

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MARYLAND GENERALLY COMPLIED  
WITH REQUIREMENTS FOR MEDICAID  
PAYMENTS MADE TO MULTI-MEDICAL  
CENTER FOR NURSING FACILITY  
SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Stephen Virbitsky  
Regional Inspector General**

May 2013  
A-03-11-00151

# *Office of Inspector General*

<https://oig.hhs.gov>

---

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

## *Office of Audit Services*

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

## *Office of Evaluation and Inspections*

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

## *Office of Investigations*

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

## *Office of Counsel to the Inspector General*

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

# *Notices*

---

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

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

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XIX of the Social Security Act requires the Medicaid program to provide medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Maryland, the Department of Health and Mental Hygiene (State agency) administers the Medicaid program.

State agencies are authorized to provide nursing facility services to Medicaid beneficiaries. Federal regulations (42 CFR part 483 subpart B) require that the nursing facilities provide nursing services, rehabilitative services, and medically-related social services for residents under the supervision of a physician. Further, the facility must not employ individuals who have been found guilty by a court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property (42 CFR § 483.13(c)(1)(ii)).

Multi-Medical Center (Multi-Medical) is a nursing facility located in Towson, Maryland. Multi-Medical is owned and operated by the Genesis HealthCare Corporation. For the period October 1, 2007, through September 30, 2008, the State agency paid Multi-Medical approximately \$6.6 million for Medicaid nursing facility services.

### **OBJECTIVE**

Our objective was to determine whether the State agency complied with Federal and State requirements for Medicaid payments made to Multi-Medical for nursing facility services.

### **SUMMARY OF FINDINGS**

The State agency generally complied with Federal and State requirements for Medicaid payments made to Multi-Medical for nursing facility services. Of the 110 claims in our sample, 75 complied with Federal and State requirements. However, 35 of the claims included some unallowable services. Services within a claim could be unallowable for one or multiple reasons. Of the 35 noncompliant claims, 6 contained more than 1 deficiency:

- For 34 claims, some services were not supported by any documentation and some were insufficiently supported by the documentation contained in the medical record.
- For six claims, orders lacked a physician's signature to authorize the services.
- For two claims, a service was billed that exceeded the allowable limit.

Using our sample results, we estimate that the State agency improperly claimed \$37,401 (\$18,701 Federal share).

In addition, Multi-Medical had some weaknesses in facility practices. Multi-Medical did not apply for a background check on 20 employees prior to their hire date, including 8 employees for whom Multi-Medical had not applied for background checks at the time of our review. Also, Multi-Medical did not properly report to the State agency three unwitnessed incidents during which a resident received an injury caused by an unknown source. Because the State agency's oversight was not always adequate, it did not ensure that Multi-Medical always complied with State and Federal requirements for facility practices.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$18,701 to the Federal Government,
- ensure that Multi-Medical has a completed background check performed for all employees and that Multi-Medical consistently follows all Federal and State preemployment requirements, and
- provide education to Multi-Medical to ensure that all unwitnessed incidents that result in an injury of unknown source are promptly reported.

## **MULTI-MEDICAL CENTER COMMENTS**

In written comments to our draft report, Multi-Medical disagreed with errors reported on 8 of the 35 claims in our findings. Multi-Medical stated that the lack of a therapist's initials is not a valid reason to disallow a service; a discharge summary provided in lieu of progress notes was an acceptable form of support; and physician orders that were incorrectly dated should be allowable. Multi-Medical stated that three of the six unwitnessed incidents did not have to be reported because the beneficiaries were able to provide details of their falls. However, Multi-Medical agreed with our second and third recommendations and described the actions it had taken, or planned to take, to address them.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We considered Multi-Medical's comments and we maintain that the findings and recommendations are valid. We disallowed the services in question because there was not sufficient evidence to support that the services were provided on the dates claimed, not because they specifically lacked a therapist's initials. We did not accept the discharge summary in lieu of progress notes because the discharge summary did not identify any services that may have been provided. The incorrectly dated order had additional discrepancies that called the documentation into question. We therefore continue to support our findings and recommendations.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments to our draft report, the State agency concurred with our first two recommendations and partially concurred with our third recommendation. The State agency

agreed with Multi-Medical that only three of the six unwitnessed incidents should have been reported to the State agency and provided additional documentation to support its position. We considered the State agency's comments and additional documentation and have removed three of the unwitnessed incidents from our findings.

## TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicaid Program.....	1
Nursing Facility Services.....	1
Maryland Nursing Facilities Services.....	1
Multi-Medical Center.....	2
<b>OBJECTIVE, SCOPE AND METHODOLOGY</b> .....	2
Objective.....	2
Scope.....	2
Methodology.....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>UNALLOWABLE NURSING FACILITY SERVICES</b> .....	4
Services Not Supported.....	4
Services Not Authorized.....	4
Services in Excess of the Allowable Limit.....	5
Services Not Allowable for Federal Reimbursement .....	5
<b>WEAKNESSES IN FACILITY PRACTICES</b> .....	5
Background Checks .....	5
Incident Reports .....	6
<b>STATE AGENCY OVERSIGHT</b> .....	6
<b>RECOMMENDATIONS</b> .....	6
<b>MULTI-MEDICAL CENTER COMMENTS</b> .....	6
<b>OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....	7
<b>STATE AGENCY COMMENTS AND OFFICE OF         INSPECTOR GENERAL RESPONSE</b> .....	7
<b>APPENDIXES</b>	
A: SAMPLE DESIGN AND METHODOLOGY	
B: SAMPLE RESULTS AND ESTIMATES	
C: MULTI-MEDICAL CENTER COMMENTS	
D: STATE AGENCY COMMENTS	

## **INTRODUCTION**

### **BACKGROUND**

#### **Medicaid Program**

Title XIX of the Social Security Act (the Act), requires the Medicaid program to provide medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Maryland, the Department of Health and Mental Hygiene (State agency) administers the Medicaid program.

#### **Nursing Facility Services**

Section 1905(a)(4)(A) of the Act authorizes State Medicaid agencies to provide nursing facility services to Medicaid beneficiaries. Participating nursing facilities must meet the requirements of section 1919 of the Act and implementing Federal participation regulations (42 CFR part 483 subpart B), which describe the services provided and the rights of residents. Nursing facilities must provide nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Services must be provided by qualified aides and health professionals under the supervision of a physician. Further, the facility must not employ individuals who have been found guilty by a court of law of abusing, neglecting, or mistreating residents or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property (42 CFR § 483.13(c)(1)(ii)).

CMS reimburses the State Medicaid agency the Federal share of the State's claimed costs, based on the Federal medical assistance percentage (FMAP). The State of Maryland's FMAP for our audit period was 50 percent.

#### **Maryland Nursing Facilities Services**

Medicaid State plan attachment 3.1 authorizes nursing facility services for individuals 21 years of age or older. The Code of Maryland Regulations (COMAR) implement attachment 3.1. COMAR 10.09.10.04(A) requires the program to cover routine care and supplies, equipment, and services when appropriate to meet the needs of the resident as described in 42 CFR Part 483, Subpart B.

Nursing facility services are eligible for reimbursement when care is medically necessary, adequately described in progress notes in the resident's medical record, and signed and dated by the individual providing care (COMAR 10.09.07.05(B)). Nursing facilities receive a set per diem rate for basic services and may claim additional specialized services separately. For the period October 1, 2007, through September 30, 2008, the State agency claimed \$1,007,939,098 (\$503,991,869 Federal share) for nursing facility services.

## **Multi-Medical Center**

Multi-Medical Center (Multi-Medical) is a 118-bed nursing facility located in Towson, Maryland, that provides short and long-term nursing and rehabilitative care. Multi-Medical is owned and operated by the Genesis HealthCare Corporation, a provider of skilled nursing and rehabilitative services. For the period October 1, 2007, through September 30, 2008, the State agency paid Multi-Medical approximately \$6.6 million for Medicaid nursing facility services.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State agency complied with Federal and State requirements for Medicaid payments made to Multi-Medical for nursing facility services.

### **Scope**

We reviewed \$6,607,174 (\$3,303,587 Federal share) of the claims that the State agency paid Multi-Medical from October 1, 2007, through September 30, 2008, for nursing facility services.

We did not review the State agency's overall internal control structure because our objective did not require us to do so. We did not review the nursing facility claims in our stratified random sample (discussed below) to determine medical necessity. We limited our internal control review to those controls related directly to processing and monitoring nursing facility claims.

We conducted survey work at the State agency offices in Baltimore, Maryland, in September 2010 and fieldwork at Multi-Medical in Towson, Maryland, from January through June 2011 and at Genesis HealthCare Corporation's Headquarters in Kennett Square, Pennsylvania, from June 2011 through May 2012.

