



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 Catholic Medical Center for Calendar Year 2003 (A-01-04-00530)

Attached is an advance copy of our final report on inpatient rehabilitation facility admissions at Catholic Medical Center (the Hospital) in Manchester, New Hampshire, 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. The Hospital operates the Rehabilitation Medicine Unit, an IRF, within its 330-bed, full-service health care facility. Medicare paid the Hospital almost \$5.6 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 44 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 41 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 three 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 \$466,792 in unallowable Medicare payments for the 44 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$1.7 million for IRF claims during 2003.

We recommend that the Hospital:

- refund to the Medicare program the \$1.7 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 objected to our findings and recommendations. The Hospital maintained that it had correctly applied the required admission criteria governing inpatient rehabilitation admissions and that its admission determinations were appropriate and correct.

We resubmitted the denied claims to the medical reviewer, who conducted a second review of all denied cases. In light of the clarifying information that the Hospital provided in its response, the medical reviewer reversed nine 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-01-04-00530.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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

APR 17 2007

Report Number: A-01-04-00530

Ms. Alyson Pitman Giles
President and Chief Executive Officer
Catholic Medical Center
100 McGregor Street
Manchester, New Hampshire 03102

Dear Ms. Giles:

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 Catholic Medical Center 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-01-04-00530 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 CATHOLIC
MEDICAL CENTER FOR
CALENDAR YEAR 2003**



Daniel R. Levinson
Inspector General

April 2007
A-01-04-00530

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

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.

Catholic Medical Center (the Hospital) operates the Rehabilitation Medicine Unit, an IRF, within its 330-bed, full-service health care facility in Manchester, New Hampshire. Medicare paid the Hospital almost \$5.6 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 44 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 41 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 three 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 \$466,792 in unallowable Medicare payments for the 44 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$1.7 million for IRF claims during 2003.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program the \$1.7 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 objected to our findings and recommendations. The Hospital maintained that it had correctly applied the required admission criteria governing inpatient rehabilitation admissions and that its admission determinations were appropriate and correct. The Hospital's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We resubmitted the denied claims to the medical reviewer, who conducted a second review of all denied cases. In light of the clarifying information that the Hospital provided in its response, the medical reviewer reversed nine 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.

Catholic Medical Center

Catholic Medical Center (the Hospital) operates the Rehabilitation Medicine Unit, an IRF, within its 330-bed, full-service health care facility in Manchester, New Hampshire. For fiscal year 2002, its final year under cost reimbursement, the Hospital received Medicare IRF payments totaling approximately \$4.3 million for 454 discharges. For fiscal year 2003, the Hospital’s first year under the prospective payment system, the Hospital received Medicare IRF payments totaling almost \$5.6 million for 412 discharges. These amounts represent a 25-percent increase in payments and a 9.25-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 431 claims for which the Hospital received total Medicare payments of \$5,580,762.

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 CMS's National Claims History file;
- selected a random sample of 100 paid claims totaling \$1,437,714 (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 44 of the 100 claims in our sample, an IRF was not the appropriate setting for the beneficiaries:

- For 41 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 three 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 \$466,792 in unallowable Medicare payments for the 44 claims. Based on the sample results, we estimate that Medicare overpaid the Hospital approximately \$1.7 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 home 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 44 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 44 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 41 of the 44 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:

- uncomplicated knee, hip, and other single-joint replacements that required only pain management and simple therapies and
- 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 3 of the 44 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 who was otherwise clinically stable was not able to participate in intensive rehabilitation because his postsurgical state limited the therapy that could actually be provided. The beneficiary's condition was suitable for a lesser level of care than that provided in 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 \$1,714,259 for inpatient rehabilitation services that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program the \$1.7 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 objected to our findings and recommendations. The Hospital maintained that it had correctly applied the required admission criteria governing inpatient rehabilitation admissions and that its admission determinations were appropriate and correct. The Hospital identified the following specific areas of concern:

1. *“Retrospective denial of a claim for lack of medical necessity cannot be based on information available only after admission.”* The Hospital stated that many of the findings appeared to be based on information not available at admission. The Hospital cited three cases in which it believed that the PSC had retrospectively evaluated the patient's progress at the IRF to decide whether the patient should have stayed longer in the acute hospital setting or been transferred to a less acute setting.
2. *“Patients found to be ‘at risk’ of complications during rehabilitation are appropriate for admission.”* The Hospital stated that the PSC had inappropriately denied several admissions for beneficiaries who had had total knee or hip replacements and whose course of treatment had proceeded without incident. The Hospital noted: “Based on the experience and expertise of the RMU's [rehabilitation medical unit] Medical Director and Preadmission screening team, patients in a given age group with certain co-morbidities or

post operative complications are determined to be at significantly increased risk of experiencing further complications in rehabilitation.” The Hospital concluded that it was inappropriate to deny a claim for a patient who was at high risk of experiencing complications but had a smooth recovery.

