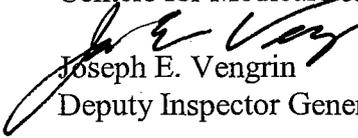




JUN 28 2006

TO: Wynethea Walker
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of PCH Health Systems' Medicare Claims for Outpatient Physical and Occupational Therapy Services for Calendar Years 2000 Through 2003 (A-09-04-00069)

Attached is an advance copy of our final report on PCH Health Systems' (PCH) Medicare claims for outpatient physical and occupational therapy services for calendar years 2000 through 2003. We will issue this report to PCH within 5 business days. We initiated this review based on a survey by Office of Inspector General Region IX staff of outpatient physical and occupational therapy services provided by qualified therapists in private practice.

Medicare Part B covers outpatient physical and occupational therapy services provided by a qualified therapist in private practice when the services are furnished in the therapist's office or the beneficiary's home. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury and that they be provided according to a plan of treatment approved by a physician.

Our objective was to determine whether Medicare payments to PCH for outpatient physical and occupational therapy services met Medicare reimbursement requirements.

None of PCH's 114 sampled claims for outpatient physical and occupational therapy services provided from 2000 through 2003 met Medicare reimbursement requirements:

- One hundred and three claims were for medically unnecessary services.
- Eleven claims were not supported.
- Most of the 114 claims had other types of errors.

As a result, PCH received \$41,124 in unallowable Medicare payments for the sampled claims. Projecting these results to the population, we estimate that at least \$9,984,065 of the \$11,137,095 paid to PCH for outpatient physical and occupational therapy claims was unallowable for Medicare reimbursement. These overpayments occurred because PCH did not have adequate procedures to ensure that outpatient physical and occupational therapy services billed to

Medicare were medically necessary and documented pursuant to Medicare reimbursement requirements.

We recommend that PCH refund \$9,984,065 to the Medicare program and work with the Centers for Medicare & Medicaid Services to determine the allowability of services billed after 2003. Because PCH no longer treats Medicare patients or bills the Medicare program, we also recommend that it request its carrier to deactivate PCH's Medicare provider number.

PCH did not provide comments on our draft report. In its comments on our draft report, National Heritage Insurance Company, the Medicare carrier that processed PCH's Part B claims, stated that it would address our recommendations by working with the Centers for Medicare & Medicaid Services regional office.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360. Please refer to report number A-09-04-00069.

Attachment



Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

JUN 30 2006

Report Number: A-09-04-00069

Mr. Mark Simone
President and Chief Executive Officer
PCH Health Systems, Inc.
4432 Forman Avenue
Toluca Lake, California 91602

Dear Mr. Simone:

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 PCH Health Systems' Medicare Claims for Outpatient Physical and Occupational Therapy Services for Calendar Years 2000 Through 2003." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

Please refer to report number A-09-04-00069 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Page 2 – Mr. Mark Simone

cc:

Ms. Anne Bockhoff Dalton
Vice President
National Heritage Insurance Company, Medicare
75 Sgt. William B. Terry Drive
Hingham, Massachusetts 02043

Direct Reply to HHS Action Official:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
75 Hawthorne Street, Fourth Floor
San Francisco, California 94105

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PCH HEALTH
SYSTEMS' MEDICARE CLAIMS
FOR OUTPATIENT PHYSICAL AND
OCCUPATIONAL THERAPY
SERVICES FOR CALENDAR YEARS
2000 THROUGH 2003**



Daniel R. Levinson
Inspector General

June 2006
A-09-04-00069

Office of Inspector General

<http://oig.hhs.gov>

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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

Medicare Part B covers outpatient physical and occupational therapy services provided by a qualified therapist in private practice when the services are furnished in the therapist's office or the beneficiary's home. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury and that they be provided according to a plan of treatment approved by a physician.

