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OPERATION RESTORE TRUST



February 28, 1997

Mr. Marshall Kelley, Director
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Mr. Kelley:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at AMI Town and Country (Medicare provider number 10-5716), a skilled nursing facility located in Tampa, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1994 through December 31, 1995.

The ORT reviewers questioned \$47,147 in charges reported for 24 of the 26 beneficiaries in our sample. This amount comprises \$22,315 related to Physical and Respiratory Therapy services rendered; \$10,873 in unallowable supply charges; \$1,618 in inappropriate drug payments; \$788 in undocumented X-ray charges; and \$11,553 for laboratory services. Therefore, we are recommending an adjustment of the above charges. In addition, we request that a focused review of physical and respiratory therapies and the use of standing orders for all therapies be conducted by the FI and State agency in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations directed to the State agency in this report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

A handwritten signature in cursive script, appearing to read "Rose Crum-Johnson".

Rose Crum-Johnson
HCFA Regional Administrator - Reg IV

Sincerely,

A handwritten signature in cursive script, appearing to read "Charles Curtis".

Charles Curtis
Regional Inspector General - Audit

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OPERATION RESTORE TRUST



February 28, 1997

Ms. Patty Aguilera, Supervisor Fraud Unit
Mutual of Omaha
PO Box 1602
Omaha, NE 68101

Dear Ms. Aguilera:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at AMI Town and Country (Medicare provider number 10-5716), a skilled nursing facility located in Tampa, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1994 through December 31, 1995.

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Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made to the FI in this report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

Rose Crum-Johnson
HCFA Regional Administrator - Reg IV

Charles Curtis
Regional Inspector General - Audit

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I. EXECUTIVE SUMMARY

This report provides the results of our Operation Restore Trust (ORT) survey of Town and Country Hospital (Town and Country), a skilled nursing facility (SNF) in Tampa, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Part A Fiscal Intermediary (Intermediary) and Part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. For these services to be allowable they must be:

- ◆ considered a specific and effective treatment for the patient's condition;
- ◆ prescribed under the assumption that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician;
- ◆ reasonable in amount, frequency, and duration; and
- ◆ fully supported by the patient medical records.

A team comprising a Florida State Agency for Health Care Administration (State Agency) nurse surveyor, a Regional Health Care Administration (HCFA) nurse consultant, and an Office of Inspector General (OIG) Office of Audit Services auditor conducted an unannounced focused survey at Town and Country. The members of the team evaluated the services for 26 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994.

We found \$47,147 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above for 24 of the 26 beneficiaries in the sample. The disallowed cost consists of \$22,315 for physical and respiratory therapy services, \$10,873 of charges for supply services, \$1,618 of charges for drug services, \$11,553 for laboratory services, \$788 of charges for x-ray and other services which were not medically necessary, not documented or not covered by Medicare.

The therapy overcharges of \$22,315 occurred because all patients received standing orders on admission for evaluation of need for Physical (PT) and Respiratory (RT) therapy services.

We are recommending that the Intermediary make an adjustment of \$47,147 for questioned charges reported by the SNF on its FY 1994 cost report.

REGION IV OPERATION RESTORE TRUST PILOT

FOCUSED REVIEW OF A SKILLED NURSING FACILITY

II. BACKGROUND

The Secretary of the Department of Health and Human Services and the President initiated Project ORT. This innovative, collaborative project was designed to address growing concerns over rising health care costs. A review of departmental records indicated that over the last 10 years, the following segments of the health care industry have experienced a surge in health care fraud:

- ◆ home health,
- ◆ nursing homes,
- ◆ hospice, and
- ◆ durable medical equipment.

Departmental records further disclosed that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds paid to the above health care segments. As a result, these States and the above health care segments were chosen as targets of the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified through investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) has identified certain SNFs in Florida as aberrant according to their billings. The method used to identify these providers was to evaluate the universe of SNF admissions in each state during CY 1994. Data for all SNF claims was summarized first by beneficiary, and then by SNF. Key statistical data included total claims per beneficiary, allowed dollars per stay, line items or services per number of beneficiaries, average dollars and claims per stay, and average dollars per day. BDMS generated a listing of SNFs with high reimbursement amounts per day and per stay. The listing of SNFs was manually scanned and 14 were judgementally selected based on total highest reimbursement.