3. *“Requiring a longer acute hospital inpatient stay for a patient who is ready for discharge is inappropriate.”* The Hospital stated that the PSC had denied some claims because the patient could have stayed in the acute care hospital longer to resolve certain medical issues before being discharged to a lesser level of care. The Hospital maintained that discharging a patient from the acute setting to inpatient rehabilitation was appropriate if the patient met the discharge criteria and was able to participate in intensive therapy.
4. *“Denying the patient the opportunity to achieve the best possible functional outcome in the shortest possible time frame is inappropriate.”* The Hospital stated that the PSC had denied claims on the grounds that the patient could have received therapy in a lesser level-of-care setting. The Hospital maintained that denying these patients access to intensive therapy in a hospital setting would unnecessarily prolong their recovery. The Hospital cited Medicare billing rules, which provide that inpatient care is reasonable and necessary when the patient requires a more coordinated, intensive program of services than is normally available outside a hospital.
5. *“Denials based on failure to reach rehabilitation goals are inconsistent with Medicare admission criteria.”* The Hospital stated that, in some cases, the PSC had based the denial, in whole or in part, on the patient’s failure to meet rehabilitation goals. Citing two cases, the Hospital pointed out that the patient’s potential for improvement, rather than goal attainment, is a Medicare admission criterion.
6. *“Denials cannot be based on uncertain and indefinite conclusions.”* The Hospital asserted that the PSC often used less than definitive statements to justify denials. The Hospital maintained that, when the determination is not clear and definitive, the payment determination should favor the provider, which did not have the benefit of hindsight when making the admission decision.

The Hospital stated that publishing the results of this review would be inappropriate until it had an opportunity to present its case through the Medicare appeals process. The Hospital also asserted that publication of the report could severely damage its reputation. The Hospital cited 45 CFR § 5.65, which states that privileged or confidential information may be withheld from disclosure, and 45 CFR § 5.66, which protects internal Government communications, including predecisional deliberative communications. The Hospital maintained that this report should be withheld from publication because it contains confidential information about the Hospital’s patients and admission practices and that the review should be treated as preliminary findings.

We have included the Hospital’s comments as Appendix D. We have omitted the two appendixes 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. As part of its second review of the denied claims, the PSC considered the clarifying information that the Hospital had provided in its response. The PSC reversed 9 of the 53 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.

Based on the PSC's responses to the Hospital's areas of concern, we concluded the following:¹

1. The Hospital stated that the PSC had based its denial of some claims on "information available only after admission." Although the PSC included some postadmission material in its original review to determine the accuracy and value of the admission decisions across the sample, including such material is not the same as basing a denial decision on outcomes. The PSC based its individual case determinations on a review of the sending hospital's notes, the preadmission field evaluation, and the Hospital's day-of-admission notes and assessments. In addition, the PSC reversed two of the three original determinations that the Hospital cited here because the clarifying information that the Hospital provided with its response indicated that the situation at the time of admission supported the Hospital's decision to admit.
2. The Hospital's assertion that "patients who are found to be 'at risk' of complications during rehabilitation are appropriate for admission" is correct only when the determination of risk is based on the clinical findings of the individual patient and not on the generic risk-stratification approach that the Hospital used.
3. The Hospital maintained that "[r]equiring a longer acute hospital inpatient stay for a patient who is ready for discharge is inappropriate." The PSC reversed some of its original determinations once it determined from the additional information that the Hospital provided that the patient required hospital-level care yet was not too ill to enter a rehabilitation program. In one case, the PSC retracted its comment about a longer stay in the acute unit but did not change its decision because the decision did not depend on that element.
4. In response to the Hospital's assertion that "[d]enying a patient the opportunity to achieve the best possible functional outcome in the shortest possible time frame is inappropriate," we note that a subacute or skilled level of care would not necessarily delay a patient's achievement of a given level of function. Patients can receive as intensive a program of therapy as they require at a subacute facility.
5. The Hospital's stated that "[d]enials based on a patient's failure to reach rehabilitation goals are inconsistent with Medicare admission criteria." As a result of the additional