Physical therapy services are designed to improve a beneficiary's physical functioning following disease or injury. These services include the evaluation and reevaluation of a beneficiary's condition. To aid in the treatment of a beneficiary, physical therapists use a variety of exercises; rehabilitative procedures; massages; and physical agents such as mechanical devices, heat and cold, water, and sound.

Occupational therapy services are medically prescribed treatments designed to (1) improve or restore functions that have been impaired by illness or injury or (2) improve the ability to perform tasks required for independent functioning when functions have been permanently lost or reduced by illness or injury. These services include evaluating the beneficiary's condition; educating the beneficiary or the beneficiary's family; and providing services to help the beneficiary develop, improve, or restore the activities of daily living.

From calendar years 2000 through 2003, PCH Health Systems, Inc. (PCH), located in California, received \$11,137,095 in Medicare payments for 48,370 outpatient physical and occupational therapy claims.

OBJECTIVE

Our objective was to determine whether Medicare payments to PCH for outpatient physical and occupational therapy services met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

None of PCH's 114 sampled claims for outpatient physical and occupational therapy services provided from 2000 through 2003 met Medicare reimbursement requirements:

- One hundred and three claims were for medically unnecessary services.
- Eleven claims were not supported.
- Most of the 114 claims had other types of errors.

As a result, PCH received \$41,124 in unallowable Medicare payments for the sampled claims. Projecting these results to the population, we estimate that at least \$9,984,065 of the \$11,137,095 paid to PCH for outpatient physical and occupational therapy claims was unallowable for

Medicare reimbursement. These overpayments occurred because PCH did not have adequate procedures to ensure that outpatient physical and occupational therapy services billed to Medicare were medically necessary and documented pursuant to Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that PCH refund \$9,984,065 to the Medicare program and work with the Centers for Medicare & Medicaid Services (CMS) to determine the allowability of services billed after 2003.

Because PCH no longer treats Medicare patients or bills the Medicare program, we also recommend that it request its carrier to deactivate PCH's Medicare provider number.

COMMENTS

PCH did not provide comments on our draft report.

In its comments on our draft report, National Heritage Insurance Company (NHIC), the Medicare carrier that processed PCH's Part B claims, stated that it would address our recommendations by working with the CMS regional office to (1) ensure that PCH refunds the \$9,984,065 to the Medicare program, (2) plan a review of the services billed by PCH after 2003, and (3) determine the best approach for deactivating PCH's Medicare provider number. The full text of NHIC's comments is included as Appendix B.

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INTRODUCTION

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health insurance coverage to people age 65 and over, the disabled, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B covers a multitude of medical and other health services, including outpatient physical and occupational therapy services. Medicare carriers, which are CMS contractors, process and pay Part B claims. National Heritage Insurance Company (NHIC) is the carrier for beneficiaries in California.

Outpatient Physical and Occupational Therapy Services

Medicare Part B covers outpatient physical and occupational therapy services provided by a qualified therapist in private practice when the services are furnished in the therapist's office or the beneficiary's home. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury and that they be provided according to a plan of treatment approved by a physician.

Physical therapy services are designed to improve a beneficiary's physical functioning following disease or injury. These services include the evaluation and reevaluation of a beneficiary's condition. To aid in the treatment of a beneficiary, physical therapists use a variety of exercises; rehabilitative procedures; massages; and physical agents such as mechanical devices, heat and cold, water, and sound.

Occupational therapy services are medically prescribed treatments designed to (1) improve or restore functions that have been impaired by illness or injury or (2) improve the ability to perform tasks required for independent functioning when functions have been permanently lost or reduced by illness or injury. These services include evaluating the beneficiary's condition; educating the beneficiary or the beneficiary's family; and providing services to help the beneficiary develop, improve, or restore the activities of daily living.

PCH Health Systems

PCH Health Systems, Inc. (PCH), a privately held corporation, provided outpatient physical and occupational therapy services in California during our audit period (2000 through 2003). Its main office was located in Burbank, California. PCH filed for Chapter 7 bankruptcy on March 28, 2005. We have been informed that its bankruptcy petition has been discharged by the court. We have also been informed that PCH no longer treats Medicare patients or submits claims for payment to NHIC.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments to PCH for outpatient physical and occupational therapy services met Medicare reimbursement requirements.

