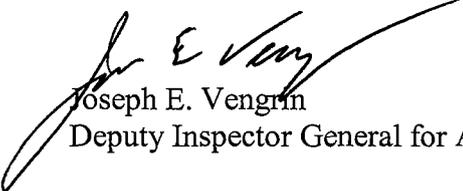




APR 12 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Inpatient Rehabilitation Facility Admissions at Whittier Rehabilitation Hospital for Calendar Year 2003 (A-01-04-00531)

Attached is an advance copy of our final report on inpatient rehabilitation facility admissions at Whittier Rehabilitation Hospital (the Hospital) in Westborough, Massachusetts, for calendar year 2003. We will issue this report to the Hospital within 5 business days.

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from conditions requiring intensive inpatient rehabilitation therapy. Medicare covers inpatient hospital rehabilitation for beneficiaries who require a more coordinated, intensive program of multiple services than is generally provided in a skilled nursing facility or on an outpatient basis. Among other criteria for inpatient hospital rehabilitation, Medicare requirements also state that the beneficiary must be expected to show significant practical improvement within a reasonable period of time. Medicare paid the Hospital, which is a 74-bed IRF, almost \$14.6 million for IRF services in 2003.

The objective of our review was to determine whether the Hospital submitted IRF claims that met Medicare requirements.

The Hospital submitted numerous IRF claims that did not meet Medicare requirements. For 47 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 43 claims, the beneficiaries were capable of significant practical improvement but could have received rehabilitation services in a less intensive setting such as a skilled nursing facility or an outpatient facility.
- For four claims, the beneficiaries were not capable of significant practical improvement as a result of therapy or were medically unable to participate in intensive treatment.

The Hospital inappropriately billed for these services because its preadmission screening procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement as a result of therapy, or were unable to participate in intensive rehabilitation treatment. As a result, the Hospital received \$527,510 in unallowable Medicare payments for the 47 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$4.8 million for IRF claims during 2003.

We recommend that the Hospital:

- refund to the Medicare program the \$4.8 million estimated overpayment for 2003;
- identify and refund any overpayments for subsequent years' IRF claims that did not meet Medicare requirements; and
- strengthen its preadmission screening procedures to provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, and are able to participate in intensive rehabilitation.

In its comments on our draft report, the Hospital strongly disagreed with our findings and recommendations and stated that all denied claims should be further reviewed by another contractor. The Hospital requested that any cases that a nonphysician reviewer disallowed because of lack of medical necessity be referred to a physician reviewer with training and experience in rehabilitation. In addition to responding to individual review decisions, the Hospital raised general objections to the methodology that our medical reviewer used to review the sampled claims.

We resubmitted the denied claims to the medical reviewer to address the Hospital's concerns. The medical reviewer, who is a physician certified by the Centers for Medicare & Medicaid Services to conduct reviews, conducted a second review of all denied claims. In light of the clarifying information that the Hospital provided in its response, the medical reviewer reversed 11 of the original determinations. We have adjusted this report to reflect the revised number and value of overpayments in our sample and the estimated value of overpayments in the population.

If you have any question or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2684. Please refer to report number A-01-04-00531.

Attachment



APR 17 2007

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number: A-01-04-00531

Dr. Alfred J. Arcidi
President and Chief Executive Officer
Whittier Rehabilitation Hospital
P.O. Box 1250
Westborough, Massachusetts 01581

Dear Dr. Arcidi:

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 Inpatient Rehabilitation Facility Admissions at Whittier Rehabilitation Hospital for Calendar Year 2003." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination regarding 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).

If you have any questions or comments about this report, please do not hesitate to contact me at (617) 565-2684 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-04-00531 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services, Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF INPATIENT
REHABILITATION FACILITY
ADMISSIONS AT WHITTIER
REHABILITATION HOSPITAL FOR
CALENDAR YEAR 2003**



Daniel R. Levinson
Inspector General

April 2007
A-01-04-00531

Office of Inspector General

<http://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:

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The Office of Audit Services (OAS) provides all 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.

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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. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

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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

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from conditions requiring intensive inpatient rehabilitation therapy. Medicare covers inpatient hospital rehabilitation for beneficiaries who require a more coordinated, intensive program of multiple services than is generally provided in a skilled nursing facility or on an outpatient basis. Among other criteria for inpatient hospital rehabilitation, Medicare requirements also state that the beneficiary must be expected to show significant practical improvement within a reasonable period of time.

Whittier Rehabilitation Hospital (the Hospital) is a 74-bed IRF in Westborough, Massachusetts. Medicare paid the Hospital almost \$14.6 million for IRF services in 2003.

OBJECTIVE

The objective of our review was to determine whether the Hospital submitted IRF claims that met Medicare requirements.

SUMMARY OF FINDINGS

The Hospital submitted numerous IRF claims that did not meet Medicare requirements. For 47 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 43 claims, the beneficiaries were capable of significant practical improvement but could have received rehabilitation services in a less intensive setting such as a skilled nursing facility or an outpatient facility.
- For four claims, the beneficiaries were not capable of significant practical improvement as a result of therapy or were medically unable to participate in intensive treatment.

The Hospital inappropriately billed for these services because its preadmission screening procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement as a result of therapy, or were unable to participate in intensive rehabilitation treatment. As a result, the Hospital received \$527,510 in unallowable Medicare payments for the 47 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$4.8 million for IRF claims during 2003.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program the \$4.8 million estimated overpayment for 2003;

- identify and refund any overpayments for subsequent years' IRF claims that did not meet Medicare requirements; and
- strengthen its preadmission screening procedures to provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, and are able to participate in intensive rehabilitation.

AUDITEE'S COMMENTS

In its comments on our draft report, the Hospital strongly disagreed with our findings and recommendations and stated that all denied claims should be further reviewed by another contractor. The Hospital requested that any cases that a nonphysician reviewer disallowed because of lack of medical necessity be referred to a physician reviewer with training and experience in rehabilitation. In addition to responding to individual review decisions, the Hospital raised general objections to the methodology that our medical reviewer used to review the sampled claims.

The Hospital's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We resubmitted the denied claims to the medical reviewer to address the Hospital's concerns. The medical reviewer, who is a physician certified by the Centers for Medicare & Medicaid Services to conduct reviews, conducted a second review of all denied claims. In light of the clarifying information that the Hospital provided in its response, the medical reviewer reversed 11 of the original determinations. We have adjusted this report to reflect the revised number and value of overpayments in our sample and the estimated value of overpayments in the population.

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INTRODUCTION

BACKGROUND

Inpatient Rehabilitation Facility Services

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from conditions requiring intensive inpatient rehabilitation therapy. According to the “Medicare Benefit Policy Manual,” Pub. No. 100-02 (the Manual), Medicare covers inpatient hospital rehabilitation for beneficiaries who require a more coordinated, intensive program of multiple services than is generally provided in a skilled nursing facility or on an outpatient basis. Among other criteria for inpatient hospital rehabilitation, Medicare requirements also state that the beneficiary must be expected to show significant practical improvement within a reasonable period of time.

Inpatient Rehabilitation Facility Prospective Payment System

Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs effective for cost-reporting periods beginning on or after January 1, 2002. Under that system, the Centers for Medicare & Medicaid Services (CMS) pays IRFs for patient discharges using a classification system that assigns beneficiaries to 1 of 100 case-mix groups depending on their clinical characteristics.

Program Safeguard Contractors

As authorized by the Health Insurance Portability and Accountability Act of 1996, CMS contracts with program safeguard contractors (PSC) to perform Medicare program integrity activities. Under CMS’s Umbrella Statement of Work, these contractors conduct medical reviews, cost report audits, data analyses, provider education, and/or fraud detection and prevention.

Whittier Rehabilitation Hospital

Whittier Rehabilitation Hospital (the Hospital) is a 74-bed IRF in Westborough, Massachusetts, which provides comprehensive inpatient and outpatient rehabilitation services. For fiscal year 2002, its final year under cost reimbursement, the Hospital received Medicare payments totaling approximately \$13 million for 1,217 discharges. For fiscal year 2003, the Hospital’s first year under the prospective payment system, the Hospital received Medicare payments totaling approximately \$15.1 million for 1,174 discharges. These amounts represent a 16-percent increase in payments and a 3.5-percent decrease in discharges from fiscal year 2002 to 2003.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the Hospital submitted IRF claims that met Medicare requirements.

Scope

Our review covered discharge dates in calendar year 2003. We selected a random sample of 100 claims from a universe of 1,114 IRF claims for which the Hospital received total Medicare payments of \$14,557,963.

We limited our review of internal controls to obtaining an understanding of the Hospital's preadmission screening process for evaluating whether beneficiaries were likely to benefit significantly from inpatient hospital rehabilitation rather than rehabilitation in a less intensive setting.

