



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

OCT 2 2006

Report Number: A-04-04-02011

Nancy Pachon, Administrator
ABC Total Rehabilitation Care, Inc.
6135 North West 167th Street, #E-28
Miami, Florida 33015

Dear Ms. Pachon:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided By ABC Total Rehabilitation Care, Inc." We will forward a copy of this report to the action official named on the next page for review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports are made available to members of 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 call me or John Drake, Audit Manager, at (404) 562-7755 or through e-mail at john.drake@oig.hhs.gov. To facilitate identification, please refer to report number A-04-04-02011 in all correspondence.

Sincerely,

A handwritten signature in blue ink that reads "Peter J. Barbera".

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

Page 2 – Nancy Pachon

Direct Reply to HHS Action Official:

Dale K. Kendrick
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF COMPREHENSIVE
OUTPATIENT REHABILITATION
FACILITY THERAPY SERVICES
PROVIDED BY ABC TOTAL
REHABILITATION CARE, INC.**



Daniel R. Levinson
Inspector General

October 2006
A-04-04-02011

Office of Inspector General

<http://oig.hhs.gov>

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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

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons.

Prior to implementation of the prospective payment system, CORFs received payment under a cost-based reimbursement methodology. The Balanced Budget Act of 1997 (sections 4523 (d) and 4541)) amended the Social Security Act and required the payment for hospital outpatient services, including services furnished by CORFs, to be made under a prospective payment system.

ABC Total Rehabilitation Care, Inc. (ABC) is a CORF located in Hialeah, Florida. With the assistance of a program safeguard contractor (PSC), we reviewed selected claims submitted by ABC and paid by Medicare. The claims selected for review included multiple physical and occupational therapy services with dates of service from January 1, 2002, through December 31, 2002. In total, ABC received \$2,086,998 for 964 claims during the period of our review.

OBJECTIVE

Our objective was to determine whether payments to ABC for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

The PSC's medical reviewers determined that 88 of the 100 sampled claims for CORF therapy services were not appropriately paid. Medical reviewers determined that these 88 claims contained 1,570 CORF therapy services that did not meet Medicare reimbursement requirements because:

- services billed were rendered outside of the approved plan of care,
- services billed did not meet Medicare duration of therapy requirements,
- documentation did not meet Medicare standards to support that services were actually provided, and
- services billed were not medically necessary.

Medical reviewers determined that ABC did not always follow Medicare requirements or fiscal intermediary (FI) guidance. ABC had written policies and procedures that, if followed, would have precluded some of the errors the medical reviewers identified.

However, ABC did not adhere to its policies and procedures for ensuring that the plans of care contained all required elements and that therapy services were adequately documented. In addition, ABC's written policies and procedures did not address Medicare requirements for duration of therapy services, identification of services rendered outside of the approved plan of care, and documentation of the patient's need for neuromuscular re-education.

As a result, ABC received \$27,602 in unallowable payments for therapy services associated with the 88 sampled claims, which contained 1,570 services that did not meet Medicare reimbursement requirements. Projecting the results of our random sample to the universe, ABC received an estimated \$226,673 in payments for unallowable services.

RECOMMENDATIONS

ABC should:

- refund to the Medicare program the \$226,673 in payments for services ABC billed from January 1, 2002, through December 31, 2002, that did not meet Medicare reimbursement requirements;
- follow its written policies and procedures to ensure plans of care contain all required elements and that services are adequately documented;
- update its written policies and procedures to address Medicare requirements for duration of therapy services, identification of services rendered outside of the approved plan of care, and documentation of the patient's need for neuromuscular re-education; and
- identify and submit adjusted claims for services provided subsequent to our audit period that did not meet Medicare reimbursement requirements.

We will provide the results of this audit to First Coast Service Options, Inc., the Medicare fiscal intermediary, so that appropriate adjustments can be made.

ABC Total Rehabilitation Care Comments

ABC management chose not to provide comments on our draft report findings and recommendations.

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INTRODUCTION

BACKGROUND

Comprehensive Outpatient Rehabilitation Facility

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons. To qualify as a Medicare-certified CORF, the facility must provide at least the following services: physicians' services, physical therapy, and social or psychological services. Additional covered CORF services include occupational and speech pathology services.

Comprehensive Outpatient Rehabilitation Facility Legislation

Section 1861 (cc)(2) of the Social Security Act (the Act) provides legislation governing CORFs. Prior to implementation of a prospective payment system (PPS), CORFs received payment under a cost-based reimbursement methodology. The Balanced Budget Act of 1997 (BBA) (Sections 4523 (d) and 4541)) required the Centers for Medicare & Medicaid Services (CMS) to implement a PPS for hospital outpatient services, including services furnished by CORFs. Accordingly, CMS implemented a PPS for CORFs effective January 1, 1999.