In addition to these 14 SNFs, we requested the two principal fiscal intermediaries in Florida (AETNA and Blue Cross) to each identify 3 SNFs for inclusion in this project based upon their data, complaints, and experience with SNF providers.

Town and Country Hospital was one of the 14 SNFs judgementally selected for review. It was selected for the survey based upon its high therapy costs, high average length of stay by the residents, high cost per stay, and high cost per day.

III. SCOPE OF REVIEW

The survey was conducted by a team comprising a nurse surveyor from the State Agency, a nurse consultant from HCFA, and an auditor from the OIG Office of Audit Services. This HCFA directed survey was conducted using HCFA's review protocols rather than the OIG's policies and procedures. Accordingly, the OIG's work was in compliance with generally accepted government auditing standards only in relation to the quantification of the unallowable services identified by other members of the team.

The objective of the survey was to determine whether charges other than room and board, billed to the Intermediary and Carrier, were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. Primarily, we wanted to determine whether unnecessary care was provided to the 26 beneficiaries in our sample, for whom Town and Country billed Medicare \$753,101 during the period January 1, 1994 through December 31, 1994. The facility's Medicare fiscal period is January 1 through December 31. Town and Country charged \$35,912,711 in its cost report for fiscal year 1994. We did not determine Medicare Part B or Medicaid reimbursement for this period.

The approach used was to identify all services billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 26 beneficiaries in our sample during their stay at Town and Country between January 1994 and December 1994. This approach was adopted because many providers, other than Town and Country bill separately for services to the SNF patients, e.g., podiatrists, portable x-ray suppliers, therapy providers and DME suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely, if ever associated with each other or the SNF's bills.

Using the team concept, the State Agency and HCFA nurses identified Medicare-funded services which were either not reasonable or necessary, and the OIG auditor quantified the charges associated with the services. The beneficiaries' medical records and related documentation were reviewed to determine the medical necessity of charged services; specifically, were the services: (i) recorded in the medical records, (ii) ordered by a physician, (iii) rendered by qualified personnel, and (iv) appropriate considering the physicians' diagnosis and the residents' physical/mental condition. The SNF's accounting records and supporting documentation were reviewed to determine: (i) the bases for charges reported to Medicare, and (ii) the amount of charges associated with questioned services.

Field work was performed at the SNF's offices in Tampa, Florida during the period May 20 through May 24, 1996.

IV. FINDINGS AND RECOMMENDATIONS

The review of the 26 beneficiaries included in our survey consisted of a retrospective analysis of their payment history for rehabilitative services under Part A and services provided under Part B while residents of the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 26 beneficiaries resulted in disallowance of \$47,147 in charges reported by Town and Country in its FY 1994 Medicare Cost Report. The disallowed cost consists of \$22,315 for physical and respiratory therapy services, \$10,873 of charges for supply services, \$1,618 of charges for drug services, \$11,553 for laboratory services, \$788 of charges for x-ray and other services which were not medically necessary, not documented or not covered by Medicare.

QUESTIONED CHARGES

	<u>Billed</u>	<u>Questioned</u>	<u>Percentage</u>
THERAPIES:			
Physical	\$ 60,357	\$ 20,738	34%
Respiratory	4,296	1,577	37%
Subtotal	<u>\$ 64,653</u>	<u>\$ 22,315</u>	35%
Supply services	40,876	10,873	27%
Drug services	230,622	1,618	1%
Laboratory	58,610	11,553	20%
X-ray & Other	<u>26,035</u>	<u>788</u>	3%
Total	\$420,796	\$ 47,147	11%

PHYSICAL AND RESPIRATORY THERAPY SERVICES

We questioned \$22,315 of physical (PT) and respiratory (RT) therapy services charged to 16 of the 26 beneficiaries included in our sample. Under paragraph 1861(h)(3) of the Social Security Act, these services are covered under Medicare Part A when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist. The Medicare Intermediary Manual at paragraph 3132 (MIM 3132) states that the ordered therapies provided in a SNF must be reasonable and necessary for the treatment of the beneficiary's illness or injury. The questioned charges did not meet the reimbursement criteria.