We performed our review from October 2004 through July 2005.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- extracted the Hospital's paid claims data for 2003 from the CMS National Claims History file;
- selected a random sample of 100 paid claims totaling \$1,373,119 (Appendix A);
- requested and obtained supporting medical and billing records from the Hospital for each sampled claim;
- reviewed the Hospital's billing records and CMS's Common Working File records to determine whether each sampled claim was paid correctly, including whether case-level adjustments were applied when necessary, Medicare was the primary payer, and other providers were not paid for the same services;
- contracted, under CMS's Umbrella Statement of Work, with a PSC to review all medical records obtained for the 100 sampled claims and to determine whether (1) the beneficiaries required the IRF level of care and (2) the IRF services provided were medically necessary and supported by adequate documentation;
- used an unrestricted variable appraisal program to estimate overpayments to the Hospital (Appendix B); and

- discussed the results of our review with Hospital officials.

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

FINDINGS AND RECOMMENDATIONS

The Hospital submitted numerous IRF claims that did not meet Medicare requirements. For 47 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 43 claims, the beneficiaries were capable of significant practical improvement but could have received rehabilitation services in a less intensive setting such as a skilled nursing facility or an outpatient facility.
- For four claims, the beneficiaries were not capable of significant practical improvement as a result of therapy or were medically unable to participate in intensive treatment.

The Hospital inappropriately billed for these services because its preadmission screening procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement as a result of therapy, or were unable to participate in intensive rehabilitation treatment. As a result, the Hospital received \$527,510 in unallowable Medicare payments for the 47 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$4.8 million for IRF claims during 2003.

MEDICARE REQUIREMENTS FOR INPATIENT REHABILITATION FACILITY SERVICES

Section 1862(a)(1)(A) of the Act excludes from Medicare coverage any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

According to Chapter 1, section 110, of the Manual, beneficiaries require a hospital level of rehabilitative care if they need a “relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function.” Two basic requirements must be met for Medicare to cover inpatient hospital rehabilitative care:

1. The efficacy, duration, frequency, and amount of the services must be reasonable and necessary for the treatment of the patient’s condition.
2. Furnishing the care on an inpatient hospital basis, rather than in a less intensive facility such as a skilled nursing facility or on an outpatient basis, must be reasonable and necessary.

The Manual elaborates on “reasonable and necessary,” stating that Medicare covers inpatient hospital rehabilitation for beneficiaries who require a more coordinated, intensive program of multiple services than is generally found outside a hospital. The Manual lists several screening

criteria for identifying cases that clearly require a hospital level of rehabilitative care. For example, one criterion is that the beneficiary must be expected to show significant practical improvement within a reasonable period of time. The Manual also states that cases that fail to satisfy the criteria are referred to a physician reviewer who makes determinations based upon the physician's knowledge, expertise, and experience and upon an assessment of each beneficiary's individual care needs, rather than on fixed criteria.

The Manual further states that Medicare coverage may be available for an inpatient assessment of a patient's potential to benefit from inpatient hospital rehabilitation, even if the assessment subsequently indicates that the patient is not a suitable candidate. According to the Manual, the assessment is covered so long as the patient's condition on admission is such that an extensive inpatient assessment of the patient's rehabilitation potential is considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential.

NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

For 47 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries. Appendix C summarizes the PSC's determinations for these 47 claims, which fall into two broad categories: claims for services that could have been rendered in a less intensive setting and claims for services for beneficiaries who were not capable of significant improvement.

Services That Could Have Been Rendered in a Less Intensive Setting

For 43 of the 47 unallowable claims, the beneficiaries could have received rehabilitation services in a less intensive setting, such as a skilled nursing facility, or on an outpatient basis. These beneficiaries were capable of significant practical improvement from therapy but did not need the IRF level of care. Examples of their conditions included:

1. uncomplicated knee, hip, and other single-joint replacements that required only pain management and simple therapies and
2. simple orthopedic injuries and medical or neurological conditions that required only general muscle strengthening and reconditioning.

Services for Beneficiaries Who Were Not Capable of Significant Improvement

For 4 of the 47 unallowable claims, the beneficiaries were not capable of significant practical improvement as a result of therapy or were medically unable to participate in intensive treatment. For instance, one beneficiary was not able to participate in intensive rehabilitation because he had very little remaining pulmonary function. The beneficiary's condition was suitable for a skilled nursing facility level of care but not for an IRF.

INEFFECTIVE PREADMISSION SCREENING PROCEDURES

The Hospital inappropriately billed for these services because its preadmission screening procedures did not consistently identify those beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement as a result of therapy, or were unable to participate in intensive rehabilitation treatment.

ESTIMATE OF UNALLOWABLE PAYMENTS

Based on the sample results, we estimate that the Hospital received at least \$4,827,609 for inpatient rehabilitation services that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program the \$4.8 million estimated overpayment for 2003;
- identify and refund any overpayments for subsequent years' IRF claims that did not meet Medicare requirements; and
- strengthen its preadmission screening procedures to provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, and are able to participate in intensive rehabilitation.

AUDITEE'S COMMENTS

In its comments on our draft report, the Hospital strongly disagreed with our findings and recommendations and stated that all denied claims should be further reviewed by another contractor. The Hospital also requested that any cases that a nonphysician reviewer disallowed because of lack of medical necessity be referred to a physician reviewer with training and experience in rehabilitation.

In addition to responding to individual review decisions, the Hospital raised the following general objections to the methodology that the PSC used to review the sampled claims:

1. *"The failure to determine whether each inpatient stay was appropriate based on coverage allowed for an inpatient assessment requires that all tentatively disallowed cases be re-reviewed."* The Hospital cited Medicare guidance stating that coverage is available for an inpatient assessment of a patient's potential for benefiting from an intensive coordinated program only if it was reasonable and necessary to perform the assessment in the hospital. The Hospital maintained that, at IRFs such as Whittier that have "a meaningful preadmission screening process," the admission should be covered for patients who have the potential for benefiting from an inpatient hospital program.

The Hospital also pointed out that Medicare coverage for an inpatient assessment at an IRF is available for a beneficiary (usually for 3 to 10 days) even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program. The Hospital cited three specific cases to support its position. The Hospital concluded that the PSC's failure to consider the criteria that justify coverage for an initial inpatient assessment necessitates another review of all disallowed cases "before any conclusions can be made about any overpayments based on lack of medical necessity."

2. *"The contract reviewers did not understand or apply the criteria that allow coverage for patients who have medical complications which require the availability of a physician or who have a risk of change in medical status that needs monitoring by a physician."* The Hospital cited Medicare guidance that provides for two alternative bases for coverage: one for beneficiaries who receive intensive therapy for about 3 hours a day and another for beneficiaries who have medical complications that require the availability of a physician but who can nonetheless make some significant practical improvement from a low-intensity physical rehabilitation program. The Hospital noted that many of its patients fall into this second category because they require a combination of medical care and rehabilitation care not available at a skilled nursing facility. The Hospital gave 21 examples of such cases that the PSC had denied.
3. *"The outside reviewers based recommendations on factual conclusions not supported by the medical record."* The Hospital gave five examples of disallowances that it believed were based on conclusions not supported by the patient's medical record. It maintained that these conclusions "strongly suggest that unqualified reviewers were used" and restated its request for another review of all 58 cases questioned in our draft report.
4. *"Speculation over whether a patient should have stayed in an acute hospital is not a proper standard for review of medical necessity."* The Hospital stated that the PSC had speculated as to whether 10 beneficiaries could have stayed longer in an acute care hospital and asserted that this standard of review was highly improper. The Hospital cited one case as an example of such speculation. The Hospital also noted that IRFs are not required to second-guess an acute care hospital's discharge decision or make an accusation of premature discharge.

The Hospital also raised the following points related to the legality of our findings and recommendations:

1. *"The failure to assess each case based on Medicare's limitation of liability criteria requires that all tentatively disallowed cases be re-reviewed."* The Hospital stated that Medicare is required to pay a provider for services if the provider and the beneficiary did not know, and could not reasonably have been expected to know, that the services were not covered. The Hospital stated that, according to Medicare requirements, all claims that a medical reviewer excludes from coverage based on lack of medical necessity must also undergo a limitation of liability review to determine whether the provider should have known that the services were not covered. According to the Hospital, a reviewer

can infer that the provider had this knowledge only if the reviewer can point to specific written guidance that makes it clear that the services were not covered. The Hospital stated: “The only applicable guidance from Medicare available in 2003 to determine medical necessity does not rely on any fixed criteria but rather the judgment of a physician that the care was reasonable and necessary for a particular patient based on the physician’s training and experience.” The Hospital added that “any conclusions relating to overpayments are incomplete and indeterminate” until each case has undergone a limitation of liability review to establish what its physicians knew or could reasonably have been expected to know when each beneficiary was admitted.