Comprehensive Outpatient Rehabilitation Facility Prospective Payment System

The BBA added Section 1834 (k) to the Act so that all services furnished by CORFs would be paid an applicable fee schedule amount. As such, the Medicare physician fee schedule became the applicable fee schedule as defined by the Act. Payment of CORF services is to be made at 80 percent of the lesser of (1) the actual charge for the service or (2) the applicable fee schedule amount.

To qualify as a Medicare-certified CORF, the facility must provide at least the following services: physicians' services, physical therapy, and social or psychological services (Section 1861 (cc)(2)). Additional covered CORF services include occupational and speech pathology services (Section 1861 (cc)(1)).

Fiscal Intermediary Responsibilities

Providers, such as CORFs, generally receive payments for covered services furnished to Medicare beneficiaries through fiscal intermediaries (FI) under contract with CMS (42 CFR § 421.103). Agreements between CMS and an FI specify the functions to be performed by the FI, which include, but are not limited to, processing claims, assisting in the application of safeguards against unnecessary utilization of services, conducting provider audits, resolving provider disputes, and reconsidering payment denial determinations to providers that furnished services (42 CFR § 421.100).

ABC Total Rehabilitation Care

ABC Total Rehabilitation Care, Inc. (ABC) became a Medicare-certified CORF in January 1999 and is located in Hialeah, Florida. The FI for ABC is First Coast Service Options, Inc. (First Coast), located in Jacksonville, Florida.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether payments to ABC for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

Scope

Our review covered service dates for calendar year 2002. For this period, ABC received Medicare payments of \$2,086,998 for 964 claims.

Although we did not perform detailed tests of internal controls, we did review ABC's written policies and procedures related to the documentation and submission of claims for CORF therapy services.

We conducted fieldwork at ABC in Hialeah, Florida. The program safeguard contractor (PSC) performed Medical review functions.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, Medicare guidelines, and FI guidance¹ for CORF therapy services;
- used CMS's Data Extraction System user interface to retrieve all ABC claim information for the period of our audit;
- selected a random sample of 100 paid claims that contained 9,995 services totaling \$208,191 (see Appendix A for our sampling methodology);
- met with PSC staff to go over the task and develop a payment error matrix;
- obtained supporting medical and billing records from ABC for each sampled claim;

¹Local Medical Review Policies (LMRPs) outline how FIs will review claims to ensure that they meet Medicare coverage requirements.

- contracted with the PSC to review all medical and billing records obtained and determined whether the CORF therapy services rendered by ABC met Medicare reimbursement requirements;
- reviewed ABC's written policies and procedures manual to determine whether policies existed to prevent the errors that the medical reviewers identified;
- utilized a variable appraisal program to estimate overpayments to ABC (see Appendix B for the results and projections of our sample); and
- met with members of ABC management to provide them with the preliminary results of our review.

On May 25, 2006, we issued a draft report to ABC management for comments. On June 21, 2006, ABC management requested additional information on the audit findings and an extension of time to respond. On June 29, 2006, we provided ABC with the information requested and gave them a 2-week extension, until July 14, 2006, to provide written comments. On July 28, 2006, we gave ABC an additional 2-week extension, until August 11, 2006. On August 15, 2006, ABC management informed us that they did not have the required resources to properly present rebuttal arguments to our audit findings. On August 18, 2006, we granted ABC management an additional 3 weeks, until September 8, 2006, to provide written comments. On September 8, 2006 ABC management informed us that they would not provide comments on our draft report findings and recommendations.

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The PSC's medical reviewers determined that 88 of the 100 sampled claims for CORF therapy services were not appropriately paid. Medical reviewers determined that these 88 claims contained 1,570 CORF therapy services that did not meet Medicare reimbursement requirements because:

- services billed were rendered outside of the approved plan of care,
- services billed did not meet Medicare duration of therapy requirements,
- documentation did not meet Medicare standards to support that services were actually provided, and
- services billed were not medically necessary.

Medical reviewers determined that ABC did not always follow Medicare requirements or FI guidance. ABC had written policies and procedures that, if followed, would have precluded some of the errors the medical reviewers identified. However, ABC did not adhere to its policies and procedures for ensuring that the plans of care contained all required elements and that therapy services were adequately documented. In addition, ABC's written policies and procedures did not address Medicare requirements for duration of therapy services, identification of services rendered outside of the approved plan of care, and documentation of the patient's need for neuromuscular re-education.