Scope

PCH received total Medicare payments of \$11,137,095 for 48,370 outpatient physical and occupational therapy claims for services provided from calendar years 2000 through 2003. We selected a stratified sample of 114 claims, consisting of 528 services, for this period. (See Appendix A for details of our sample methodology and results.)

We did not assess PCH's overall internal control structure. We limited our internal control review to obtaining an understanding of controls over the submission of claims to Medicare for outpatient physical and occupational services.

We performed our review from September 2004 through August 2005 and conducted fieldwork at PCH in Burbank, California, and at a Medicare program safeguard contractor (PSC), Electronic Data Systems, in Los Angeles, California.¹

Methodology

To accomplish our objective, we contracted with the PSC to perform a medical review of our sample of 114 claims. The PSC evaluated each claim to determine whether PCH's outpatient physical and occupational therapy services met Medicare reimbursement requirements.

In addition, we:

- reviewed applicable Federal and State requirements,
- examined the results of a prior medical review that the PSC performed for PCH,
- used CMS National Claims History data to identify the population of PCH's Medicare claims for outpatient physical and occupational services for 2000 through 2003,
- requested medical records from PCH and the beneficiaries' ordering physicians for all 114 sampled claims,

¹The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program and authorized CMS to contract with entities, such as PSCs, to perform certain program safeguard activities, including medical review, cost report audits, data analysis, provider education, and fraud detection and prevention. We relied on the medical review determinations of Electronic Data Systems, which was under contract with CMS to promote the integrity of the Medicare program.

- obtained Medicare Common Working File data for all 114 sampled claims to determine whether the ordering physicians saw the beneficiaries at least every 30 days,
- reviewed PCH's policies and procedures for billing Medicare for outpatient physical and occupational therapy services,
- interviewed PCH officials to obtain an understanding of the Medicare billing processes for outpatient physical and occupational therapy services, and
- used a variable unrestricted appraisal program to estimate the dollar impact of overpayments in the population.

PCH did not provide comments on our draft report, issued March 13, 2006. At the end of April 2006, we sent a follow-up letter to PCH indicating that its written comments on the draft report were overdue. We requested that PCH promptly submit its comments to enable us to properly consider and present PCH's views concerning the findings and recommendations in the report. We also made attempts to contact PCH by phone. As of the date of this report, we had received no response from PCH.

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

FINDINGS AND RECOMMENDATIONS

None of PCH's 114 sampled claims for outpatient physical and occupational therapy services provided from 2000 through 2003 met Medicare reimbursement requirements:

- One hundred and three claims were for medically unnecessary services.
- Eleven claims were not supported.
- Most of the 114 claims had other types of errors.

As a result, PCH received \$41,124 in unallowable Medicare payments for the sampled claims. Projecting these results to the population, we estimate that at least \$9,984,065 of the \$11,137,095 paid to PCH for outpatient physical and occupational therapy claims was unallowable for Medicare reimbursement. These overpayments occurred because PCH did not have adequate procedures to ensure that outpatient physical and occupational therapy services billed to Medicare were medically necessary and documented pursuant to Medicare reimbursement requirements.

MEDICALLY UNNECESSARY SERVICES

Federal regulations (42 CFR § 411.15(k)) require, in part, that "services that are not reasonable and necessary . . . [f]or the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" be excluded from Medicare coverage. The

“Medicare Carriers Manual” (the Manual), part 3, chapter II, sections 2210.A and 2217.B, requires that outpatient physical and occupational therapy services be reasonable and necessary for the treatment of a beneficiary’s illness or injury.

For physical therapy services to be reasonable and necessary, section 2210.B states that they “must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision.” In addition: “There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.”