2. *“The recommendation that . . . [the Hospital] refund an alleged overpayment is also premature because of the applicability of Medicare’s waiver of liability provisions.”* The Hospital cited Medicare guidance stating that overpayments may not be collected from providers that the fiscal intermediary determines to be without fault. It further stated that these determinations, called waiver of liability determinations, establish whether the provider had a reasonable basis for submitting the Medicare claim based on the information then available to the provider. The Hospital concluded that it would ask its fiscal intermediary to grant a favorable waiver of liability determination for each case that our report cited as involving an overpayment because of the “highly subjective nature of determinations relating to the appropriateness of admitting a patient for rehabilitation care at an IRF level, and the carefully documented, reasonable determination by its physiatrists in each of the 58 cases” The Hospital further concluded that the most our report could state is that we are forwarding our conclusions to the fiscal intermediary.

The Hospital’s comments are included as Appendix D. We have omitted the case evaluations and medical records referenced in the Hospital’s comments because they contain personally identifiable information.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

We resubmitted the denied claims to the PSC and asked it to address the Hospital’s concerns. The PSC’s medical reviewer is a physician certified by CMS to conduct reviews. As part of its second review of all 58 cases, the PSC considered the clarifying information that the Hospital had provided in its response. The PSC reversed 11 of its original determinations as a result of the second review. We have adjusted this report to reflect the revised number and value of overpayments in our sample and the estimated value of overpayments in the population.

In addition to responding to the Hospital’s case evaluations, the PSC addressed the Hospital’s general objections to the methodology used to review the sampled claims. Based on the PSC’s response, we concluded the following:¹

¹The Hospital raised four categories of objections but, in most cases, did not specify which of the 58 original denied claims were in each category. For this reason, we were unable to determine how many of the PSC’s 11 reversals fell into each category.

1. The Hospital asserted that the “failure to determine whether each inpatient stay was appropriate based on coverage allowed for an inpatient assessment requires that all tentatively disallowed cases be re-reviewed.” Taken to its logical extreme, the Hospital’s position would mean that only patients who had virtually no rehabilitation potential would not be considered candidates for assessment in an IRF setting for 3 to 10 days. Although patients whose conditions do not require the services of an IRF might potentially benefit from these services, these patients must also require a hospital level of care for the stay to be covered by Medicare. The PSC did not reverse any of the three original determinations that the Hospital cited in support of this objection.
2. The Hospital stated that the “contract reviewers did not understand or apply the criteria that allow coverage for patients who have medical complications which require the availability of a physician or who have a risk of change in medical status that needs monitoring by a physician.” As a result of the clarifying information that the Hospital provided, the PSC reversed 5 of the 21 original determinations that the Hospital cited in support of this objection. The PSC did not reverse the remaining 16 determinations in this category because the Hospital had based its admission decisions in these cases on a generic risk stratification rather than on well-founded assessments of individual patient-specific factors. When the admitting assessment indicates that the patient is clinically stable and the physician notes repeatedly state “doing well/doing as expected,” the facility has not demonstrated the need for daily physician care, which would dictate placement in an IRF.
3. In response to the Hospital’s assertion that the “outside reviewer based recommendations on factual conclusions not supported by the medical record,” we note that much of what the Hospital objected to in its examples hinged on terminology that the PSC used to describe the patient’s potential or status. During its second review of these cases, the PSC expressed the revised findings in more objective terms. In addition, the PSC reversed three of the five original determinations that the Hospital cited as a result of the clarifying information that the Hospital provided.
4. The Hospital maintained that the PSC’s speculation as to whether 10 beneficiaries should have stayed in an acute hospital is not a proper standard for review of medical necessity. Although we initially anticipated in conversations with the Hospital that as many as 10 cases could fall into this category, by the time our draft report was published, only 1 case was left here, and it is the same case that the Hospital cited. The PSC overturned this one denial once it had determined from the Hospital’s clarifying information that the patient required a hospital level of care yet was potentially able to participate in a program of rehabilitation.

In response to the Hospital’s comments regarding limitation of liability (i.e., section 1879 of the Act) and waiver of recovery (i.e., section 1870 of the Act), we note that the fiscal intermediary will review all cases that we have recommended disallowing; determine whether an overpayment exists; and, if necessary, determine whether the limitation of liability or waiver of recovery provisions apply.

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVE

The objective of our review was to determine whether Whittier Rehabilitation Hospital (the Hospital) submitted inpatient rehabilitation facility claims that met Medicare requirements.

POPULATION

The population included 1,114 claims for inpatient rehabilitation services at the Hospital with discharge dates between January 1, 2003, and December 31, 2003.

SAMPLE DESIGN

We designed a stratified random sample consisting of two strata. The first stratum consisted of 636 claims with paid amounts between \$0.01 and \$14,000. The second stratum consisted of 478 claims with paid amounts of \$14,000.01 or greater.

Stratum Number	Description of Stratum	Number of Population Claims	Payment Amounts
1	\$.01-\$14,000	636	\$5,785,582
2	\$14,000.01 or greater	<u>478</u>	<u>8,772,381</u>
		1,114	\$14,557,963

SAMPLE SIZE

The sample consisted of 100 paid claims totaling \$1,373,119. We selected 50 claims from each stratum in our identified population.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

The following table presents our sample results:

<u>Stratum</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
1 – \$0.01 - \$14,000	50	\$462,763	31	\$276,640
2 – \$14,000.01 or greater	<u>50</u>	<u>910,356</u>	<u>16</u>	<u>250,870</u>
Total	100	\$1,373,119	47	\$527,510

VARIABLE PROJECTIONS

Projected Value of Erroneous Claims

Point estimate	\$5,917,176
90-percent confidence level	
Lower limit	\$4,827,609
Upper limit	\$7,006,567

MEDICAL REVIEW DETERMINATIONS

Following are excerpts from the medical reviewer's determinations for the 47 unallowable claims. We have provided the complete medical review results to the Hospital.

Count	Sample Number	Excerpt	Disallowed Amount
1	1-1	Fatigued, dehydrated, deconditioned gastrointestinal issues. May have remained in acute facility a few days longer and then discharged home with therapies, or to a SNF [skilled nursing facility].	\$11,299.87
2	1-2	Uncomplicated hip replacement recovery. Needed non-hospital rehabilitation.	12,589.00
3	1-3	Neck vertebral fracture, without compression. No complex needs. Do not see need for hospital level rehabilitation; SNF would have sufficed.	13,637.86
4	1-4	Myeloma patient with history of chronic rotator cuff tear, degenerative joint disease. Needed general strengthening, but nothing intensive. Could have been handled at a lesser level of care.	867.06
5	1-5	Patient recovering from vascular leg surgery. Postoperative state needing nursing care, PT [physical therapy], convalescence. SNF more appropriate.	11,953.21
6	1-6	Discharge summary stated patient self-limited. Needed instruction in activities of daily living. Did achieve goals but PSC [program safeguard contractor] did not see need for RHLOC [rehabilitation hospital level of care].	13,637.86
7	1-7	Ovarian cancer, variety of chronic problems, no new deficits, and facial injury from recent fall. All needed services could have been delivered in home, outpatient therapy, or at SNF for short stay.	2,228.65
8	1-9	Straightforward hip replacement in robust patient. Recovery and clinical situation not requiring a hospital setting.	7,439.20
9	1-11	No rehabilitation potential post leg amputation and open wound. History of congestive heart failure, diabetes, coronary artery disease, and stroke. High level SNF would have sufficed.	2,228.65

Count	Sample Number	Excerpt	Disallowed Amount
10	1-12	Recurring gastrointestinal bleeding, cauterization, and other acute abdominal processes. Needed reconditioning, management of many medications. Lower level of care with gentle PT for mobilization.	6,770.67
11	1-13	A fall resulting in bruised ribs. Needed pain and medical management. No new deficits. Lesser level of care may well have sufficed.	13,637.86
12	1-14	Fractured upper arm not requiring surgery, but sustaining functional limitations, needed remobilization. Could have been handled at home with caregiver or SNF.	8,722.57
13	1-17	Small stroke resulting in unsteadiness, cognitively 100 percent. Needed OT [occupational therapy], PT. SNF or outpatient rehabilitation would have sufficed.	7,360.75
14	1-21	Needed routine reconditioning post cardiac valve surgery. Usual precautions relevant to all post sternotomy patients needed minor medicine adjustment, which could have been done at a lesser level of care with equal efficiency.	9,585.51
15	1-24	Elderly stroke patient injured when fell. Pain in hip/shoulder, contusions-no fractures, limited rehabilitation potential, complicating factors of gastrointestinal bleeding causing a temporary return to acute. Admit to RHLOC was not needed based on acute clinical needs, and unexecuted plans for PT, OT.	6,847.63
16	1-25	Post ankle surgery. Discharged non-weight bearing, short-term limited rehabilitation potential. Could have been instructed in use of crutches while in acute inpatient hospital and discharged to a lesser level of care, SNF, due to stair problem at home.	12,070.65
17	1-26	Post cardiac pacemaker insertion. Needed reambulation, recuperation, pacemaker monitoring at lesser level of care. Indication for RHLOC not seen.	1,388.65
18	1-27	Needed medical treatment, reconditioning. Did not require intensive rehabilitation or hospital level. SNF would have sufficed.	8,138.43

