentation provided by other physicians, that the patient had clinical complications warranting a completion of the full course of treatment in the Hospital's acute inpatient unit beyond the 3-day stay. The premature IRF admission, lengthy IRF stay, and costly outlier payment would likely have been avoided if the acute inpatient unit had better managed the patient's clinical complications and if the IRF had complied with documentation requirements.



VIA OVERNIGHT DELIVERY

November 19, 2012

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
Office of Inspector General
U.S. Department of Health and Human Services
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

**Re: Norwalk Hospital's Response to
Draft Report Number A-01-11-00531 (October 22, 2012)
Office of Inspector General ("OIG")
U.S. Department of Health and Human Services ("DHHS")**

Dear Mr. Armstrong:

This letter responds to the OIG's Draft Report Number A-01-11-00531 entitled "Norwalk Hospital Did Not Comply With Medicare Inpatient Rehabilitation Facility Documentation Requirements" (the "Draft Report"). In the Draft Report, the OIG recommends that Norwalk Hospital (the "Hospital"):

1. refund to the Medicare program \$2,738,379 for 98 inpatient rehabilitation facility ("IRF") claims from 2010 that, according to the OIG, did not comply with Medicare requirements;
2. work with the Centers for Medicare and Medicaid Services ("CMS") to resolve the 225 IRF claims from 2010 that were not included in the OIG's sample, with potential overpayments estimated at \$5,236,378;
3. identify IRF claims in subsequent years that did not meet Medicare documentation requirements and refund any associated overpayments; and
4. develop and implement procedures to ensure that the Hospital bills Medicare only for IRF services that comply with Medicare documentation requirements.



Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 2

Introduction

Established in 1893, the Hospital is a 328-bed not-for-profit community hospital that operates a 25-bed accredited IRF unit and has been a partner in the Medicare Program since its inception in 1965. The Hospital's IRF unit has provided high quality care to the community for the last 30 years. Although we agree, as discussed below, that the IRF unit's documentation could have been enhanced, the IRF unit provided reasonable and necessary services that improved the quality of life for its patients.

The Hospital respects the OIG's role in assessing compliance to ensure that Medicare dollars are spent on reasonable and necessary services. The compliance program at the Hospital is dedicated to the same basic principles and based on the OIG's Compliance Program Guidance for Hospitals. The Hospital aims to provide quality medically necessary care, generate and maintain comprehensive documentation, code and bill accurately and correctly, monitor and audit billings, and promptly refund any identified overpayments.

Response to OIG Recommendation Number 4

In response to the OIG's fourth recommendation, the Hospital agrees that it should continuously improve its procedures to ensure that it bills Medicare only for IRF services that comply with Medicare documentation requirements. At the time of the OIG audit, the Hospital had a preadmission screening process in place for the IRF unit. That process involved physician review and discussion of each case referred for admission to the unit. When the Hospital's preadmission screening process resulted in a decision to decline a referral for admission, the Hospital cooperated with the referring physician as well as the patient and his or her family to identify and locate an appropriate, alternative care setting.

The OIG's audit prompted the Hospital to take immediate steps to review the IRF unit's documentation protocols and practices to make certain that the steps in the process and decisions made were documented consistent with Medicare documentation requirements. While the OIG audit results were pending, the Hospital retained FTI Consulting, Inc. ("FTI"), an internationally-known, reputable consulting firm with extensive expertise in all Medicare requirements for IRF services and whose work product has been acceptable to OIG, CMS and the Department of Justice for settlement purposes in reviews and investigations of other Medicare providers and suppliers. Under FTI's guidance, the Hospital enhanced and improved the IRF unit's procedures for preadmission screening, post-admission assessment, the interdisciplinary team approach, care delivery and discharge procedures with particular focus on ensuring that the IRF team was documenting consistent with Medicare documentation requirements. This effort involved a thorough review of the IRF unit's policies and procedures, one-on-one training of all IRF unit

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 3

clinicians, including rehabilitation physicians, and follow-up audits to confirm that the team had achieved full compliance with the revised policies and processes. The Hospital completed this work prior to April 1, 2012.