### **Methodology**

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements regarding Medicaid reimbursement for nursing facility services;
- interviewed State agency officials to gain an understanding of how they administer and monitor the Medicaid nursing facility program;
- interviewed Multi-Medical personnel to determine their procedures for obtaining employee background checks and for reporting incidents to the State agency;
- reviewed available background check documentation for all employees working at Multi-Medical during the fieldwork portion of our review;
- reviewed incident logs and incident reports compiled by Multi-Medical staff;
- extracted Multi-Medical's Medicaid claims from the data provided by the State agency;

- identified 748 claims for \$1,000 or more that the State agency paid during our audit period for nursing facility services provided by Multi-Medical;
- selected for review a stratified random sample of 110 claims totaling \$1,569,585 (\$784,792 Federal share);
- reviewed the supporting documentation for all services in each sampled claim to determine their allowability;
- verified for each sampled claim the number of days of service at the per diem rate for the approved level of care;
- held discussions with the utilization control agent to better understand the documentation requirements;
- provided the results of our review to officials from Genesis and Multi-Medical on May 29, 2012, and discussed those results with State agency officials on June 21, 2012.

Appendixes A and B contain details of our sampling and estimation methodologies.

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

### **FINDINGS AND RECOMMENDATIONS**

The State agency generally complied with Federal and State requirements for Medicaid payments made to Multi-Medical for nursing facility services. Of the 110 claims in our sample, 75 complied with Federal and State requirements. However, 35 of the claims included some unallowable services. Services within a claim could be unallowable for one or multiple reasons. Of the 35 noncompliant claims, 6 contained more than 1 deficiency:

- For 34 claims, some services were not supported by any documentation and some were insufficiently supported by the documentation contained in the medical record.
- For six claims, orders lacked a physician's signature to authorize the services.
- For two claims, a service was billed that exceeded the allowable limit.

Using our sample results, we estimate that the State agency improperly claimed \$37,401 (\$18,701 Federal share).

In addition, Multi-Medical had some weaknesses in facility practices. Multi-Medical did not apply for a background check on 20 employees prior to their hire date, including 8 employees for whom Multi-Medical had not applied for background checks at the time of our review. Also,

Multi-Medical did not properly report to the State agency three unwitnessed incidents during which a resident received an injury caused by an unknown source. Because the State agency's oversight was not always adequate, it did not ensure that Multi-Medical always complied with State and Federal requirements for facility practices.

## **UNALLOWABLE NURSING FACILITY SERVICES**

Of the 110 claims in our sample, 35 included unallowable services: 34 claims included services that were either not supported by any documentation or were not sufficiently supported, 6 claims included services for which there was no physician's signature to authorize the order, and 2 claims included a service that exceeded the allowable limit. Six claims contained more than one deficiency.

### **Services Not Supported**

Section 1902(a)(27) of the Act requires the State plan to provide for agreements with providers to keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries and to agree to furnish the State agency with such information when requested.

The State agency requires that nursing facilities must maintain records for all patients in accordance with accepted professional standards and practices. Patient records must include: 1) documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment [plan of care], and of the care and services provided; 2) diagnostic and therapeutic orders; and 3) observations and progress notes (COMAR 10.07.02.20).

For 34 of the 110 sampled claims, the State agency paid Multi-Medical for some nursing facility services for which there was insufficient supporting documentation.

For 31 of these claims, the medical records maintained by Multi-Medical did not sufficiently support the claimed services. For example, for 1 claim, Multi-Medical claimed 26 units of turning and positioning service. However, the documentation supported only 22 units. We found similar errors on 30 other claims.

For the remaining three claims, the medical records did not support that Multi-Medical had provided any of the claimed services. For example, the State agency paid Multi-Medical for 11 billed units of speech therapy; however, Multi-Medical did not produce documentation to support that any speech therapy had been provided. Similar errors were found on two other claims.

### **Services Not Authorized**

Nursing facility services are eligible for reimbursement under Medicaid only when the services are provided under the supervision of a physician (42 CFR § 483.40). Further, 42 CFR § 483.40(b) states that the physician must: (1) review the resident's total program of care, including medications and treatments, at each visit; (2) write, sign, and date progress notes at each visit; and (3) sign and date all orders with the exception of certain vaccines, which may be

administered according to physician-approved facility policy after an assessment for contraindications.

For 6 of the 110 sampled claims, the State agency paid Multi-Medical for nursing facility services for which the order lacked a physician's signature.

### **Services in Excess of the Allowable Limit**

The State agency reimburses providers for physical therapy services, performed by or under supervision of a licensed physical therapist, that are directly related to the physician's written plan of care that specifies the frequency and duration of treatment (COMAR 10.09.07.05). COMAR 10.09.10.09-1 provides for reimbursement of physical, occupational, and speech therapy services in 15-minute increments, with a maximum duration of 1 hour per day.