FINDING #1

Physical Therapy Services

We questioned the medical necessity and documentation of \$20,738 for PT services provided to 15 of 26 beneficiaries that Town and Country was reimbursed during the period of our review. In order to be covered under Medicare Part A, PT services must relate directly and specifically to an active written treatment regimen established by the physician or be the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (M.M. 3101.8). To be considered reasonable and necessary the following conditions must be met:

- The services must be considered a specific and effective treatment for the patient's condition.
- There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.
- The amount, frequency, and duration of the services must be reasonable.

Our review of the residents' records showed the PT services were not medically necessary. Additionally, review of the medical records revealed a lack of evidence in nursing or therapy notes to show that services had been rendered to the beneficiary.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the \$20,738 from PT charges reported by the SNF on its FY 1994 cost report.
- Conduct a focused review of all PT services provided at Town and Country since the period of our review.

We recommend that the State agency should:

- Ensure through a Corrective Action Plan that PT services be provided only after a specific treatment plan has been established by the physician and appropriate assessments are documented to indicate a medical need for the service.

FINDING #2

Respiratory Therapy Services

We questioned the documentation for \$1,577 of RT services provided to 3 of 26 beneficiaries that Town and Country was reimbursed during the period of our review. These services are reimbursable under Medicare Part A if furnished by a transfer hospital or by a nurse on the staff of the skilled nursing facility. The services are considered medically necessary and reasonable if they meet the following criteria.

- Consistent with the nature and severity of the individuals' complaints and diagnosis,
- Reasonable in terms of modality, amount, frequency, and duration of the treatments, and
- Generally accepted by the professional community as being safe and effective treatment for the purpose used.

Our review of the residents' records showed the RT services were not medically necessary.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the \$1,577 from RT charges reported by the SNF on its FY 1994 cost report.
- Conduct a focused review of all RT services provided at Town and Country since the period of our review.

We recommend that the State agency should:

- Ensure through a Corrective Action Plan that RT services be provided only after a specific treatment plan has been established by the physician and appropriate assessments are documented to indicate a medical need for the service.

FINDING #3

Supply Services

We questioned \$10,873 of supply services charged to 20 of the 26 beneficiaries included in our sample. Federal regulations 42 CFR 409.25 state that supplies, appliances, and equipment are covered as extended care services only if they are ordinarily furnished by the skilled nursing facility for the

care and treatment of inpatients. We considered that these items should have been included in the room and board charge.

RECOMMENDATION

We recommend that the Intermediary should:

- Adjust the \$10,873 from other services charged to the SNF on its FY 1994 cost report.
- Conduct a focused review of all supply services provided at Town and Country since the period of our review.

FINDING #4

Drug Services

We questioned \$1,618 of drug services charged to 5 of the 26 beneficiaries included in our sample. They were found to be not properly documented or not covered by Medicare. Enteral nutrients provided during a stay that is covered by Part A are classified as food and included in the routine Part A payment sent to SNF (Provider Reimbursement Manual, 2203.1E).

We recommend that the Intermediary should:

- Adjust the \$1,618 from drug services charged to the SNF on its FY 1994 cost report.

FINDING #5

Laboratory Services

We questioned \$11,553 of laboratory services charged to 17 of the 26 beneficiaries included in our sample. Our review of the residents' records showed the laboratory services were either not documented or not covered by Medicare.

We recommend that the Intermediary should:

- Adjust the \$11,553 from laboratory services charged to the SNF on its FY 1994 cost report.
- Conduct a focused review of all laboratory services provided at Town and Country since the

period of our review.

We recommend that the State agency should:

- Ensure through a corrective action plan that all laboratory services are ordered by a physician and results of tests are properly documented in the medical records.

FINDING #6

X-ray and Other Tests

We questioned \$788 of x-ray and other tests charged to 3 of the 26 beneficiaries included in our sample. They were found to be either not medically necessary, not documented or not covered by Medicare.

We recommend that the Intermediary should:

- Adjust the \$788 from x-ray and other tests charged to the SNF on its FY 1994 cost report.

TEAM MEMBERS

Veronica Stephens-Echols, RN, Health Care Financing Administration

Robert Julian, Auditor, Office of Inspector General - Audit Services

Margaret Bonnell, RN Specialist, Florida Agency for Health Care Administration