¹The Hospital raised six categories of objections but did not specify which of the 53 original denied claims were in each category. For this reason, we were unable to determine how many of the PSC's nine reversals fell into each category. However, for categories 1 and 5, we were able to identify the number of reversals among the examples that the Hospital cited.

information that the Hospital provided, the PSC reversed one of the two original determinations that the Hospital cited. It did not reverse the other determination because its denial of this claim was based on information available to the Hospital at the time of admission, not on the patient's failure to reach goals. Specifically, the patient was so handicapped by a large, heavy fracture-stabilization device when she was admitted to the Hospital that she was not able to participate in an intensive rehabilitation program.

6. In response to the Hospital's assertion that the PSC had based denials on "uncertain and indefinite conclusions," the PSC reevaluated its original conclusions in light of the Hospital's comments so that the final determinations would be as conclusive and definitive as possible. The PSC also restated the individual case determinations so that their meanings would be clear and unequivocal.

In response to the Hospital's request for nonpublication of our final report, we note that the Freedom of Information Act (FOIA) exemption (b)(4) exempts from disclosure "commercial or financial information that is obtained from a person and is privileged or confidential." Regulations (45 CFR § 5.65(b)(4)(ii)) state that information is "confidential" if disclosure would substantially harm the competitive position of the person who submitted the information. Here, FOIA exemption (b)(4) does not apply because the information in the report concerning patients or admission practices is not confidential commercial or financial information that would substantially harm the Hospital's competitive position. Moreover, the perceived threat of harm to the Hospital's reputation is not a sufficient basis for us to withhold publication of the report.

FOIA exemption (b)(5), as explained by 45 CFR § 5.66, exempts from disclosure privileged memorandums and letters within or between Federal agencies. The exemption does not apply to communications with those outside the Federal Government. This audit report has been disclosed to the Hospital; therefore, FOIA exemption (b)(5) is not applicable and does not support withholding publication of the report.

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVE

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

POPULATION

The population included 431 claims for inpatient rehabilitation services at the Hospital with dates of discharge 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 271 claims with paid amounts between \$0.01 and \$14,000. The second stratum consisted of 160 claims with paid amounts of \$14,000.01 or greater.

Stratum	Description of Stratum	Number of Population Claims	Payment Amounts
1	\$0.01–\$14,000	271	\$2,361,267
2	\$14,000.01 or greater	<u>160</u>	<u>3,219,495</u>
Total		431	\$5,580,762

SAMPLE SIZE

The sample consisted of 100 paid claims totaling \$1,437,714. We selected 50 claims from each stratum in our identified population.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

The following table presents our sample results:

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
1 – \$0.01 - \$14,000	50	\$425,898	31	\$257,117
2 – \$14,000.01 and above	<u>50</u>	<u>1,011,816</u>	<u>13</u>	<u>209,675</u>
Total	100	\$1,437,714	44	\$466,792

VARIABLE PROJECTIONS

Projected Value of Erroneous Claims

Point estimate	\$2,064,536
90-percent confidence level	
Lower limit	\$1,714,259
Upper limit	\$2,414,814

MEDICAL REVIEW DETERMINATIONS

Following are excerpts from the medical reviewer's determinations for the 44 unallowable claims. We have provided the complete medical review results to the Hospital.

Count	Sample Number	Excerpt	Disallowed Amount
1	1-4	Recovering from cardiac surgery. Needed to recuperate, receive gentle rehabilitation. Stable in all respects. Just deconditioned. No need for Rehabilitation hospital level of care (RHLOC). Skilled nursing facility (SNF) would have sufficed.	\$12,549.64
2	1-5	Two-day rehabilitation hospital readmission after leg vascular surgery, initially referenced in 1-23. Goals were not set due to the shortness of stay. Suitable for recuperation at SNF.	1,973.64
3	1-6	Recovery from spine surgery was not medically complex. Occupational therapy (OT) and Physical therapy (PT) requirements were not intensive. SNF would have sufficed.	11,484.17
4	1-7	Uncomplicated recovery course after knee replacement. Did not need RHLOC. SNF appropriate.	5,246.43
5	1-8	Knee replacement, no intensive needs. SNF would have met patient's requirements.	9,921.03
6	1-10	Obese patient post knee replacement. No complications, no intensive physician management required. Needed ordinary post single joint therapy, which did not require RHLOC. SNF appropriate.	5,246.43
7	1-11	Routine hip replacement therapy requirements, no intensive medical needs. SNF level appropriate for surgical recovery precautions.	9,507.32
8	1-12	Knee replacement with routine rehabilitation requirements. No need for intensive MD intervention. SNF level appropriate.	5,246.43
9	1-15	Recovery from hip surgery could have been handled at SNF. Stable patient with routine medicine for pain management.	9,261.38
10	1-17	Hip surgery recuperation: SNF remobilization PT, OT, and nursing care.	7,432.68