For 2 of the 110 sampled claims, the State agency paid Multi-Medical for nursing facility services that exceeded the allowable limit. For example, for one claim, the State agency paid Multi-Medical for five units of physical therapy billed for 1 day of service; however, only four units were allowable. We found a similar error on one other claim.

### **Services Not Allowable for Federal Reimbursement**

Using the results of our sample, we estimate that the State agency improperly claimed \$37,401 (\$18,701 Federal Share) for nursing facility services provided by Multi-Medical that did not comply with Federal and State requirements.

## **WEAKNESSES IN FACILITY PRACTICES**

For 20 individuals, Multi-Medical did not apply for background checks prior to their hire dates. Also, Multi-Medical did not properly report to the State agency three incidents of resident injury by an unknown source.

### **Background Checks**

Federal regulations prohibit nursing facilities from employing individuals who have been "(A) [f]ound guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) [h]ave had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property..." (42 CFR § 483.13(c)(1)(ii)).

Section 19-1902(a) of the Annotated Code of Maryland states that before an eligible employee may begin work for an adult dependent care program, the program must apply for a State criminal history records check or request a private agency to conduct a background check and request a reference from the potential employee's most recent employer.

Multi-Medical did not apply for a background check prior to hiring 20 employees, including:

- 12 employees for whom Multi-Medical applied for background checks after their hire date and

- 8 employees for whom Multi-Medical had not applied for background checks at the time of our review.

For example, a nurse's aide was hired in 2000, but Multi-Medical did not apply for a background check until 2011. A respiratory therapist began working at Multi-Medical in 2001, but Multi-Medical did not apply for a background check until 2005. By not ensuring that all employees met the Federal and State pre-employment requirements for background checks, Multi-Medical potentially jeopardized the safety of the adults in its care.

### **Incident Reports**

Federal regulations require that nursing facilities ensure that "all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and appropriation of resident property are reported immediately to the administrator of the facility and to other officials (including to the State survey and certification agency) in accordance with State law through established procedures (42 CFR § 483.13(c)(2)).

Multi-Medical did not properly report to the State agency three unwitnessed incidents of a resident injury by an unknown source. By not reporting the incidents, Multi-Medical potentially jeopardized the safety of the adults in its care. Also, because CMS posts this information on its Nursing Home Compare website, prospective residents were not provided with complete information to help them find and compare nursing homes and make informed decisions about nursing home care.

### **STATE AGENCY OVERSIGHT**

Because its oversight was not always adequate, the State agency paid some unallowable claims and did not ensure that Multi-Medical always complied with State and Federal requirements for conducting background checks and reporting incidents of resident injuries.

### **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$18,701 to the Federal Government,
- ensure that Multi-Medical has a completed background check performed for all employees and that Multi-Medical consistently follows all Federal and State preemployment requirements, and
- provide education to Multi-Medical to ensure that all unwitnessed incidents that result in an injury of unknown source are promptly reported.

### **MULTI-MEDICAL CENTER COMMENTS**

In written comments to our draft report, Multi-Medical disagreed with errors reported on 8 of the 35 claims in our findings. Multi-Medical stated that the lack of a therapist's initials is not a valid reason to disallow a service; a discharge summary provided in lieu of progress notes was an

acceptable form of support; and physician orders that were incorrectly dated should be allowable. Multi-Medical also stated that three of the six unwitnessed incidents did not have to be reported because the beneficiaries were able to provide details of their falls. However, Multi-Medical agreed with our second and third recommendations and described the action it had taken, or planned to take, to address them.

Multi-Medical's comments are included as Appendix C to this report. The attachment to Multi-Medical's comments was not included because it contained personally identifiable information.

#### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We considered Multi-Medical's comments and we maintain that the findings and recommendations are valid. We disallowed the services in question because there was not sufficient evidence to support that the services were provided on the dates claimed, not because they specifically lacked a therapist's initials. We did not accept the discharge summary in lieu of progress notes because the discharge summary did not identify any services that may have been provided. The incorrectly dated order had additional discrepancies that called the documentation into question. We therefore continue to support our findings and recommendations.

#### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments to our draft report, the State agency concurred with our first two recommendations and partially concurred with our third recommendation. The State agency agreed with Multi-Medical that only three of the six unwitnessed incidents should have been reported to the State agency and provided additional documentation to support its position. We considered the State agency's comments and additional documentation and have removed three of the unwitnessed incidents from our findings.

The State agency's comments are included as Appendix D to this report.