Response to OIG Recommendation Numbers 1-3

The Hospital disagrees with, and strongly objects to, the OIG's first three recommendations and reserves all rights in the event that CMS accepts the OIG's proposed recommendations. The Hospital's specific reasons for not concurring with the OIG's proposed recommendations are set forth below.

A. Singling out Norwalk Hospital for this type of audit was unnecessary and unprecedented.

This audit marks the first time, in Region I and possibly nationwide, that the OIG has targeted a specific hospital for compliance with the revised Medicare documentation requirements for IRFs, which took effect on January 1, 2010. 42 C.F.R. §412.622 (a)(4) and (5) (the "2010 Documentation Requirements"). In fact, during discussions with the Hospital the OIG referred to its audit as a "pilot audit." The OIG's treatment of the Hospital, the OIG's analysis of the audit results, and the OIG's recommendations to CMS should have been similar to other "pilot audits," such as the study presented in the OIG's September 2012 report entitled "Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims with Late Patient Assessment Instruments for Calendar Years 2009 and 2010" (A-01-11-00534). That audit did not single out any individual IRF. Especially in this case, which involved an assessment of compliance with documentation requirements and did not involve review of billing, coding, or timely filing errors, the Hospital feels strongly that the OIG should have conducted a wider review, sampling compliance across the industry before targeting a specific hospital.

Not only has the OIG singled out the Hospital, but it has also chosen to use a title for the report that is conclusory. For this reason, we respectfully request that the OIG revise the title to truly reflect how the OIG characterized the audit to the Hospital: "Review of Inpatient Rehabilitation Facility Admissions at Norwalk Hospital for Calendar Year 2010."

B. The OIG's use of a documentation "checklist" to recommend denial of IRF claims is illogical and inconsistent with CMS' coverage and payment requirements.

CMS issued revised regulations governing IRF services "to reflect changes that have occurred in medical practice during the past 25 years and the implementation of the IRF PPS." 74 Fed. Reg.

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 4

39762, 39788 (August 7, 2009). In revising the IRF coverage and payment requirements, CMS indicated that the requirements would be “used to determine whether individual IRF claims are for reasonable and necessary services under section 1862(a)(1) of the Act” (*id.*) and revised 42 C.F.R. §412.622 to set forth specific, technical documentation standards. When CMS promulgated the final regulations, it also issued revisions to Section 110 in Chapter 1 of the Medicare Benefit Policy Manual (“MBPM”).¹

CMS recognized in the introduction to Section 110 that “Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary’s individual care needs.” Further, in Section 110.1, CMS states that “Medicare contractors must consider the documentation contained in a patient’s IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.” (emphasis added). This statement signifies that consideration of documentation is an important, but not necessarily the exclusive, means of assessing medical necessity. In responses to Frequently Asked Questions generated during the CMS roll out of the revised regulations in 2009, CMS emphasized that medical reviewers must look at “appropriateness of IRF admission,” as illustrated by its response to the following question concerning documentation of preadmission screening:

Clarification regarding whether an IRF claim could be denied because a preadmission screening contains missing or conflicting information.

Answer: We expect that IRFs would make every effort possible to include the basic information that we are requesting in the medical record so that medical reviewers can determine the appropriateness of the admission. The information should sufficiently describe the services furnished and the medical need for these services. If missing or conflicting information is not reasonably explained in the appropriate document in the IRF medical record, then the IRF claim could be subject to denial.

¹ Although CMS indicated that the MBPM provisions were simply intended to summarize the regulatory coverage requirements and “will not contain substantive requirements beyond those that are in the regulation,” (*id.* at 39789 and 39790), CMS added ten specific preadmission screening documentation requirements to the Manual that were not set forth in the regulation. These requirements, which the OIG used to assess the Hospital and discussed in the Draft Report, included: documentation of prior level of function, expected level of improvement, expected length of time necessary to achieve improvement, evaluation risk for clinical complications, conditions that caused the need for rehabilitation, treatment needed, expected frequency and duration of treatment, anticipated discharge destination, anticipated post-discharge treatments and any other relevant information.