Count	Sample Number	Excerpt	Disallowed Amount
19	1-28	Fractured arm, bruised hip. Very elderly/frail patient, limited rehabilitation potential. Maintain safety while providing gentle PT, modest OP, suitable for SNF, not RHLOC.	2, 035.95
20	1-33	Unstable patient with end stage chronic obstructive pulmonary disease. Limited rehabilitation potential. Not a candidate for intensive rehabilitation.	13, 020.60
21	1-35	Post thoracic spine compression fractures. Needed remobilization via PT, OT but not needed at hospital level.	11, 230.65
22	1-38	Routine knee replacement on functional individual. Do not see need for hospital rehabilitation.	7,658.41
23	1-39	Trochanteric bursitis, peripheral neuropathy, diabetic. Does not need hospital rehabilitation level of care. Suitable for lesser level of care.	11, 953.21
24	1-40	Chronic obstructive pulmonary disease needing reconditioning/oxygen regulation, which does not require a hospital level of care. Patient stable with no neurological deficits.	11, 415.96
25	1-41	Medically stable with wrist bruises post fall. Only admission laboratory tests ordered. Made at most modest progress. Suitable for SNF level of care.	9, 175.91
26	1-42	Needed gentle reconditioning post long medical illness. On dialysis with mostly medical management. Not needing intensive rehabilitation. Lasted 7 days before returned to acute hospital.	7,075.06
27	1-43	Post fall with neck strain, contusion. No new deficits. Needed SNF level of short term rehabilitation. Not at intensity of need that justifies RHLOC.	12,797.86
28	1-45	Weak post asthma exacerbation. Intensive rehabilitation level not needed.	11,953.21
29	1-46	Recovery from cardiac condition. Needed gentle rehabilitation to regain former level of mobility. Did not require RHLOC for this low level program prior to returning home.	9,585.51
30	1-47	Post non-surgical treatment for hip fracture. Needed strengthening. PT goals were modest and progress was slow. Did not need RHLOC.	7,205.29

Count	Sample Number	Excerpt	Disallowed Amount
31	1-48	Walking and moving with supervision needed post hip replacement. The typical modest level of rehabilitation, not at RHLOC for 5 days.	11,128.67
32	2-2	Wrist fracture needed reconditioning. Undergone a medical workup and medication adjustment, more appropriately done at acute level. Rehabilitation goals were very modest, achievable at a SNF.	14,231.81
33	2-4	Reconditioning, strengthening, remobilization needed for a stable anemia patient requiring a modest level of rehabilitation not at a hospital setting.	14,651.18
34	2-6	Alzheimer's patient requiring general reconditioning, but nothing else, no specific defects. RHLOC not needed.	20,699.10
35	2-10	Knee replacement recovery not requiring hospital level of care. Patient was fully functional prior to surgery. Home with services or SNF would have sufficed.	16,997.72
36	2-14	Needed to convalesce from vascular surgery. Did not need multidisciplinary rehabilitation at RHLOC.	14,231.81
37	2-16	Stable post knee replacement. Needed PT and skilled nursing rehabilitation care.	14,632.73
38	2-17	Post cardiac pacemaker procedure. Mild cognitive loss evaluation. Remobilization needed, not hospital level.	17,622.37
39	2-18	Medical illnesses to include cancer, chronically hypotensive. Little rehabilitation accomplished. Suitable for SNF, not RHLOC.	16,985.58
40	2-26	Paralysis patient needed neurological, anti convulsive monitoring. Do not see need for intensive rehabilitation.	15,591.14
41	2-29	Convalescing post major gastrointestinal surgery. Not medially complex enough with modest rehabilitation needs. Appropriate for lesser level of care.	16,293.76
42	2-33	Treated for multiple medical issues. Gait stabilization needed. Could have stayed in acute facility while on heparin and received therapy then discharged home with services.	14,462.37

Count	Sample Number	Excerpt	Disallowed Amount
43	2-35	Needed routine rehabilitation for uncomplicated post knee replacement. Pain management, therapies that could have been accomplished at lesser level of care than RHLOC.	15,063.92
44	2-36	Uncomplicated cardiac surgery course. Ambulation and wound care that could have been handled at lesser level of care.	15,827.38
45	2-40	A routine program needed post elective hip replacement. Could have been handled at a lesser level of care.	14,632.73
46	2-46	Pulmonary, cardiac, kidney disease patient. Gentle reconditioning needed within the capability of SNF.	14,721.82
47	2-50	Knee replacement. Uncomplicated postoperative course appropriate for a SNF.	14,223.92
Total			\$527,509.71



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HAND DELIVER

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Regional Inspector General for Audit Services
Office of Audit Services
John F. Kennedy Federal Building
Boston, MA 02203

Re: Comments of Whittier Rehabilitation Hospital In Connection With
Draft Report No. A-01-04-00531 (January 2006)

Dear Mr. Armstrong:

On behalf of Whittier Rehabilitation Hospital ("Whittier"), this letter and its attachments set forth Whittier's written comments in connection with your Draft Report No. A-01-04-00531, entitled "Review of Rehabilitation Facility Admissions at Whittier Rehabilitation Hospital for Calendar Year 2003."

Following an exit conference on August 10, 2005, Whittier by letter to the Audit Manager, dated August 31, 2005, submitted some initial comments based on a review of 15 of the tentatively disallowed admissions. That letter enclosed an analysis of each of the 15 cases that explained why the admission was appropriate for a hospital level of care or at least a covered inpatient assessment, and it attached portions of the medical records for each case supporting the conclusion. We incorporate herein by reference as part of Whittier's official comments to your Draft Report that letter, dated August 31, 2005, and the accompanying analysis and medical records for each of those 15 cases. The case numbers relating to that analysis are Stratum No. 1, Case Nos. 2, 4, 6, 8, 11, 20, 24, 32, 42 and 47; and Stratum No. 2, Case Nos. 22, 23, 26, 28 and 44. In addition, Whittier is submitting with this letter the evaluations of additional cases which were completed by its expert medical reviewers, experienced and trained in rehabilitation care, and which explain why each admission was reasonable and necessary for proper care of the beneficiary, and attached copies of relevant parties of the medical records. Please include these assessments and medical records as a part of Whittier's official response to your Draft Report. Whittier requests, as your staff stated it would do at the exit conference, that all of this additional

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information be considered by you before finalizing your tentative conclusion with regard to any case.

In Whittier's letter, dated August 31, 2005, Whittier stated that, based on its initial review of just 15 cases, it was evident that there is a serious question as to the competence of the medical reviewers who did the reviews for you. As a result, Whittier requested that your office have all 58 tentatively disallowed claims further reviewed by a contractor other than the one originally used. Upon review of the remaining 43 cases, Whittier renews its request for such a further review. In a further review, Whittier also requests that, for any case in which a non-physician reviewer suggests an issue relating to medical necessity, the case be referred to a physician reviewer for a determination of the medical necessity of the patient's hospitalization. Medicare regulations and guidance require that in disallowing claims based on medical necessity the final judgment should only be made by a physician reviewer familiar by training and experience with the conditions requiring rehabilitation care at an IRF.¹ See Medicare Benefit Policy Manual ("Manual"), § 110.4. ("For determinations about reasonableness, medical necessity, and appropriateness of setting, the QIO physician reviewer is expected to make a determination on the basis of their [sic] knowledge, expertise and experience, and upon an assessment of each beneficiary's individual care needs rather than on fixed criteria.") In the end, Medicare guidance requires that a final decision on non-coverage for lack of medical necessity may only be made by a physician with training and experience in rehabilitation.

I. THE FAILURE TO DETERMINE WHETHER EACH INPATIENT STAY WAS APPROPRIATE BASED ON COVERAGE ALLOWED FOR AN INPATIENT ASSESSMENT REQUIRES THAT ALL TENTATIVELY DISALLOWED CASES BE RE-REVIEWED.

One glaring flaw in the review of these cases by your contract reviewers was their failure to assess each case to determine whether the admission was covered based on the beneficiary's right to an inpatient assessment of his/her status and potential for benefiting from a rehabilitation program, i.e. the patient's ability to make significant practical improvement in a reasonable time at an IRF.

Medicare guidance recognizes that "preadmission screening cannot be expected to eliminate all unsuitable candidates." See Manual, § 110.2. Thus, "[c]overage is available for an inpatient assessment of a patient's potential for benefiting from an intensive coordinated

¹ It should also be noted that none of the criteria applicable to initial reviews may be considered dispositive and, in fact, do not apply to the physician whose decision should be based solely on his knowledge, expertise and experience. See Manual, § 110.4 ("The [initial screening] criteria do not apply to cases referred to a QIO's physician reviewer.") See also Manual, § 110.1 (. . . [D]enials of services based on . . . diagnosis or specific treatment norms, 'the three hour rule,' or any other 'rules of thumb,' are not appropriate.")