For occupational therapy services to be reasonable and necessary, section 2217.B states that there should be:

an expectation . . . that the therapy will result in a significant practical improvement in the individual’s level of functioning within a reasonable period of time. Where an individual’s improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and thus are not covered.

Of the 114 sampled claims, 103 were for medically unnecessary outpatient physical and occupational therapy services. Specifically, all treatment was ongoing and long term, without potential for significant improvement in the beneficiaries’ conditions, and the therapy services did not require the expertise of qualified physical therapists. As a result, PCH was overpaid \$38,750.

For example, one beneficiary, who was living in an assisted living facility, had Alzheimer’s and Parkinson’s diseases. As a result of these conditions, the beneficiary suffered from gait disorder, balance problems, weakness, and functional impairment. There was no chance of significant practical improvement within a reasonable period. The therapy that the physical therapist provided was considered maintenance and could have been provided by a registered nurse assistant. Accordingly, the therapy was not medically necessary or reasonable under Medicare guidelines.

UNSUPPORTED SERVICES

Federal regulations (42 CFR § 486.161) require physical therapists in independent practice to maintain clinical records for all patients. These records should contain sufficient information to identify the patients clearly, to justify the diagnosis and treatment, and to document the results accurately. Clinical records should be “retained for a period of time not less than . . . that determined by the respective State statute or the statute of limitations in the State” if a State statute exists.

The Business and Professions Code of the State of California, section 2620.7, requires that physical therapists maintain patient records generally “for a period of no less than seven years following the discharge of the patient.”

Of the 114 sampled claims, 11 were for unsupported outpatient physical and occupational therapy services. One of the 11 claims was for a beneficiary whose entire medical record was missing. The remaining 10 claims were for beneficiaries whose medical records for the claim period were missing. A PCH official stated that PCH was unable to find those records. Because of the lack of medical records, we could not determine whether PCH actually provided the services claimed. As a result, PCH was overpaid \$2,374.

OTHER TYPES OF ERRORS

The Manual, part 3, chapter II, section 2215, requires the following:

- The services must be provided by a qualified (licensed) therapist in the therapist’s office or the beneficiary’s home (section 2215.D).
- The services must be furnished under a written plan of treatment established and signed by the physician or therapist caring for the beneficiary and reviewed by the physician at least every 30 days (section 2215.E).
- The beneficiary must be under the care of a physician and must be seen by the physician at least every 30 days (section 2215.E).
- The services must be provided either by or under the direct personal supervision of the therapist in independent practice, and the services of support personnel must be included in the therapist’s bill (section 2215.F).

Further, the Manual, part 3, chapter IV, section 4020.2, requires that the physical or occupational therapist enter on the claim the date that the attending physician last saw the beneficiary. Entering this information certifies that the treatment plan approved by the attending physician is on file.

In addition to including medically unnecessary or unsupported services, each of the 114 sampled claims, except for the claim for which the beneficiary’s entire medical record was missing, had other types of billing errors. A significant number of sampled claims had errors in two areas: “no or improper treatment plan” and “patient not seen by a physician at least every 30 days.”

- PCH was paid for 30 claims that did not have treatment plans and for 35 claims for which the treatment plans did not have a physician signature. PCH was also paid for six claims for which a physician did not review the treatment plans every 30 days.
- PCH was paid for 39 claims for which a physician did not see the beneficiaries at least every 30 days.

INADEQUATE PROCEDURES

PCH did not have adequate procedures to ensure that outpatient physical and occupational therapy services billed to Medicare were medically necessary, documented pursuant to Medicare reimbursement requirements, and supported by a properly documented and signed treatment plan. Further, PCH did not have adequate procedures to ensure that a physician saw the beneficiary at least every 30 days.

EFFECT OF IMPROPER BILLINGS

For the 114 claims in the sample, PCH received \$41,124 in Medicare payments for outpatient physical and occupational therapy services that did not meet Medicare reimbursement requirements. Projecting these results to the population, we estimate that at least \$9,984,065 of the \$11,137,095 paid to PCH for outpatient physical and occupational therapy claims was unallowable for Medicare reimbursement.