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 5

Follow up to information for the November 12 provider training call, available at: https://www.cms.gov/InpatientRehabFacPPS/Downloads/IRF-Training-call_version_4.pdf. See, question 10. (emphasis added)

CMS made a similar comment in clarifying a question about documentation of the post-admission physician evaluation:

Clarification regarding whether an IRF claim may be subject to denial if the post-admission physician evaluation was not completed within the 24 hours immediately following the IRF admission, even though the patient's medical and functional status appeared to warrant an IRF admission.

Answer: Yes, an IRF claim is subject to denial if the documentation requirements are not met. However, we expect that IRFs would make every effort possible to include the basic information that we are requesting in the medical record so that medical reviewers can determine the appropriateness of the IRF admission.

Follow up to information for the November 12 provider training call, available at: https://www.cms.gov/InpatientRehabFacPPS/Downloads/IRF-Training-call_version_4.pdf. See, question 18. (emphasis added)

According to the Draft Report, the OIG's objective in the audit was "to determine whether the Hospital billed IRF claims that complied with Medicare documentation requirements." However, the OIG's audit did not review medical necessity. In fact, the OIG repeatedly stated that the OIG's review would not and actually did not examine the overall medical necessity of any particular claim. Furthermore, the OIG indicated that several claims may demonstrate medical necessity and, hence, encouraged the Hospital to pursue the Medicare claims appeal process.

It is difficult to understand why the OIG concluded that overpayments occurred based solely on a checklist review without a proper analysis of medical necessity. Rote checklist reviews elevate form over substance and lead to illogical and incorrect results. A missing note or a failure to document within a prescribed time frame (e.g. preadmission assessment no earlier than 48 hours prior to admission or post-admission assessment within 24 hours) could obviate payment for a case that otherwise proves to be reasonable and necessary. With respect to the timing requirements, the fact that a physician may have documented the preadmission assessment within 24, 48 or 72 hours of admission does not change or otherwise affect a patient's need for inpatient rehabilitation services.

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 6

In a review of any institution, a case might contain all the checklist documentation elements but lack support for medical necessity. For example, the OIG determined that Case #11 met the 2010 Documentation Requirements. However, FTI reviewed Case #11 and found that the patient's functional deficits did not support the need for inpatient rehabilitation services. It is certainly not in the Hospital's interest to refute the OIG's finding in one of the only two cases found to be in compliance, but the Hospital has elected in this response to highlight this contradiction because it demonstrates the underlying flaw in the OIG's rote reliance on a documentation checklist to assess the reasonableness and necessity of inpatient rehabilitation admissions.

CMS clearly warns against the use of any such "rule of thumb" to deny an IRF claim in both the revised sections 110 and 110.2.2 of MBPM as well as the previous section 110.1 of MBPM, which instructed its contractors as follows:

Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.

Since the OIG's review did not examine medical necessity, there is no basis for recommending that overpayments occurred. Simply put, the OIG's analysis was incomplete. Without an appropriate and complete analysis of whether each individual claim was reasonable and necessary, there is no support for a recommendation that the Hospital refund overpayments to CMS.

C. The OIG's audit approach contained other limitations that exacerbated the unreasonableness of the recommendations.

In addition to reliance on the documentation checklist, the OIG's audit approach contained two other limitations that further exacerbated the error rate and high dollar overpayments that form the basis for the OIG's recommendations.

1. The OIG did not review the Hospital's preadmission screening process.

Although Medicare regulations require that an IRF have an "effective" preadmission screening process in place, the OIG's methodology, as described in the Draft Report, indicates that it did not request copies of policies and procedures or otherwise examine the Hospital's procedures

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 7

and processes other than after the fact to “discuss[ed] the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements.” Draft Report at page 3. As discussed above, the Hospital did have a preadmission screening process in place. The medical director of the IRF unit met in person with other members of the unit’s team daily to review and discuss each patient referred to assess appropriateness for admission. If a patient was not appropriate, then referral for admission was declined, and the Hospital worked with the patient and family to find an appropriate alternative setting. The OIG’s exclusive reliance on the documentation checklist approach, with no substantive assessment of the Hospital’s process, resulted in an incomplete review that cannot support the conclusion that the Hospital was wrongly paid for IRF services provided.