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rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital." See Manual, § 110.3.1. Where a meaningful preadmission screening process is in effect at an IRF, as is the case at Whittier, the admission could and should be covered where the "preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program." See Manual § 110.2. Such inpatient assessments are routinely covered for "between 3 to 10 calendar days, but on occasion may require more." See Manual, § 110.3.1. Moreover, coverage for an inpatient assessment at an IRF is available for a beneficiary "even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program." Id.

At Whittier, all potential admissions are reviewed through a rigorous and thorough preadmission screening process. This review is conducted by Medical Care Evaluators who review the patient's medical record and, when possible, conduct interviews of the patient and family members. The Evaluators complete an extensive preadmission assessment form prior to admission. This process effectively screens out clinically inappropriate patients who should be treated at a skilled nursing facility or on an outpatient basis. This screening process generally assures only appropriate and medically necessary admissions. For example, while Whittier admitted 1,465 patients in its fiscal year 2003, preadmission screening process rejected 320 additional referrals on the basis that rehabilitation was not medically necessary. In 2004, Whittier admitted 1,444 patients, but rejected 502 as clinically inappropriate. In all cases when the patient is accepted for admission, Whittier's preadmission screening process at least establishes that the candidate has the potential to benefit from an inpatient rehabilitation program so that he/she should receive an inpatient evaluation from a rehabilitation team which includes a physician.

Since your contracted medical reviewers did not assess the appropriateness of the inpatient stay based on the criteria that justify coverage for an initial inpatient assessment, a criteria different from that used to assess the medical necessity for actual participation in rehabilitation care at an IRF level, none of the conclusions for the 58 cases are valid. In short, the medical review is simply incomplete and indeterminative with regard to coverage. As a result, your Draft Report cannot fairly conclude that there were any overpayments. All tentatively disallowed cases must first be re-reviewed before any conclusions can be made about any overpayments based on lack of medical necessity.

Keeping in mind that the coverage for an inpatient assessment is proper, even if the assessment concludes that the patient is not appropriate for hospital level care, the following cases are illustrative of those many cases in which an inpatient assessment was appropriate and, therefore, covered by Medicare:

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Case No. 1-11

Your reviewer states this beneficiary had "limited potential for rehab" and should have been treated at a SNF. This patient had his leg amputated, suffered a stroke five days before admission, and had other medical issues. These two medical conditions, amputation and stroke, are among the 13 medical conditions that Medicare lists as generally appropriate for rehabilitation at an IRF. See 42 CFR § 412.23(b)(2)(iii). The preadmission screening properly identified that he had the potential to benefit from an inpatient rehabilitation program. Only an inpatient assessment could determine accurately his medical status, such as the extent of his need for wound care, and whether he could make significant practical improvement from rehabilitation care. Whittier's inpatient assessment team provided him with an entirely appropriate inpatient assessment over just three days and concluded that he should be treated at a SNF and he was transferred. This is precisely how the process is supposed to work. Inpatient assessments of 3-10 days (and even longer in some cases) are covered services at an IRF. See Manual, § 110.3.1.

Case No. 1-4

This patient had a stroke which is one of the 13 designated diagnoses that Medicare generally accepts as being a proper medical condition for rehabilitation care at the hospital level. See 42 CFR § 412.23(b)(2)(iii). This medical diagnosis warrants the conclusion that it was reasonable to provide him with an inpatient assessment. Only by an inpatient assessment could it be determined whether he was capable of significant practical improvement in a hospital rehabilitation program. It was reasonable and necessary to perform the assessment at the hospital because, while he was stable with an INR of 4.1, he needed physician monitoring. While at Whittier he developed a GI bleed after only two days and was transferred to an acute hospital. However, coverage for two days at Whittier was appropriate to perform the inpatient assessment.

Case No. 1-17

This man had a brain stem stroke two days before being admitted to Whittier for an inpatient assessment of his status and whether he would benefit from inpatient rehabilitation. Your reviewer states that "SNF or maybe even OPT might have sufficed." (Emphasis added). However, it is precisely the purpose of an inpatient assessment to determine the patient's medical status and whether he is capable of making significant practical improvement as a result of rehabilitation care at Whittier. The medical diagnosis of stroke is one of 13 medical diagnoses that Medicare generally recognizes is appropriate for treatment at an IRF. See 42 CFR § 412.23(b)(3)(iii). This alone suggests the appropriateness of coverage for his inpatient assessment. This patient made rapid progress during his inpatient assessment and the team of evaluators quickly concluded there were no unresolved medical issues and he was discharged home in just seven days. This length of stay is within the generally recognized period of 3-10

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days for coverage of inpatient assessment. Medicare guidance recognizes that patients should be receiving therapy during the covered period for an inpatient assessment. See Manual § 110.3.1. ("This 3- to 10-day period [for a covered inpatient assessment] is often one where the patient is receiving therapies rather than simple screening assessments.")

II. THE CONTRACT REVIEWERS DID NOT UNDERSTAND OR APPLY THE CRITERIA THAT ALLOW COVERAGE FOR PATIENTS WITH MEDICAL COMPLICATIONS WHICH REQUIRE THE AVAILABILITY OF A PHYSICIAN OR HAVE A RISK OF A CHANGE IN MEDICAL STATUS THAT NEEDS MONITORING BY A PHYSICIAN.

One of the basic reasons why a patient should participate in a rehabilitation program at a hospital level of care, as opposed to a lower level of care in a nursing facility, is the need for physician availability to adequately monitor or treat complicating medical conditions and to closely supervise the rehabilitation care to ensure safe and effective treatment. As explained by Medicare:

"An inpatient stay for rehabilitation care can also be covered even though the patient has a secondary diagnosis or medical complications that prevent participation in a program consisting of three hours of therapy a day. Inpatient care in these cases may be the only reasonable means by which even a low intensity program may be carried out."

See Manual, § 110.4.3. Thus, there is coverage in an IRF when patients have medical complications that require the medical services available in an IRF, especially the availability of a physician to monitor and/or treat a complicating secondary diagnosis or medical complication. In such cases, coverage is available even if the patient receives only "a low intensity program." Id. The reason, of course, is that, because of the patient's medical complications that cannot be treated in a SNF, the only reasonable place for the beneficiary to receive rehabilitation therapy safely and effectively is in an IRF which can do both.

Medicare guidance provides that there are two alternative bases for coverage. One is when a patient needs and receives intensive, multi-disciplinary therapy (usually about three hours a day). The second is when a patient's medical complications require the continuing availability of a physician and the patient nonetheless can make some significant practical improvement even from a low intensity program. As further explained by Medicare:

"A patient probably requires a hospital level of care if they have either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to the primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment."

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See Manual, § 110.4 (emphasis added.) The current Draft LCD for Inpatient Rehabilitation, LCD No. L16555 ("Draft LCD"), under consideration by Associated Hospital Service, Whittier's Fiscal Intermediary, clearly states that there are four separate and alternative bases for concluding that it would be appropriate to provide rehabilitation care in an IRF and not at the lower level of care available in a SNF or on an outpatient basis. One of them is the patient's need for physician availability, including when a patient has "a risk of change in medical status" that needs to be monitored by a physician. As the Draft LCD states:

"It would not be appropriate to provide rehabilitation care in a less intensive setting due to:

...

- 2) A patient's need for the 24-hour availability of a physician with specialized training or experience in rehabilitation due to the presence of a co-morbid medical condition or a risk of change in medical status. . . ."

See Draft LCD, Part 2, Indications.

The Draft LCD sets forth guidance on what will be considered medically reasonable and necessary for coverage in an IRF. In specifying that one basis for coverage is the need for intensive therapy of three hours a day, the Draft LCD nonetheless makes it clear that alternatively coverage at an IRF level also exists when a medical condition limits such participation in intensive therapy. The Draft LCD explains the two alternatives, either of which warrants the conclusion of coverage at the hospital level:

"The patient requires and can tolerate at least three hours per day of skilled therapy at least five times per week or, in the instance of a medical condition that limits participation, an equivalent amount of combined therapy, medical, and nursing care, and other professional care . . ."

Id. A significant number of the patients admitted to Whittier have substantial medical complications or present a significant "risk of change in medical status." See Draft LCD, Section 2. Many of Whittier's patients are not admitted to obtain intensive therapy of three hours per day and do not receive that intensive therapy. Rather, because of limiting medical conditions or "a risk of change in medical status" they receive at least three hours each day of a combination of medical care from a physician, nursing care and other professional care plus low intensity therapy. This allows them to achieve significant practical improvement as a result of their rehabilitation therapy. This combination of medical care and rehabilitation care is not available at a SNF and, as a result, the patient stay is covered at a hospital level of care. At Whittier each multidisciplinary team includes a physiatrist, a physician especially trained or experienced in the field of rehabilitation, who is directly involved on a day-to-day basis with the

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monitoring and treatment of complicating medical conditions to ensure safe and effective rehabilitation therapy.