Count	Sample Number	Excerpt	Disallowed Amount
11	1-18	Cardiac surgery recuperation requiring therapies and help with activities of daily living. SNF level of care appropriate.	9,577.10
12	1-20	Stable diabetic patient with routine recovery from knee replacement surgery. Did not require hospital level of care. SNF level appropriate.	6,093.42
13	1-21	Post cardiac surgery, oxygen desaturation with exertion. Needed to recuperate, receive gentle therapy. Appropriate care available at a SNF level.	12,549.64
14	1-25	Very minor problems of dizziness and slight imbalance post stroke. Did not require intensive rehabilitation. SNF appropriate.	10,181.25
15	1-26	Routine recovery after knee replacement for stable elderly patient. Needed PT, instruction in joint protection appropriate at SNF.	6,592.68
16	1-27	Routine recovery after knee replacement for stable elderly patient. Needed PT, instruction in joint protection appropriate at SNF.	10,715.41
17	1-28	Post spine surgery. Clinically stable needing remobilization. Did not require cardiac monitoring or intensive pain management. SNF suitable.	2,226.70
18	1-29	Post spine surgery. Routine mobility and safety impairments. Needed recuperative care, gentle mobility therapies. SNF would have sufficed.	8,905.45
19	1-30	Recovery from hip replacement. Needed routine rehabilitation, primarily PT, plus modest activities of daily living instruction. SNF appropriate.	5,246.43
20	1-31	Medically stable elderly hip replacement patient. Needed routine post single joint replacement therapy. PT and joint protection instruction. SNF appropriate.	9,921.03
21	1-35	Parkinson's disease patient having problems with a heavy neck brace for a fracture. An inappropriate attempt at intensive rehabilitation with undeveloped plan of management. Considerable trouble with pain medicine regimen. SNF appropriate.	13,625.90
22	1-36	Post total knee replacement uncomplicated recovery, not requiring RHLOC. SNF appropriate.	7,712.56

Count	Sample Number	Excerpt	Disallowed Amount
23	1-37	Post total knee replacement uncomplicated recovery, not requiring RHLOC. SNF appropriate.	9,454.62
24	1-38	Needed general reconditioning needed post fall, not requiring RHLOC. SNF appropriate	10,302.69
25	1-41	Post admission for hypoventilation probably due to narcotic analgesics. SNF appropriate.	10,980.89
26	1-42	Premature acute care hospital discharge after knee replacement. Continuing cancer, blood, and other medical issues. Once resolved, appropriate for SNF.	7,432.68
27	1-43	A recuperative stay needed for spinal surgery recovery. Did not need RHLOC. SNF appropriate.	8,905.45
28	1-45	Routine knee replacement therapy needed. With adequate resolution of clinical issues at acute inpatient hospital, SNF appropriate.	10,715.41
29	1-47	Questionable readiness for discharge from acute care hospital and actual rehabilitation potential. Recovery from clinically complicated hip surgery. Suitable for SNF once stabilized.	5,166.74
30	1-48	Revision knee replacement patient needing blood transfusion on last day at acute care hospital. Although clinically stable, post surgical status limited what could actually be done with patient. Suitable for SNF.	10,715.41
31	1-50	Recovery post knee surgery. Received only a few hours of therapy. Appropriate for home with services or SNF for short term.	2,226.70
32	2-4	Recovery requirements post knee surgery routine for immediate post surgical state. Needed minimal to moderate assistance with activities of daily living. SNF appropriate.	14,619.90
33	2-5	Patient up walking by two days after hip surgery. Had fallen on face and ribs, causing more pain than the surgery. SNF level appropriate.	14,308.35
34	2-7	Post hip replacement. Needing routine care with somewhat altered mental state from pain medication. SNF appropriate.	15,170.43