2. The OIG refused to consider and utilize the acute care records that were part of the IRF patient chart.

In the Draft Report, the OIG cites Section 110.1.1 of MBPM “[r]eiterating” section §412.622(a)(4)(i)) by requiring that “all preadmission screening documentation (including documentation transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) be retained in the patient’s medical record at the IRF.” Draft Report at page 5, Footnote 4. The OIG goes on to state that “[i]nformation housed only in the acute care hospital’s medical record that is not in some way included in or copied over to the IRF medical record may not be used to demonstrate the IRF’s compliance with the requirements in 42 C.F.R. §412.622(a)(3),(4), and (5) or the Manual, Chapter 1, section 110.” *Id.*

The majority of the patients admitted to the Hospital’s IRF unit are transferred from the acute care unit of the Hospital or another acute care hospital. In 2010, the medical director of the IRF unit and the rest of the unit’s team based admission decisions on a review of a detailed consulting report from the psychiatrist who assessed patients during their acute care stays to determine whether they would meet the coverage requirements for inpatient rehabilitation. These consult reports were maintained electronically. Like many hospitals, the Hospital is moving towards the development of an electronic medical record that will contain documentation of all aspects of a given patient’s care and treatment, regardless of where those services are provided on the Hospital’s campus. In 2010, limited portions of IRF medical records were maintained electronically, including psychiatrist consult reports. These reports were readily accessible from the computer terminals on the IRF unit. In addition, when a patient was admitted to the IRF unit, the patient’s acute care chart was sent with the patient to the IRF unit where the paper acute care chart remained for three days while the patient’s post admission assessment was conducted and the interdisciplinary care plan developed.

While not specifically stated in the Draft Report, the OIG informed the Hospital that the psychiatrist’s consulting reports, which formed the basis for the inpatient rehabilitation team’s

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 8

preadmission screening assessment, could not be considered because they were not copied and physically included in the IRF unit's paper medical record. However, the IRF clinical team considered these reports as a part of the inpatient rehabilitation medical record. Section 110.1.1 of MBPM requires that preadmission screening documentation be retained "in the patient's medical record at the IRF." The electronic records containing psychiatrists' consults were maintained in the patient's electronic medical record, which was readily accessible from computer terminals at the IRF unit. It is hard to imagine that CMS developed a regulation and manual provision only three years ago when the entire health care industry was moving toward electronic medical records and excluded the possibility that a medical record relevant to preadmission screening might be maintained electronically. Yet, the OIG apparently would only have considered the psychiatry consults if the Hospital had printed out copies of the electronic record and placed them physically in the printed patient record. As a result, since the OIG did not consider the psychiatry records to be part of the IRF chart, it apparently did not consider these records, nor accorded any weight to these records, in the audit. It is incomprehensible that the OIG would not incorporate these readily available acute care records when deciding to impose such a devastating overpayment amount based on medical necessity. The acute care records were considered to be a part of the IRF records, and the Hospital considered these acute care records in making decisions about admissions.

D. IRF experts disagree with the OIG's conclusions.

The Hospital has engaged FTI to review the Medicare claims in the OIG's sample and provide FTI's professional, expert opinion on whether the records in those cases supported the claims as reasonable and necessary. Although FTI's review is ongoing, FTI has already determined for a significant number of sample cases, including the two cases described in Appendix C of the Draft Report, that the medical records support the conclusion that IRF services provided were reasonable and necessary.

The following summarizes FTI's findings for the cases cited in Appendix C:

1. Example 1: Complexities of medical co-morbidities required inpatient level of care

The OIG report contends that the patient's medical record did not document the following:

- The rehabilitation physician's defined goals and identified methods to attain measurable functional improvement for the patient at the onset of the admission and throughout the stay; and

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 9

- Evidence that the rehabilitation physician integrated a medical and functional course of care for the patient, as the progress notes were brief and addressed mostly medical issues.