The failure to understand and apply the applicable coverage criteria related to patients with medical complications or who had "a risk of a change in medical status" is especially clear for Whittier's patients who required pulmonary and cardiac rehabilitation. With respect to patients who need rehabilitation due to pulmonary disorders, Whittier is highly regarded for its Pulmonary Rehabilitation Program and its successful outcomes. Pulmonary rehabilitation is a multi-disciplinary program provided by a team that consists of a Psychiatrist, Pulmonologist, RN, CM, MSW, PT, OT, ST (as needed), RT, TR (as needed), and a dietician (as needed). Pulmonary patients are extremely fragile and are known to decompensate quickly. As a result, they require physician monitoring because of the "risk of change in medical status," as specifically sanctioned by the Draft LCD. Our pulmonary rehabilitation program includes interventions from all disciplines, but is supported 24/7 in a therapeutic milieu. Whittier's staff is trained to reinforce the skills of pursed-lip breathing, pacing and assessment of oxygen need and titration. Respiratory therapists are available on all three shifts, which is not found at a SNF level of care. In addition, dieticians with experience are available to monitor and make recommendations specific to the complex caloric needs of a patient with a respiratory disorder. The program incorporates disease education, training in energy conservation, pacing, pursed lip breathing, proper nutrition, anxiety management and the correct techniques for oxygen, nebulizer, MDI, CPAP and BiPAP use.

Your reviewers improperly recommended disallowance of four pulmonary cases. See Case Nos. 1-33, 1-40, 1-45, and 2-21. In each of these cases, the patients needed physician supervision due to complicating medical conditions or a risk of change in medical status. Specialized multidisciplinary pulmonary therapy relating to their pulmonary needs, as well as treatment of other medical conditions and careful physician monitoring allowed them to safely make significant practical improvements which would not have been achieved at a SNF.

Patients admitted to Whittier in need of cardiac rehabilitation are generally complex cases in which "the major disorder is poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to a cardiac disorder." The Medicare PPS, IRF-PAI Training Manual states explicitly that such major disorders are appropriately included among cardiac disorders that fall within Category 9 of the 21 Rehabilitation Improvement Categories that have been developed specifically for IRFs. Whittier operates a highly specialized Cardiac Rehabilitation Program designed for patients whose conditions run the risk of life-threatening changes while attempting to make gains through rehabilitation care. The need for physician monitoring of the "risk of change in medical status," see Draft LCD, is critical for assuring that they receive safe and effective rehabilitation care. Cardiac rehabilitation is a multi-disciplinary program provided by a team that consists of a Psychiatrist, Cardiologist, RN, CM, MSW, PT, OT, ST (as needed), RT, TR (as needed), and dietician (as needed). Cardiac patients are fragile and may decompensate quickly. Our cardiac rehabilitation program includes interventions from all

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disciplines and is supported 24/7 in therapeutic milieu. Our cardiac patients have telemetry available, if needed, and daily physician monitoring of their medical status to treat changes before they become emergent. Our nurses have advanced cardiac support training and can provide nursing management of an intensity not generally found at a lower level of care. Dietitians, with experience, are available daily to monitor and make recommendations specific to the complex caloric needs of a patient with a cardiac disorder. Whittier has psychiatry, neuropsychiatry and social work services available in-house to treat patients who have had cardiac surgery and may experience post-op depression. The program incorporates disease education, proper nutrition, anxiety management and progressive strengthening.

Your reviewers improperly recommended disallowance of seven cardiac rehabilitation cases. See Case Nos. 1-21, 1-26, 1-46, 2-2, 2-17, 2-28 and 2-38. In each of these cases the patient was demonstrably in need of the specialized care of both a physiatrist and a cardiologist to ensure that his/her rehabilitation care was provided in a safe and effective manner. This could not be accomplished in a SNF. In one case, in addition to the need for close medical monitoring and management of her cardiac symptoms, the patient needed hemodialysis treatment which was provided to her at Whittier, and which could not be provided in a SNF. See Case No. 2-17. In another cardiac case the patient was required to be monitored on telemetry while participating in therapy. Telemetry is not available at a SNF level of care. See Case No. 2-2.

This failure to recognize and apply the criteria for coverage based on the existence of complicating medical conditions that precludes rehabilitation care at a lower level of care is evident for virtually all of the cases at issue. As a result, the conclusions reached for these cases are simply incorrect. Some illustrative examples of cases in which the beneficiary had additional co-morbid medical complications which required an IRF level of care include the following cases:

Case No. 2-23² (patient diagnosed with co-morbidity of organic brain syndrome which required close monitoring for mental status change and confusion and who received psychiatric care which resulted in a new medication for her dementia);

Case No. 2-26 (co-morbid complicating diagnosis of convulsions, hemiplegia and depressive disorder);

Case No. 2-44 (co-morbid conditions including falls (Code E888), lack of coordination (Code 781.3), abnormality of gait (Code 7812) and shoulder joint pain (Code 719.41) and

² In this case the patient, age 87, had a total hip replacement due to a fracture which falls into two of the type of medical conditions that Medicare generally recognizes as appropriate for treatment at an IRF. One is hip fracture and the other is the fact that the patient had a hip joint replacement and was "age 85 or older at the time of admission to the IRF." See 42 CFR § 412.23(b)(2)(iii)(M)(3).

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patient required the services of a neurologist who started him on Sinemet and monitored the response);

Case No. 2-46 (patient had complicating co-morbid medical conditions including atrial fibrillation and coronary arteriosclerosis);

Case No. 2-10 (co-morbid medical conditions of hemiplegia due to stroke, hypertension and atrial fibrillation);

Case No. 2-22 (co-morbid medical conditions, including atrial fibrillation, congestive heart failure, diabetes, decubitus ulcer, ulcer of heel, staph aureous pneumonia and coronary artery disease);

Case No. 2-33 (patient needed a heparin drip which had to be closely monitored by a physician);

Case No. 1-2 (patient was 87 years old and underwent a hip joint replacement due to a fracture (see footnote 2, supra);

Case No. 1-4 (patient needed physician monitoring of elevated PT/INR and potassium levels); and

Case No. 1-5 (co-morbid medical condition of unstable diabetes and other medical conditions that required intensive medical supervision by a physician).

It is clear that your medical reviewers did not understand and apply the criteria for coverage at an IRF level when the existence of complicating medical conditions or a "risk of change in medical status" requires the availability of a physician which precludes care below the level of an IRF. This failure means that, for your Draft Report to have any integrity with respect to its conclusions, each case must be re-reviewed to assess the applicability of this basis for coverage for the 58 cases under consideration.

III. THE OUTSIDE REVIEWERS BASED RECOMMENDATIONS ON FACTUAL CONCLUSIONS NOT SUPPORTED BY THE MEDICAL RECORD.

The outside contractors made recommendations for non-coverage based on factual conclusions not supported by the medical record. As a result, many of their recommendations are manifestly incorrect. The following cases are illustrative of the use of factual conclusions not supported by the medical record which strongly suggests that unqualified reviewers were used. This puts in question the accuracy of conclusions reached in all of the 58 cases. This is an additional reason why, as requested by Whittier, each of the 58 cases should be reviewed again by a separate and competent team of evaluators, including a physician experienced in rehabilitation care.

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Case No. 1-33

In this case your medical reviewer concluded that this patient "had very little remaining pulmonary function at all" and "had very limited potential" for benefiting from a rehabilitation program. This case is highlighted in your Draft Report as one of six cases of involving beneficiaries who were not capable of significant improvement. Your Draft Report states: "For instance, one beneficiary was not able to participate in intensive rehabilitation because he had very little remaining pulmonary functions." Draft Report p. 4. In fact, the medical record documents that upon admission this patient required contact guard assist to ambulate. This means someone had to be holding on to him in order to walk. The medical record documents that, as a result of his specialized therapy at Whittier, he improved significantly to "independence" with ambulation 200 feet with no assistive device and independence in ADL's. Thus, he improved from having to hold on to someone to walk to a person who could walk with no assistance at all. This is substantial and meaningful progress which would not have been achieved at a lower level of care. In short, your medical reviewers conclusion that this person was not capable of significant improvement is belied by the fact that he did make significant improvement, as set forth in the medical record.

Case No. 2-28

This is also one of the six cases referred to in your Draft Report for which you contend that the beneficiary was not capable of significant practical improvement. However, this conclusion is based on erroneous factual conclusions by your reviewer which are plainly contradicted by the facts in the medical record. Your reviewer states that the patient was "demented and confused" and made "little progress" due to "limited cognition at baseline." The medical record documents that this patient, in fact, made substantial progress as a result of his therapy. This patient at the start of his therapy was min. assist. for 50 feet for walking, i.e. someone had to be physically supporting 50% of his weight in order for him to ambulate at all. After participating in rehabilitation therapy, this patient improved so that he could walk independently 150 feet with only the safeguard that someone should be watching him. In fact he progressed so that he could walk unassisted 150 feet four times with a brief rest between walks. He also made significant progress in transfers, grooming, bathing, and dressing. In addition, the reviewer's conclusion that he had "limited cognition at baseline" is flatly contradicted by the medical record which includes a geripsych report that concludes that he was "speech fluent," "good eye contact," and "no delusions," and that he was "thinking logical and goal directed." In short, this patient was not so demented that he could not participate in therapy. The fact that he made substantial rehabilitation gains, as documented in the medical record, is proof of the inaccuracy of your reviewer's conclusion that "little progress" was made.