# **APPENDIXES**

## APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

### POPULATION

The population consisted of Medicaid claims that the State agency paid during the period October 1, 2007, through September 30, 2008, for nursing facility services provided by Multi-Medical Center.

### SAMPLING FRAME

The sample frame consisted of 748 Medicaid claims totaling \$6,607,174 (\$3,303,587 Federal Share). We identified and removed 19 claims from the population that were less than \$1,000.

### SAMPLE UNIT

The sample unit was a claim. A claim included all services provided to a resident for one month. All services in the claim were reviewed.

### SAMPLE DESIGN

We used a stratified random sample containing three strata as follows:

Stratum	Range	Number of Claims	Total Medicaid Reimbursement
1	\$1,000.00-\$9,999.99	633	\$4,467,859
2	\$10,000.00-\$23,699.99	105	1,888,555
3	\$23,700.00 and above	10	250,760
	<b>Total</b>	<b>748</b>	<b>\$6,607,174</b>

### SAMPLE SIZE

We selected a sample of 40 claims from stratum 1, 60 claims from stratum 2, and 10 claims from stratum 3, resulting in a total sample of 110 claims.

### SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OAS), statistical software to generate the random numbers.

### METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in stratum 1 and stratum 2. After generating 40 random numbers for stratum 1 and 60 random numbers for stratum 2, we selected the corresponding frame items. We chose all 10 sample items in stratum 3.

### ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount and Federal share of the overpayments.

**APPENDIX B: SAMPLE RESULTS AND ESTIMATES**

**Sample Results: Total Amounts**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>No. of Overpayments</b>	<b>Value of Overpayments</b>
1	633	\$4,467,859	40	\$272,458	9	\$1,709
2	105	1,888,555	60	1,046,367	20	27,136
3	10	250,760	10	250,760	6	3,595
<b>Total</b>	<b>748</b>	<b>\$6,607,174</b>	<b>110</b>	<b>\$1,569,585</b>	<b>35</b>	<b>\$32,440</b>

**Estimated Value of Overpayments**

*(Limits calculated for a 90-percent confidence interval)*

	<u><b>Total Amounts</b></u>	<u><b>Federal Share</b></u>
Point Estimate	\$78,128	\$39,064
Lower limit	\$37,401	\$18,701
Upper limit	\$118,855	\$59,428

## APPENDIX C: MULTI-MEDICAL CENTER COMMENTS



Multi-Medical Center

Genesis HealthCare<sup>SM</sup>

December 5, 2012

Stephen Virbitsky  
 Office of Audit Services, Region III  
 Office of Inspector General  
 Public Ledger Building, Suite 316  
 150 South Independence Mall West  
 Philadelphia, PA 19106

7700 York Road  
 Towson, MD 21204  
 Tel 410 821 5500  
 Fax 410 512 3520  
 TDD 800 735-2258

Re: Report Number A-03-11-00151

Dear Mr. Virbitsky:

Multi-Medical Center would like to thank you for the opportunity to comment on the Office of Inspector General (OIG) Audit Report dated October 18, 2012 ("Draft Report"). Multi-Medical Center agrees in part and disagrees in part with the audit findings. As you requested, this letter provides a statement describing the nature of the corrective action taken or planned for those findings with which we concur. Similarly, we provide a statement of the specific reasons for those findings with which we do not concur and a statement of any alternative corrective action taken or planned. This letter is timely filed by December 5, 2012 which is within the period of 30 days from the date of the Draft Report and the request for extension granted by Mr. Leonard D. Picari.

The Draft Report included 35 claims with deficiencies. Four of those claims contained deficiencies in more than one category. This resulted in the following number of claims with deficiencies by category

Category	Number of Claims
Services Not Supported	31
Services Not Authorized	6
Services in Excess of Allowable Limit	2

**I. 31 Claims, Some Services Insufficiently Supported By Documentation.**

Multi-Medical Center concurs that 25 of the claims identified by the OIG did not sufficiently support billing of Nursing Facility Services. Many of the claims noted with unsupported services contained billing inaccuracies that appeared to be unintentional and relative to human error due to manual calculation. For six claims (131 units), we respectfully disagree with the findings since criteria and documentation required for reimbursement is present in the medical record and supports the services billed. Of these six claims, two contained more than one deficiency.

A. The *Maryland Medical Assistance Program: Nursing Facility Assessment and Reimbursement Handbook (Handbook)* outlines the criteria and key documentation that is required for reimbursement. In order to bill for therapy services, the following documentation is required (a) physician order; (b) therapy evaluation; (c) treatment plan; (d) daily service record; (e) weekly progress notes. In addition, the Handbook provides an example of a daily service record in the Appendix section of the Handbook. We believe that our document contained in the medical records commonly known as

Mr. Stephen Virbitsky  
 December 5, 2012  
 Page 2 of 6

the *Service Log Matrix* conforms to the aforementioned document and satisfies reimbursement guidelines. Please see the information below related to specific disallowances.