Count	Sample Number	Excerpt	Disallowed Amount
35	2-11	Deconditioned from gastrointestinal surgery: weak and unsteady, with no specific problems, medically stable. SNF appropriate.	14,219.33
36	2-14	Routine PT, OT for recovery from hip surgery. Medically uncomplicated, some wound drainage. Suitable for SNF.	14,308.35
37	2-28	Post stroke, medically stable. A moderate rehabilitation candidate with requirements able to be provided at a SNF.	19,036.88
38	2-29	Post small strokes and resulting carotid artery surgery. SNF level of care appropriate.	15,768.00
39	2-30	Reoccurrence of a preexisting seizure disorder. Weakness resolved at acute care hospital stay. SNF suitable.	21,083.24
40	2-32	Recovery from vascular surgery needing conditioning at a lesser level of care. SNF appropriate.	14,219.33
41	2-35	Post single knee replacement. Required mostly PT, routine needs of any postoperative patient in a recuperative state. SNF appropriate.	17,651.77
42	2-39	Other than ultrasound imaging for leg vein clot evaluation, uneventful recovery from hip surgery. Required PT, OT. SNF suitable.	14,308.35
43	2-48	Diabetic bilateral amputee refused OT, received minimal PT. Suitable for SNF to regain strength, conditioning.	19,785.41
44	2-50	Patient with vascular dementia post-small stroke. Needed therapies but not sufficiently ill to require hospital setting. SNF suitable.	15,195.79
Total			\$466,792.44

REPLY TO: CAPITAL OFFICE
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March 31, 2006

VIA FEDERAL EXPRESS

Michael J. Armstrong,
Regional Inspector General for Audit Services
Office of Audit Services, Region I
JFK Federal Building
Boston, MA 02203

Re: Report Number A-01-04-00530, Catholic Medical Center

Dear Mr. Armstrong:

This is in response to your letter to Ms. Alyson Pitman Giles, President and Chief Executive Officer, Catholic Medical Center ("CMC"), dated January 3, 2006 and the draft report attached thereto entitled "Review of Inpatient Rehabilitation Facility Admissions at Catholic Medical Center for Calendar Year 2003" ("Draft Report") prepared by the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG"). Sulloway & Hollis, P.L.L.C. has been retained as counsel in this matter and submits this formal response on behalf of CMC. CMC understands that this formal response will be summarized in the body of the final report and included in its entirety as an appendix thereto.

Summary

CMC strongly objects to the findings set forth in the Draft Report. After careful consideration, CMC maintains that it correctly applied the required admission criteria governing inpatient rehabilitation admissions and that its admission determinations were appropriate and correct. CMC rejects any findings that its preadmission screening process failed to properly select patients appropriate for admission. Every potential admission to the inpatient rehabilitation unit is reviewed by a highly qualified, multi-disciplinary team of health care professionals which completes a comprehensive preadmission screening process consistent with Medicare requirements.

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CMC further maintains that the Program Safeguard Contractor's ("Contract Reviewer") findings do not appropriately apply the relevant rules and regulations governing inpatient rehabilitation admissions. Specifically, CMC finds, for example, that the Contract Reviewer erred by 1) inappropriately basing its determinations on information not available at the time of admission; 2) improperly recommending extended acute care stays because it failed to recognize the capabilities of the inpatient rehabilitation program to adequately address the patient's medical needs; 3) failing to recognize the need for inpatient medical management of patients with increased risk of complications; 4) improperly denying admissions for patients requiring intensive and multidisciplinary rehabilitation care; and 5) improperly denying claims based on subjective and ambiguous conclusions. CMC has provided herein additional general comments concerning the Contract Reviewer's findings in addition to an individual assessment of each admission prepared by Zubin S. Batlivala, M.D., the Medical Director of the CMC Inpatient Rehabilitation, Unit which summarizes the justification of the admission determination.

Catholic Medical Center Applies Appropriate Admission Criteria Consistent with Medicare Billing Rules:

Catholic Medical Center ("CMC") originally established its inpatient rehabilitation medicine unit ("RMU") to better serve the community need for a facility where patients can receive intensive therapy from a multidisciplinary team of providers under close medical supervision. Without the availability of such services, some patients would be unable to receive needed rehabilitative therapy and many more would experience unnecessary delays in the initiation of required therapy treatments while they remained hospitalized for management of their medical conditions. Additionally, other patients would experience unnecessarily prolonged stays in skilled nursing facilities where they would not receive the level of intensive multidisciplinary therapy required to return them to their optimal level of functioning in a timely manner.