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Case No. 2-22

Your Draft Report also highlights this as a case in which the patient was not capable of significant improvement. Your reviewer concluded that the beneficiary "made negligible progress in any respect" and "had little or no rehabilitation potential." As demonstrated by the medical record upon admission this beneficiary had the potential to improve to a level where he could return home at a wheelchair level. While this potential was not fully achieved due to significant medical complications, when Whittier felt that he could no longer benefit from intensive therapy, it decided to end the hospital level of care and had him transferred to a nursing home. Your reviewer does not understand that when there is potential for improvement and improvement is being made the stay is covered until such time as "further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting." See Manual, § 110.5. This is precisely what happened here when the Whittier rehabilitation team appropriately recognized that further progress was not likely at the hospital level and they transferred him to a SNF. Your reviewer concluded that the beneficiary "made negligible progress in any respect." This conclusion is factually incorrect. The medical record documents that he went from min assist level for bed mobility and transfers to supervised level. He also progressed to wheelchair mobility of 100' x 3 with supervision. This is significant progress and the reviewer's statement of "negligible progress" is simply wrong and is contradicted by the medical record.

Case No. 1-24

In this case, also identified in your Draft Report as one in which the beneficiary was not capable of improvement, your reviewer concludes that this patient "[h]ad limited rehab potential." The medical record demonstrates otherwise by recording that she made significant progress to close supervision for mobility and modified independent for self care. Again, the reviewer simply made an incorrect factual conclusion which is not based on the actual facts set forth in the medical record.

Case No. 1-32

This case is separately highlighted in your Draft Report. It is included therein in a separate section entitled "Medical Conditions Required Acute Hospital Care." See Draft Report at p. 5. The Draft Report states that the beneficiary "was medically unstable when admitted to the IRF." Id. This assertion is factually incorrect and is plainly contradicted by the medical record. In fact, the medical record demonstrates that this patient was correctly deemed stable enough to be discharged from the acute care hospital. See the complete history and physical by Dr. Ray Villalobos, a Whittier physiatrist, who concluded that she was stable enough for admission to Whittier with the goal to "[g]et her back home with home health reviewers."

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What happened to this patient is that after being at Whittier for 2 days, she developed abdominal pain and was taken to the emergency room at the acute hospital for an outpatient evaluation. Your Draft Report incorrectly suggests that she was re-admitted to the acute hospital after 2 days. In fact, she was deemed stable enough at the emergency room to be returned to Whittier to resume her therapy and the treatment of her medical conditions, as part of the inpatient assessment being conducted. On the fifth day, a complication developed which could not have been predicted upon her admission. As the medical record documents, she was sent to an acute hospital due to the fact that her potassium level spiked to 6.5, suggesting that she was at risk for cardiac arrhythmia. Upon admission, her potassium level was 4.8 which falls into the normal range of 3.5 to 5.3.

Your Draft Report incorrectly and very unfairly ignores the actual facts set forth in the medical record by inaccurately concluding that the patient "was medically unstable when admitted." Draft Report at p. 5 (emphasis added). Even your outside reviewer in his/her evaluation does not make such an assertion, but only states "as it turns out was very unstable." This observation is based on what developed after she was admitted to Whittier and on what occurred during her whole length of stay and is not based on what was known at the time of admission to Whittier.

IV. SPECULATION OVER WHETHER A PATIENT SHOULD HAVE STAYED IN AN ACUTE HOSPITAL IS NOT A PROPER STANDARD FOR REVIEW OF MEDICAL NECESSITY.

At the exit interview your office suggested that in ten of the fifty-eight cases, a conclusion of lack of medical necessity was in part based on the reviewer's speculation that the patient could have stayed in an acute care hospital. This standard of review is highly improper. IRFs, of course, must screen referrals as they are presented. They are not required to second guess an acute care hospital's discharge decision or make an accusation of premature discharge. IRFs, such as Whittier, also provide hospital level of care, and coverage is often medically necessary precisely because they can monitor and treat complicating medical conditions, and at the same time provide coordinated rehabilitation care.

The example in the Intermediary's Draft LCD of a possible premature discharge is extremely limited and was not the standard utilized by your reviewers. See Draft LCD at Section 3. This policy states that medical necessity for an IRF admission may be questioned only if the admission "is due to a medical condition that is more appropriately considered part of the acute care stay (premature discharge from the acute care hospital to the rehabilitation facility)." Id. at Section 3 (emphasis added). None of the 58 cases involved a premature discharge because in no case was the medical condition "more appropriately" part of the acute stay rather than the IRF stay. The examples cited in the LCD limit the use of this standard to cases where the transferred patient had a medical condition that prevented meaningful participation in a rehabilitation program or if "he stayed another few days" he could have been

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discharged to home or to outpatient care. In all of the cases in your sample, the inpatient assessment given to each admission determined that his/her medical condition did not prevent meaningful participation in a rehabilitation program. Otherwise, the patient was transferred by Whittier to the appropriate facility for the level of care needed. When coordinated rehabilitation care can be given at the same time that the IRF manages or monitors the patient's medical conditions, then the admission is covered by Medicare at an IRF level. Speculations on what might have happened to a patient if he/she stayed in an acute facility is not a proper standard for determining medical necessity.

Case No. 1-20

This case demonstrates the highly improper use of speculation over whether a patient could have stayed longer at an acute care hospital. Whittier, because of its ability to provide hospital level of care when needed, was just as appropriately able to provide care for draining her wound, monitoring her blood levels and transfusing, as needed. In fact, on her fifth day of hospitalization at Whittier, a transfusion was needed. However, while her medical condition was being monitored and treated she also participated in rehabilitation therapy every day, made good functional progress and was discharged home. If she had stayed in the acute hospital, as suggested by your reviewer, until after the transfusion, she would have stayed at least an additional five days in an acute facility before receiving any meaningful rehabilitation therapy. This would have made her total confinement much longer and her recovery would have been unnecessarily delayed. Contrary to the improper second-guessing approach used by your reviewer, this is precisely the type of case that warrants coverage at an IRF level of care, *i.e.* her medical condition, as your reviewer admits, could not be handled at a SNF, and she, in fact, participated daily in the rehabilitation program so that she could be discharged to her home.

V. THE FAILURE TO ASSESS EACH CASE BASED ON MEDICARE'S LIMITATION OF LIABILITY CRITERIA REQUIRES THAT ALL TENTATIVELY DISALLOWED CASES BE RE-REVIEWED.

Pursuant to the Medicare Act, 42 U.S.C. §1395pp, in cases involving lack of coverage the Medicare Program is required to pay a provider for services under Part A and Part B when the Medicare Program determines that the provider and the beneficiary "did not know, and could not reasonably have been expected to know, that the payment would not be made . . ." See 42 U.S.C. §1395pp(a); see also 42 CFR §411.400(a)(2) (Medicare pays for services not reasonable or necessary when neither the provider nor the beneficiary "knew, or could reasonably have been expected to know, that the services were excluded from coverage under §411.15(g) or (k)"). See also Medicare Financial Management Manual ("MFMM"), Chapter 3-Overpayments, §70.1 (Rev. 29, 01-02-04) ("An overpayment does not exist if a determination is made that the limitation of liability provision applies.")

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Under established Medicare rules, when a medical reviewer determines that a service should be excluded from coverage based on lack of medical necessity, Medicare requires that the claim decision must also include a limitation of liability determination. See MFMM, supra at §70.1 ("The claim decision must incorporate a limitation of liability determination."). Medicare requires that this determination be made separately for each claim, thus precluding any possibility of extrapolating to reach an alleged larger overpayment amount. See MFMM, supra, at §70.1. ("Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary.")