**1. *Insufficient Documentation Relevant to Therapist Initials***

For five claims, all key documentation was located and provided as outlined in the *Handbook* to satisfy reimbursement requirements. According to the *Handbook*, a daily service record must include date of treatment, treatment modality, minutes for each modality, and total treatment minutes. While the therapists for the selected claims in your sample provided additional documentation (therapist initialed the service log matrix and progress note), initialing the notes is not required and lack of a therapist's initials is not a valid reason to disallow service. In the instances in which the audit disallowed these services, sufficient documentation was provided on the service log matrix pursuant to the *Handbook* and our internal procedures.

Based upon the information presented above for the five claims, we request reconsideration of services billed on the following claims:

Sample #	Date of Service	Units	Revenue Code
S1-1	March 2008	14	430
S1-20	October 2007	8	430
S1-28	November 2007	2	430
S2-35	October 2007	12	430
S3-1	September 2008	11*	440

\* In the *OIG Draft Report*, claim was noted with more than one deficiency.

**2. *Insufficient or No Documentation Relevant to Weekly Progress Notes***

Per the *Handbook*, progress notes for therapy services must include an initial assessment note, an update status, and discharge instructions on a weekly basis. For two claims, all key documentation was located and provided to satisfy those reimbursement requirements.

We noted for one deficiency, 11 units were disallowed since no documentation was provided. The medical record revealed that the start of care for therapy services began on 9/4/2008 and ended on 9/10/2008. A discharge summary was completed in lieu of a progress note since services ended on the aforementioned date. Since the discharge summary has the same elements of a progress note, the discharge summary clearly documented the initial assessment, update status, and discharge instructions to satisfy the documentation requirements for reimbursement purposes.

Deficiencies were noted relevant to missing minutes on weekly progress notes. According to the aforementioned documentation requirements for weekly progress notes, inclusion of minutes on the note is not a requirement for reimbursement purposes. The minutes in question are documented on the service log matrix as previously discussed.

Mr. Stephen Virbitsky  
 December 5, 2012  
 Page 3 of 6

Lastly, units were disallowed since no progress note was available in the medical record. Specifically, the medical record revealed that a progress note was written on 9/18/2008 and services ended on 9/22/2012. As outlined in the Handbook, progress notes must be completed at least weekly. Since the time period between the last progress note and discharge summary is less than seven days, an additional progress note was not required for reimbursement purposes.

Based upon the information presented above for the two claims, we request reconsideration of services billed on the following claims:

Sample #	Date of Service	Units	Revenue Code
S3-1	September 2008	11*	440
S3-9	September 2008	82*	430
S3-9	September 2008	2*	440

\* In the OIG Draft Report, claim was noted with more than one deficiency.

### 3. *Insufficient Documentation Relevant to Therapy Certification*

A. According to the *Handbook*, therapy evaluations are required for reimbursement purposes. The evaluation must include the reason for referral, onset date of the problem, prior and current level of functioning, and assessment summary. In addition, the evaluation identifies modalities, frequency of services, and goals and is typically updated every 30 days or sooner, if required, by the therapist and signed by the attending physician or physician extender.

We concur that one recertification was not signed by the physician. Since the *Handbook* does not provide any guidance on unsigned certifications, we referenced the following CMS manual – *Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services*. In Section 220.1.3 D, the manual outlines the procedure for handling delayed certifications. Since a physician order was signed by the physician, the medical record clearly documents the need for care and that the patient was under the care of a physician in which a delayed certification would be appropriate. For one claim, we obtained a delayed certification for the services in question since requirements for a delayed certification were satisfied (see Attachment A).

Based upon the information presented above for one claim, we request reconsideration of services billed on the following claim:

Sample #	Date of Service	Units	Revenue Code
S3-9	September 2008	82*	430

\* In the OIG Draft Report, claim was noted with more than one deficiency.

B. **Corrective Action.** As a result of the services insufficiently supported by documentation, Multi-Medical Center's corrective action will include continuing education to all staff to document and maintain all necessary entries in the record as required to bill Medicaid for Nursing Facility Services as outlined in the *Handbook*. For each service, Multi-Medical Center strives to ensure

Mr. Stephen Virbitsky  
 December 5, 2012  
 Page 4 of 6

that the beneficiary's medical record includes: (a) physician orders for services if applicable; (b) documented evidence of assessment of patient's needs, establishment of an appropriate and ongoing treatment plan or plan of care, and documentation of care and services provided; (c) observations and progress notes.