Patients admitted to the CMC inpatient rehabilitation unit are evaluated through an extensive preadmission screening process that includes a complete review of the patient record. Once the necessary information is gathered, the patient is reviewed by a team of individuals comprised of a Medical Director, Director of Nursing, a Physical Therapy Manager, Case Manager and Referral Specialist. This team decides whether the patient is appropriate for admission. Through this process, the team determines which patients are candidates for inpatient rehabilitation services and which are more appropriately treated in a less intensive setting. In reaching a determination, the team applies both the admission criteria as set forth in the Medicare Benefits Policy Manual 100-02, §110 and its collective professional judgment and expertise in assessing the patient's individual care needs. Through this process, the RMU is able to identify appropriate candidates for admission.

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As a result of this extensive and careful review, the staff identifies those patients who are suitable for admission to the RMU and those who are not. During calendar year 2003, the RMU received 1077 referrals and admitted 541 (50.2%). A total of 310 (28.8%) of the referrals were denied admission to the RMU because they were determined to be inappropriate for treatment on the unit, could be treated in at a lesser level of care, were unable to participate in treatment or were medically unstable.

In spite of the RMU's best efforts to identify patients who will be successful in inpatient rehabilitation, there is no way to predict with certainty how any particular patient's treatment will progress. Sometimes patients who appear to be excellent candidates on preadmission screening are unable to succeed in rehabilitation treatment for reasons that cannot be reasonably anticipated prior to admission. In other cases, patients who because of multiple increased risk factors, may have been expected to require continuous medical supervision or intervention, progress quickly and without incident. The need for the admission is based on the information available at the time the preadmission screen is performed and not based on a retrospective review of the patient's progress. Accordingly, a retrospective review of the appropriateness of the admission must likewise be based on the record available at the time of admission.

Medicare Rules Governing Inpatient Rehabilitation Admissions Contemplate that the Admission Decision Will Require the Exercise of Professional Discretion and Judgment.

Medicare currently sets forth the criteria to be considered in assessing the need for inpatient rehabilitation hospital admission in its Medicare Benefits Policy Manual 100-02 Section 110 and previously in Hospital Manual CMS Pub.10, Section 211. The rules governing such admissions specifically recognize that the determination is based on an assessment of each individual patient's needs stating:

Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule" or any other "rules of thumb" are not appropriate. CMS-Pub. 10, Sec. 211, Medicare Policy Benefits Manual 100-02 Section 110.

The rules further state that:

Rehabilitative care in a hospital, rather than in an SNF, at an SNF level in a swing bed hospital, or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services

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than is ordinarily available out of a hospital. A patient who has one or more conditions requiring intensive and multidisciplinary rehabilitation care, or who has a medical complication in addition to his primary condition so that the continuing availability of a physician is required to ensure safe and effective treatment, probably requires a hospital level of rehabilitative care. CMS- Pub. 10, Section 211¹

This criteria recognizes the degree of professional judgment that must be exercised in making each admission determination. It provides no hard and fast rules but rather a broad and necessarily vague set of parameters to assist in the decision making. This is further supported by the guidance provided for conducting retrospective reviews. Nurse reviewers, conducting retrospective reviews refer to identified criteria that, if satisfied, justify approval of the claim. However, if the criteria are not met, the claim is not denied. The rules specifically require that retrospective determinations about reasonableness, medical necessity, and the appropriateness of setting must be made by a QIO physician reviewer based on "his or her knowledge, expertise and experience and upon an assessment of each beneficiary's individual care needs rather than on fixed criteria." *Id.* Likewise, the determination to admit a patient to the RMU is based on the expertise and experience of the entire treatment team, including a Board Certified Psychiatrist, upon a careful assessment of the patient's individual care needs. There is substantial room in this process for professional decision-making and judgment that may vary between equally qualified providers.

Review of Findings

Catholic Medical Center has reviewed the findings presented by the Office of the Inspector General on August 23, 2005 and has prepared the following comments:

Retrospective denial of a claim for lack of medical necessity cannot be based on information available only after admission.

- Many of the findings appear to be based on information not available to the RMU at the time of admission. It is a truism that some admission determinations would be different if the RMU knew the outcome in advance, however, it is inappropriate to deny an admission based on information obtained after the fact and not available when the admission determination was made.