The criteria that must be applied on a case by case basis to determine whether a provider can be deemed to have known that the services were excluded from coverage are set forth at 42 CFR §411.406. This regulation requires that one of four conditions must exist from which it may be demonstrated that the provider is to be considered to have known of non-coverage at the time of the admission. This regulation requires the reviewer to point to some specific "notice" received from the QIO, Intermediary, a utilization review committee or the attending physician that the particular services actually provided in the case under review or "reasonably comparable services" were not covered. In addition, this regulation also allows the reviewer to infer knowledge when it "is clear that the provider . . . could have been expected to have known that the services were excluded from coverage." See §411.406(a)(e) (emphasis added). To do so, the reviewer must be able to point to specific written guidance from CMS, an Intermediary or QIO that makes it "clear" that the service was not covered, or the reviewer must point to "accepted standards of practice by the local medical community" that establish that the care is not a covered service. In assessing these four sources of knowledge, the reviewer may only "focus on information that was available to the provider at the time . . . "and [l]ater learned facts cannot be used as a criteria for determining whether or not an action is reasonable or necessary." See St. Mary Medical Center, ALJ Decision, June 8, 1989, CCH, See Medicare and Medicaid Guide, ¶37.924. In applying the criteria in 42 CFR §411.406 to determine whether the provider "could not reasonably have been expected to know," 42 U.S.C. §1395pp (emphasis added), that the claim would later be denied, the determination must be "based on all the relevant facts pertaining to each particular denial." See Medicare Claims Processing Manual, Chapter 30-Financial Liability Provisions, ¶40.1 (Rev. 1, 10-01-03). In addition, the determination must support the conclusion that the source of knowledge specified in 42 CFR §411.406 provided sufficient particular guidance so that "the provider clearly should have known that the claim would be denied." Id. at §40.1.2 (Rev. 1, 10-01-03) (emphasis added). As a result, the mandated limitation of liability analysis is different from the determination of a lack of medical necessity. It determines the actual state of knowledge of the provider as it relates to the existing specific guidance and the specific facts of each case. Thus, it is improper to deny the applicability of limitation of liability by simply saying that a provider generally knew there was a requirement of medical necessity.

The Medicare guidance available at the time of the admissions in 2003 contain only "initial screening" criteria which do not apply to the physician reviewers who are "expected to

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make a determination on the basis of their knowledge, expertise and experience, and upon an assessment of each beneficiary's individual care needs rather than on fixed criteria." See Manual, §110.4; see also Manual, ¶110.1 ("[D]enials of services based on . . . specific treatment norms, 'the three hour rule,' or any other 'rules of thumb,' are not appropriate.") The only applicable guidance from Medicare available in 2003 to determine medical necessity does not rely on any fixed criteria but rather the judgment of a physician that the care was reasonable and necessary for a particular patient based on the physician's training and experience. As a result, there will be many cases with respect to which physicians may reach different conclusions as to the existence of medical necessity, but either conclusion will be "reasonable." For all of the 58 cases under review, at the time of admission or at the time of the inpatient assessment, or both, a trained and experienced psychiatrist made the determination that based on his training and experience it was reasonable and necessary for proper care that the beneficiary receive the benefit of an inpatient rehabilitation program. Because Whittier's physicians made good faith reasonable determinations that each patient was appropriate for IRF level of care, it cannot be concluded that Whittier "clearly should have known that the claim would be denied." Medicare Claims Processing Manual, Chapter 30, §40.1.2.

For each of the 58 tentatively disallowed cases, Whittier also maintains that coverage existed because of the beneficiary's entitlement to an inpatient assessment for at least 3-10 days. The admission for this reason must be analyzed for limitation of liability purposes by looking at the only articulated Medicare standard that states when it is reasonable and necessary to perform an assessment on an inpatient basis, *i.e.*, "[i]f preadmission screening information indicated that the patient had potential for benefiting from an inpatient program," Manual, §110.2. Since a review of the pre-admission screening information applicable to each of the 58 cases establishes that each patient did have potential for benefiting from an inpatient program, it cannot be said that Whittier "clearly should have known" that an inpatient assessment would not be covered.

Until the separate, but mandated determination whether Medicare's limitation on liability provisions apply to each case is completed, based on analysis of each case and what Whittier's physicians knew or could reasonably have been expected to know at the time of admission, any conclusions relating to overpayments are incomplete and indeterminate. See Financial Management Manual, Chapter 3 – Overpayments, § 70.1 ("An overpayment does not exist if a determination is made that the limitation of liability provision applies.")

VI. THE RECOMMENDATION THAT WHITTIER REFUND AN ALLEGED OVERPAYMENT IS ALSO PREMATURE BECAUSE OF THE APPLICABILITY OF MEDICARE'S WAIVER OF LIABILITY PROVISIONS.

The above-stated reasons demonstrate that the underlying analysis that is the basis for the conclusions in your Draft Report is incomplete and, therefore, indeterminate with respect to the issues of lack of medical necessity and limitation of liability. However, your Draft Report should not include a recommendation that Whittier refund any amounts because its Fiscal

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Intermediary is required to conduct a "waiver of liability" analysis for each case before any decision about a refund can be made.

In the 1972 Amendments to the Medicare Act, Congress decided that overpayments to providers should not be collected from providers who were "without fault" with respect to the overpayments and enacted 42 U.S.C. §1395gg. See Senate Report No. 92-1230, Committee on Finance, September 26, 1972 (stating Congress' intent that under certain circumstances "the provider or other person shall be deemed to be without fault with respect to an overpayment and that under such circumstances no collection should be made.") The Medicare Program implemented this law by promulgating 42 CFR §405.350(c). See Notice of Proposed Rulemaking, 39 Fed. Reg. 13897 (April 18, 1972) ("The proposed amendments revise the present regulations to implement section 281 of the Social Security Act Amendments of 1972 (Pub. L. 92-603) which limits the recovery of incorrect payments from beneficiaries, providers of services, physicians and suppliers who are without fault in causing such incorrect payments.") See also 42 CFR § 405.350 (c). When the Secretary adopted 42 CFR § 350(c), the Secretary unequivocally declared that the intent and purpose was that a "without fault" provider was to be "relieved of liability for the incorrect payment." Notice of final Rulemaking, 41 Fed. Reg. 1491 (January 8, 1976). Medicare guidance from CMS states that overpayments may not be collected from providers who are "without fault." In its Medicare Financial Management Manual, CMS has expressly confirmed that Section 1870(b) of the Social Security Act, 42 CFR §1395gg(b), requires that providers who are "without fault" are not to be held liable for overpayments. CMS states:

A. Overpaid Provider or Physician Not Liable Because It Was Without Fault (§1870(b) of the Act.)

If a provider or physician was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The FI or carrier makes these determinations."

See MFMM, Chapter 3 at § 70.3 (Rev. 29, 01-02-04); see also MFMM, Chapter 3 at § 70 (Rev. 29, 01-02-04) ("If the FI or carrier determines that an overpaid provider or physician was without fault, it relieves the provider of liability for the overpayment."). The criteria utilized by the Fiscal Intermediary to determine whether a provider is "without fault" and, therefore, may keep any overpayment is also set forth in the MFMM. As explained by CMS:

"A provider is liable for overpayments it received unless it is found to be without fault. The FI or carrier, as applicable, makes this determination.

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The FI or carrier considers a provider without fault, if it exercised reasonable care in billing for, and accepting, the payment, *i.e.*,

- It made full disclosure of all materials facts; and
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or if it had reason to question the payment, it promptly brought the question to the FI or carrier's attention."

See MFMM, Chapter 3 at § 90.

Thus, unlike the "limitation of liability" provisions that analyze the state of knowledge of the provider at the time of service, the "waiver of liability" provisions determine, based on the then "information available" to the provider, whether it had "a reasonable basis" for submitting the Medicare claim. Given the highly subjective nature of determinations relating to the appropriateness of admitting a patient for rehabilitation care at an IRF level, and the carefully documented reasonable determination by its physiatrists in each of the 58 cases, Whittier will request its Fiscal Intermediary to determine that it is entitled to a favorable waiver of liability determination for each case that your final report suggests involves a possible overpayment. At most, all your Draft Report can properly state, assuming it cures the other defects in its analysis of potential overpayments, is that your office is forwarding its conclusions to the Fiscal Intermediary with the request that it perform the required determination for each case whether Whittier is eligible for a "waiver of liability."

VII. CONCLUSION.

Whittier is deeply appreciative of the opportunity provided by you to provide additional analysis of both the applicable standards for the review of admissions to its inpatient facility and each of the cases under review.. However, the conclusions in your Draft Request are totally dependent on whether the outside contractor utilized by your office conducted a proper assessment of these cases. As demonstrated above, the recommendations by your reviewers are both wrong or inconclusive for at least four reasons: (1) they failed to consider and apply the criteria for coverage in an IRF for an inpatient assessment of whether the patient would make practical improvement in a reasonable period; (2) they failed to recognize and apply the criteria that makes coverage in an IRF appropriate when a beneficiary has complicating additional medical conditions or is at risk for a change in medical status so that the physician availability at an IRF level is necessary to assure safe and effective rehabilitation care; (3) they failed properly to review each medical record which resulted in factual conclusions that are plainly contradicted

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by the medical records; and, (4) they failed to consider and apply the mandated analysis of each case required to determine whether Medicare's limitation of liability rule is applicable. These are major defects in the basis for the conclusions set forth in the Draft Report. As a result, Whittier requests that your office have each of the 58 cases re-reviewed by a different contractor who is, in fact, knowledgeable and experienced with the applicable criteria and who will obtain the required ultimate judgment of a physician reviewer who is trained and experienced in the delivery of rehabilitation care at the inpatient hospital level.

If you desire any additional clarification of the information we have provided, please feel free to call us.

Sincerely,

A handwritten signature in cursive script that reads "Richard P. Ward".

Richard P. Ward

Enclosure

cc: Al Arcidi (w/o enc.)
David Currie, Esq.
David Lamir