For the above reasons, the OIG concludes that its medical reviewers could not determine whether the IRF care was reasonable and necessary.

FTI found that the documentation supported the patient's inpatient rehabilitation admission. The patient required the services of occupational therapy and speech therapy in order to improve his "activities of daily living" (ADLs), cognition, and nutrition. He received limited therapy services initially due to seizures and the adverse effects of medication. His therapy was increased as his medical condition improved and he received 15.75 hours of therapy during the last full week of care. Unfortunately, the patient began to experience intermittent desaturation during therapy. He returned to the acute hospital setting for surgery. The complexity of this patient's medical co-morbidities required an inpatient level of care; a lower level of care would not have been able to safely manage the patient's medical conditions.

2. Example 2: Record supports need for inpatient level of IRF care based on complexity of rehabilitation services and need for medical management

Appendix C of the OIG report states: "The patient's medical record did not indicate that the rehabilitation physician:

- Evaluated the patient's practical potential for cognitive rehabilitation prior to and at the time of admission, as the patient was admitted with delirium, somnolence, and aspiration, all clinical complications that limit the patient's ability to actively participate in and benefit from intensive rehabilitation; and
- Integrated a medical and functional course of care for the patient, as the progress notes were brief and lacked evidence of communication with the interdisciplinary team."

Additionally, the OIG found that because the patient's medical record did not include sufficient detail and justification for the IRF admission, medical reviewers could not determine whether the IRF care was reasonable and necessary. The medical reviewers also determined that the patient had clinical complications warranting a completion of the full course of treatment in the Hospital's acute inpatient unit beyond the three-day stay.

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 10

FTI found that the record supported the need for inpatient rehabilitation services based on the complexity of the rehabilitation services and the need for medical management of the patient's other medical comorbidities. The patient experienced an acute right cerebrovascular accident that required the services of three therapy disciplines. Prior level of function was independent in ambulation and ADLs. The patient's medical conditions related to diabetes, hypertension and dysphagia, were managed by the medical staff. The patient subsequently made progress in her cognitive, eating, grooming and social cognition function and was able to be discharged to a lower level of care for further rehab treatment. FTI noted that a clinical finding of aspiration does not necessarily limit a patient's ability to actively participate in a rehab program. Many rehab patients experience aspiration and effective medical management prevents clinical complications associated with the condition.

FTI is a leading expert in this field. Its assessment of these cases, as well as the balance of the audit sample, should be given significant consideration.

Conclusion

Norwalk Hospital respectfully requests that the OIG revise the Draft Report to eliminate the first three recommendations for significant refunds and self-audits. There is no basis for recommending that the Hospital make financially crippling refunds based solely on a documentation "checklist" review. In essence, the OIG is recommending to CMS that the Hospital be reimbursed only \$162,656 for all of the IRF services furnished to all of the Medicare beneficiaries during calendar year 2010. Such a draconian result would not cover even a fraction of the Hospital's actual costs and expenses for 2010. Even if these patients were admitted to skilled nursing facilities instead, Medicare would have paid a significant amount in 2010 for the care of these patients.

Alternatively, Norwalk Hospital respectfully requests that the OIG revise the first three recommendations in the Draft Report to recommend that CMS delay recoupment of any overpayments and that the self-audit of any subsequent years be delayed until the Hospital has had an opportunity to exhaust its appeal rights through the third level of the Medicare claims appeal process (the administrative law judge hearing). Without the appeal process, neither the OIG nor the Hospital (or even CMS for that matter) is able to know conclusively whether each IRF claim should be reimbursed.

Michael J. Armstrong
Office of Inspector General
November 19, 2012
Page 11

Thank you for the opportunity to review and comment on the Draft Report. We sincerely hope that you will consider and accept our comments and recommendations.

Sincerely,

A handwritten signature in blue ink that reads "Daniel J. DeBarba, Jr." with a stylized flourish at the end.

Daniel DeBarba, Jr.
President and Chief Executive Officer

Enclosure

OIG's Draft Report