## II. Six Claims Orders Lacked a Physician's Signature to Authorize Services

Multi-Medical Center strives to obtain the prescriber's signature on all telephone and monthly recapitulations of computerized pharmacy orders (monthly orders) in accordance with State and Federal Regulations. For four claims, we concur that telephone or monthly orders lacked a prescriber's signature. We believe that this failure to obtain this signature was due to human error.

A. The medical necessity of the essential services provided of enteral nutrition therapy and ventilator care were provided under the supervision of a physician which is clearly evident in other sections of the medical record. For one enteral nutrition therapy claim and one ventilator care claim (27 units in total), we respectfully disagree with the findings since criteria and documentation required for reimbursement is present in the medical record and supports the services billed discussed below.

### 1. Services Not Authorized: Enteral Nutrition Therapy

For claim S2-22, a tube feeding order was signed by the Certified Registered Nurse Practitioner (CRNP) on 7/24/2008 which contains the rate of administration under the *Tube Feeding Method/Frequency* section on the form (40 ml per hour; hours per day = 20). It appears that the CRNP may have incorrectly dated the form 7/24/2008 versus 7/25/2008 since the nightly chart check for orders within last 24 hours revealed a Licensed Practical Nurse's signature on 7/26/2008 at 0200 hrs.

Based upon the information presented above for one enteral nutrition therapy claim, we request reconsideration of services billed on the following claim:

Sample #	Date of Service	Units	Revenue Code
S2-22	August 2008	22	559

### 2. Services Not Authorized: Ventilator Care

According to the *Handbook*, services for ventilator care can be billed for any part of the day in which a patient receives artificial ventilation of the lungs by mechanical means through a ventilator. The key documentation required for reimbursement purposes includes the following: (a) physician order; (b) flow sheet or treatment/medication sheets; (c) other supporting documentation as necessary.

For one claim (S2-48), we concur that the physician did not sign the monthly order; however, a revision to the original order was noted and signed by the physician on 3/3/08. Specifically, the

Mr. Stephen Virbitsky  
 December 5, 2012  
 Page 5 of 6

physician ordered pressure support ventilation (PSV) with settings for up to two hours as tolerated. While this order was later discontinued since the patient was unable to tolerate the ventilator weaning process per the physician, we believe that reconsideration of the services provided under this order should be allowable since the criteria and key documentation were properly documented to satisfy reimbursement guidelines.

Based upon the information presented, we request reconsideration of services billed on the following claims:

Sample #	Date of Service	Units	Revenue Code
S2-48	March 2008	5	419

**B. Corrective Action.** As a result of the services insufficiently supported by lack of physician orders, Multi-Medical Center's corrective action will include continuing education to all staff to ensure orders are signed in accordance with regulatory requirements

### III. Services in Excess of the Allowable Limit

Multi-Medical strives to provide an accurate and comprehensive record of all services provided. We concur with the audit findings which appear to be isolated and a result of human error.

### IV. Weaknesses in Facility Practices

#### 1. Background Checks

Multi-Medical Center strives to obtain the required criminal background checks for all employees before they commence employment. Of the eight employees for whom a background check had not been completed as of the review five have since terminated employment. Background checks for the remaining three have been completed and meet published hiring criteria.

Of the 12 employees for whom a background check was completed late, the examples cited by the OIG are accurate. However, those examples are outliers. Background checks for five of the 12 exceptions were obtained within 65 days of the hire date. Also, despite being late, all of the background checks met our hiring criteria, meaning that our patients were not in harms way.

**Corrective Action.** Multi-Medical Center has strengthened our background check process in the last several years. The results of this strengthening are evident when learning that the hire date for 17 of the 20 exceptions was prior to 2009.

Mr. Stephen Virbitsky  
December 5, 2012  
Page 6 of 6

**2. Incident Reports**

Of the six incident reports mentioned in the Draft Report, we concur with three of the findings. For the remaining three incidents, we respectfully disagree with the findings since incidents were of known source. Specifically, incident reports dated November 11, 2007 and August 25, 2008, both alert and oriented patients were able to provide specific details of their falls. On another report dated January 25, 2008, the description of the incident was very specific to the cause of the fall. Since the three incident reports indicate the source of the injury, we believe that these incidents were not required to be reported as outlined in a memorandum to Administrators from the Director, Office of Health Care Quality on April 12, 2005.