RECOMMENDATIONS

We recommend that PCH refund \$9,984,065 to the Medicare program and work with CMS to determine the allowability of services billed after 2003.

Because PCH no longer treats Medicare patients or bills the Medicare program, we also recommend that it request its carrier to deactivate PCH's Medicare provider number.

COMMENTS

PCH did not provide comments on our draft report.

In its comments on our draft report, NHIC, the Medicare carrier that processed PCH's Part B claims, stated that it would address our recommendations by working with the CMS regional office to (1) ensure that PCH refunds the \$9,984,065 to the Medicare program, (2) plan a review of the services billed by PCH after 2003, and (3) determine the best approach for deactivating PCH's Medicare provider number. The full text of NHIC's comments is included as Appendix B.

APPENDIXES

SAMPLE METHODOLOGY AND RESULTS

METHODOLOGY

Population

The population consisted of 48,370 Medicare claims paid to PCH Health Systems, Inc. (PCH), for physical and occupational therapy services provided from calendar years 2000 through 2003. PCH provided these services to 3,976 beneficiaries in California and received a total of \$11,137,095 from Medicare.

Sample Unit

The sample unit was a Medicare paid claim for physical and occupational therapy services. The amount paid for a claim included only payments for physical and occupational therapy services. Payments for other services were not part of the sample unit.

Sample Design

We used a stratified sample design that included two strata. The first stratum consisted of 48,356 claims with Medicare payments less than \$1,000 each. We reviewed 100 randomly selected claims from the first stratum. The second stratum consisted of 14 claims with Medicare payments of \$1,000 or more each. We reviewed all 14 claims from the second stratum.

Estimation Methodology

We used the Office of Audit Services RAT-STATS unrestricted variable appraisal program to project the sample results. We used the lower limit of the 90-percent confidence level for our recommended refund.

RESULTS AND PROJECTION

	<u>Population</u>	<u>Sample</u>	<u>Errors</u>
Stratum 1			
Items	48,356	100	100
Payments	\$11,118,863	\$22,892	\$22,892
Stratum 2			
Items	14	14	14
Payments	\$18,232	\$18,232	\$18,232

Projection of Sample Results
(at the 90-percent confidence level)

Point estimate	\$11,088,163
Lower limit	\$9,984,065
Upper limit	\$12,192,261
Precision percent	9.96%

APPENDIX B



MEDICARE
PART B CARRIER

April 11, 2005

Department of Health & Human Services
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Attention: Lori A. Ahlstrand
Regional Inspector General for Audit Services

Subject: Office of Inspector General's Draft Report, "Review of PCH Health Systems' Medicare Claims for Outpatient Physical and Occupational Therapy Services for Calendar Years 2000 through 2003" (A-09-04-00069).

Dear Ms. Ahlstrand:

NHIC is in receipt of the Office of Inspector General's (OIG) draft report entitled, "Review of PCH Health Systems' Medicare Claims for Outpatient Physical and Occupational Therapy Services for Calendar Years 2000 through 2003". The basis of the audit was to identify any program overpayments resulting from billing and documentation practices at PCH.

NHIC will address the recommendations on this report by working with our CMS Regional Office to recover the cited overpaid funds, to plan any review of post-2003 services submitted by PCH, and to determine the best approach for deactivating PCH's Medicare provider number.

If you have any questions regarding NHIC's corrective actions, please contact Jennifer Otten, Manager of Audit & Controls, in Chico, California at 530-896-7143 (or at jennifer.otten@eds.com).

Sincerely,

Anne Bockhoff Dalton
Vice President
National Heritage Insurance Company

NHIC

National Heritage Insurance Company
75 Sgt William B Terry Drive
Hingham, MA 02043
A CMS CONTRACTED CARRIER