As an example, the Draft Report suggests that a patient (see Appendix B; Stratum 1, Sample 23) should not have been dismissed from the acute hospital stay to the

¹ Please note that this Section is modified slightly when restated in the Medicare Benefits Policy Manual, 110-02, Sec. 110. Both manuals were in effect during the period reviewed, i.e. calendar year 2003. CMS-Pub. 10, Sec. 211 was in effect until October 1, 2003 and the Medicare Policy Benefits Manual thereafter.

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inpatient rehabilitation unit based on her subsequent readmission to the acute care hospital. Both the surgeon and cardiologist treating her in the hospital and the RMU team evaluating her on pre-admission screening found her to be appropriate for admission. Unfortunately, after admission to the RMU, the patient developed complications that required her readmission to the hospital. It is unreasonable to expect that the patient's later complications should have been predicted by the inpatient rehabilitation team and, accordingly, denial of this admission was inappropriate.

A second case involved a woman who was an excellent candidate for inpatient rehabilitation but who announced her desire to be discharged home after admission to the RMU (see Appendix B; Stratum 2, Sample 48). There was no indication in the record or during the preadmission screen that the patient would reject rehabilitative treatment. The Contract Reviewer's findings suggest an SNF transfer would have been more appropriate, thereby acknowledging that she should not have been discharged home, however, it seems highly unlikely that this patient would have tolerated an SNF admission given her rejection of an inpatient rehabilitation stay.

In another example, the Contract Reviewer, based the denial largely on the fact that after admission, the patient was determined to need surgery which interrupted his rehabilitation stay (see Appendix B; Stratum 1, sample 22). The Medicare Billing Rules clearly recognize that some patients who appear to be good candidates for rehabilitation prior to admission may later be found after admission to be unable to participate meaningfully in the program and that this is not grounds for denial of a claim. CMS-Pub. 10, Sec. 211, Medicare Policy Benefits Manual 100-02 Section 110. "An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential." Id.

There are many more examples where the Contract Reviewer used this type of retrospective evaluation of the patient's progress to decide the patient should either have stayed longer in the hospital or been transferred to a less acute setting. It is inappropriate to use information obtained after admission to retrospectively deny an admission and, accordingly, any stays which were denied based on such information should be re-evaluated based on the information available at the time of admission.

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Patients found to be "at risk" of complications during rehabilitation are appropriate for admission

- The Contract Reviewer denied a number of admissions for total knee or hip replacements where the course of treatment proceeded without incident yet the patient was of an age and had co-morbidities and/or post operative complications such that the risk of an incident occurring during rehabilitative therapy was sufficient, in the professional judgment of the preadmission team, to justify the medical supervision and management available on the RMU. Based on the experience and expertise of the RMU's Medical Director and Preadmission screening team, patients in a given age group with certain co-morbidities or post operative complications are determined to be at significantly increased risk of experiencing further complications in rehabilitation. It is inappropriate to deny a claim when a patient who is at high risk of experiencing complications does not experience such complications, but rather has a smooth recovery. The need for medical supervision is not lessened and the stay is no more or less justified based on how the recovery proceeds.

Requiring a longer acute hospital inpatient stay for a patient who is ready for discharge is inappropriate

- In some cases, claims were denied because it was concluded that the patient could have stayed in the acute care hospital longer to resolve certain medical issues before being discharged to a lesser level-of-care. It is appropriate to discharge a patient from the acute setting into inpatient rehabilitation when the patient meets discharge criteria from the hospital and is ready to begin intensive rehabilitative therapy. A patient should not be denied the opportunity to begin therapy and return to a state of independence if he or she is ready for discharge and is able to participate in intensive therapy. This is precisely the role inpatient rehabilitation units are intended to serve. It is not necessary to resolve all medical issues prior to discharge from the hospital as the inpatient rehabilitation unit is specifically designed to care for patients who have a need for medical care as well as therapy. It would not be in the patient's best interest to retain a patient in an acute care setting, thereby delaying the initiation of intensive rehabilitation treatment so that the inpatient rehabilitation stay could be avoided in favor of a lower level of care that does not adequately address the patient's needs.