**Corrective Action.** As a result of incident reports not reported, Multi-Medical Center's corrective action will include continuing education to key staff members to ensure incident reports are appropriately filed with the appropriate regulatory authorities.

**V. Conclusion**

As discussed in the detail above, Multi-Medical Center acknowledges that some, but not all, of the claims identified by the OIG failed to comply with the applicable State and Federal laws and policies governing the provision of long term care services to Medicaid beneficiaries. While Multi-Medical Center believes that these claims are anomalous and not representative of Multi-Medical Center's general compliance efforts, Multi-Medical Center has taken measures to reassess its compliance strategy to ensure that all long term care services are provided in accordance with such laws and policies.

Please feel free to contact me with any questions or comments.

With best regards.

Sincerely,



Bernard Rochowiak  
Administrator

## APPENDIX D: STATE AGENCY COMMENTS



STATE OF MARYLAND

# DHMH

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, Secretary

April 24, 2013

Mr. Stephen Virbitsky  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106

RE: *Maryland Generally Complied With Requirements for Medicaid Payments Made to Multi-Medical Center For Nursing Facility Services (draft)*  
Report A-03-11-00151

Dear Mr. Virbitsky:

Thank you for the opportunity to review the above-referenced report. The Maryland Department of Health and Mental Hygiene (Department) appreciates your conclusion that Maryland has generally complied with Federal and State requirements. We also appreciate your recommendations for improving our level of compliance.

We have carefully reviewed each recommendation outlined in the report. We would like to note that two of the recommendations fall under the purview of the Department's Office of Health Care Quality (OHCQ), which is separate from the Office of Health Services (OHS). We have shared this report with that Office and are sharing their comments.

1. Refund \$18,701 to the Federal Government. The Department concurs with this finding. In terms of corrective action, the Department contracts with a Utilization Control Agent (UCA) to conduct onsite postpayment reviews of claimed services to ensure that service is provided and documented in accordance with Federal and State regulations and policies. The UCA that was responsible for reviews at the time for which the audit was conducted is no longer our contractor. The Department will continue to educate and monitor the current contractor on those requirements addressed in the report.
2. Ensure that Multi Medical has a completed background check performed for all employees and that Multi Medical consistently follows all Federal and State preemployment requirements. OHCQ has reviewed this recommendation and noted that recent surveys have not triggered surveyors to review facility practices regarding background checks. Nevertheless, OHCQ will assign a surveyor to investigate current practices to ensure compliance with requirements.

Mr. Stephen Virbitsky  
April 24, 2013  
Page 2

3. Provide education to Multi Medical to ensure that all unwitnessed incidents that result in an injury of unknown source are promptly reported. We were not provided with resident-specific details regarding the incidents on which this recommendation is based. However, OHCQ notes its support of Multi Medical's disagreement with the findings in three incidents. The facility noted that in two cases, the residents were alert and oriented and were able to provide specific details of their falls. In the third case, the facility noted that the description of the incident was very specific as to the cause of the fall.

In a memorandum dated December 16, 2004, the Centers for Medicare and Medicaid Services defines an "injury of unknown source" as an injury in which "both of the following conditions are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; **and**
- The injury is suspicious because of the extent of the injury or the location of the injury... or the number of injuries observed at one particular point in time or the incidence of injuries over time."<sup>1</sup>

Regarding the three incidents with which the facility concurred, the Department also concurs. In a subsequent complaint investigation conducted in November 2011, OHCQ cited the facility for failure to report an injury of unknown origin. The most recent QIS survey (August 2012) did not reveal any deficiencies related to failure to report such injuries. The Department continues to educate the providers on the reporting of unknown injuries through its survey review process.

Again, thank you for the opportunity to review and comment on your findings. If you have any questions regarding this response, please do not hesitate to contact either:

Jane Sacco, Division Chief for Long Term Care Services, OHS, at (410) 767-6771 or [jane.sacco@maryland.gov](mailto:jane.sacco@maryland.gov), or

Margie Heald, Deputy Director for Federal Programs, OHCQ at (410) 402-8101 or [Margie.Heald@maryland.gov](mailto:Margie.Heald@maryland.gov)

Sincerely,



Susan J. Tucker, Executive Director  
Office of Health Services

cc: Leonard Piccari  
Joseph Girardi  
Mark Leeds  
Susan Panek  
Jane Sacco  
Patricia Nay, M.D.  
Margie Heald, R.N.  
Thomas Russell

<sup>1</sup> CMS Memorandum (Ref: S&C-05-09) of December 16, 2004 to State Survey Agency Directors. Please note that the **bold and underlined** text are derived directly from this document.