Denying the patient the opportunity to achieve the best possible functional outcome in the shortest possible time frame is inappropriate

- Some claims were denied because it was felt that the patient could have received therapy in a lesser level-of-care but where the patient needed and was able to

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participate in a more intensive therapy program. It is inappropriate to require a patient who is fully capable of participating in intensive therapy and returning to a pre-morbid functional status in a short time frame, to be transferred to a lesser level of care where they will be unable to receive intensive therapy. The recovery will be unnecessarily prolonged thereby exposing the patient to the accompanying risks of an extended inpatient stay. As stated above, the Medicare billing rules provide that inpatient care is reasonable and necessary when the patient requires a more coordinated, intensive program of services than is ordinarily available outside of the hospital.

Denials based on failure to reach rehabilitation goals is inconsistent with Medicare admission criteria.

- In some cases, the Contract Reviewer bases the denial, in whole or in part, on the fact that the patient failed to meet rehabilitation goals (e.g. see Appendix B; Stratum 1, sample 35 and Stratum 1, sample 39). Goals attainment is not a criteria for admission. It is the patient's potential for improvement and not goal attainment that factors into the admission decision. Claims denials based on failure to attain rehabilitation goals are improper.

Denials cannot be based on uncertain and indefinite conclusions

- In many cases the Contract Reviewer has indicated that he/she "feels" the patient could have received services at another level or that the patient "probably could have been handled at a lesser level of care" or "might have benefited from a day or two longer at acute". We do not fault the reviewer for articulating less than definitive statements. To the contrary, these vague conclusions confirm the fact that these decisions are often judgment calls based on the experience and expertise of individual reviewer. Some differences among professionals would be expected given the broad and vague admission criteria. When, however, the determination is not clear and definitive, the payment determination should favor the provider who did not have the benefit of hindsight when making the admission decision. Denial should only result when the determination is unequivocal.

In addition to these general observations, the Medical Director for the inpatient rehabilitation unit has completed a review of the patient records at issue and documented his findings. Please find attached the results of the completed reviews at Appendix A.

Also included at Appendix B is a copy of the original comments of the Contract Reviewer provided to CMC prior to the issuance of the Draft Report. The Draft Report includes only excerpts of the Contract Reviewer's comments that do not accurately and

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completely reflect the Contract Reviewer's findings. Accordingly, the complete text of the Contract Reviewer's findings is included for review.

Based on CMC's review of the records, it maintains that the admissions to the RMU were medically necessary and appropriate. The admissions met the required admission criteria and were necessary and appropriate based on the medical judgment, experience and expertise of the Medical Director and other preadmission team members.

Request for Non-Publication of the Final Report.

Through counsel, CMC has been engaged in discussions with the Office of the Inspector General to express concerns about the publication of the Final Report in this matter. It is our understanding that this review of inpatient rehabilitation services is unique and that no similar reviews have been conducted in recent memory. Thus, there is no baseline for comparing the admission criteria as applied by CMC to the practices of other similar facilities. Because the admission criteria for inpatient rehabilitation intentionally allow room for the exercise of significant independent professional judgment, it is reasonable that qualified professionals may have differences of opinion in their application. Accordingly, and given the strong disagreement between the professional reviewers in this case, there appears to be a substantial risk of error in this review.

Under these circumstances, CMC believes it would be inappropriate for the results of this review to be published, until such time as CMC has had an opportunity to present its case through the Medicare appeals process. The publication of this report could be severely detrimental to the good reputation of CMC which, as a non-profit hospital, relies on the generosity of donors for financial support. In addition, the publication of these findings may grossly mislead other inpatient rehabilitation providers who may rely on them without the benefit of knowing the outcome of the later appeals process.

In accordance with 45 C.F.R. § 5.65 trade secrets and commercial or financial information that is obtained from a person that is privileged or confidential may be withheld from disclosure. This exemption is interpreted broadly. CMC asserts that this report contains confidential information concerning its patients and its admission practices that should be exempt from publication. In the alternative, 45 C.F.R. § 5.66 protects internal government communications including pre-decisional deliberative communications. The exemption applies if the communication is made before a final decision is reached on a question of policy and if it expresses recommendations or opinions on the question. CMC proposes that this review should be treated as preliminary findings until such time as the issues have been properly considered in the appeals process and appreciates your consideration of this matter and the delicate nature and sensitivity of the information. We welcome the opportunity to discuss this matter with you further.

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Thank you for attention to this response.

Sincerely,



Cinde Warmington

CW:vf
Enclosures

cc: Alyson Pitman Giles, President and CEO
Karen Murray, Compliance Officer