As a result, ABC received \$27,602 in unallowable payments for therapy services associated with the 88 sampled claims, which contained 1,570 services that did not meet Medicare reimbursement requirements. Projecting the results of our random sample to the universe, ABC received an estimated \$226,673 in payments for unallowable services.

MEDICARE REQUIREMENTS AND FISCAL INTERMEDIARY GUIDANCE

Federal regulations contain the Medicare requirements for CORF services. In addition, FI guidance specifies that CORF services must: (1) be furnished under a written plan of treatment, (2) meet Medicare duration of services requirements, (3) be medically necessary, and (4) be adequately documented.

Medicare Requirements

Written Plan of Treatment – Federal regulations state, “The services must be furnished under a written plan of treatment that — (i) Is established and signed by a physician before treatment is begun; and (ii) Prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals” (42 CFR § 410.105(c)(1)).

Duration of Services Performed – CMS Program Transmittal AB-00-14 states, “Providers should not bill for services performed for less than 8 minutes.” Specifically, several current procedural terminology (CPT) codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. “For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes” (CMS Program Transmittal AB-00-14).

Medical Necessity – Florida Local Medical Review Policy (LMRP) 97010 states that neuromuscular re-education can be considered reasonable and necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

- the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or

- the patient has muscle weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had spinal cord disease or trauma.

Medicare Requirements and Fiscal Intermediary Guidance

Adequate Documentation – Medicare regulations state: “. . . The clinical record contains sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately . . .” (42 CFR § 485.721(b)). Florida LMRP 97010 states in part that the progress notes must contain necessary and sufficient information, which indicates that the services were actually provided and were reasonable and necessary to treat the patient’s condition.

SERVICES PROVIDED BY ABC DID NOT MEET MEDICARE REQUIREMENTS

The medical reviewers determined that 88 of the 100 sampled claims contained 1,570 CORF therapy services that did not meet Medicare reimbursement requirements for CORF services:

- For 876 therapy services, the scope of services provided did not comply with the written plan of treatment. For example, the medical reviewers determined that a written plan for a patient prescribed treatment sessions 3 times per week for 6 weeks for a total of 18 sessions. However, ABC provided 3 more treatments during the 7th week. As a result, ABC received \$18,012 in unallowable payments.
- For 633 therapy services, the duration time for therapy services provided did not fall within the required range of 8 minutes to 23 minutes. For example, the medical reviewers determined that ABC claimed a 5-minute therapeutic massage. As a result, ABC received \$8,203 in unallowable payments.
- For 56 therapy services, the services provided did not meet documentation standards. For example, the medical reviewers determined that the documentation supplied for one claim indicated that only one unit of therapeutic activities was provided on the date of service; however, two units were billed. As a result, ABC received \$1,269 in unallowable payments.
- For 5 therapy services, the services provided were not medically necessary. For example, the medical reviewers determined that a patient’s need for neuromuscular re-education was not present. As a result, ABC received \$118 in unallowable payments.

POLICIES AND PROCEDURES NEED IMPROVEMENT

Medical reviewers determined that ABC did not always follow Medicare requirements or FI guidance. ABC had written policies and procedures, which, if followed, would have precluded some of the errors identified by the medical reviewers.

ABC did not adhere to its policies and procedures for ensuring the plans of care contain all required elements and that therapy services were adequately documented. In addition, ABC's written policies and procedures did not address Medicare requirements for duration of therapy services, identification of services rendered outside of the approved plan of care, and documentation of the patient's need for neuromuscular re-education.

OVERPAID COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY CLAIMS

ABC received \$27,602 in unallowable payments for therapy services associated with the 88 sampled claims because they contained 1,570 services that did not meet Medicare reimbursement requirements. Projecting the results of our random sample to the universe, ABC received an estimated \$226,673 in payments for unallowable services. (See Appendix A.)

RECOMMENDATIONS

ABC should:

- refund to the Medicare program the \$226,673 in payments for services billed from January 1, 2002, through December 31, 2002, that did not meet Medicare reimbursement requirements;
- follow its written policies and procedures to ensure plans of care contain all required elements and that services are adequately documented;
- update its written policies and procedures to address Medicare requirements for duration of therapy services, identification of services rendered outside of the approved plan of care, and documenting the patient's need for neuromuscular re-education; and
- identify and submit adjusted claims for services provided subsequent to our audit period that did not meet Medicare reimbursement requirements.

We will provide the results of this audit to First Coast, the Medicare FI, so that it can make appropriate adjustments.

ABC Total Rehabilitation Care Comments

ABC management chose not to provide comments on our draft report findings and recommendations.

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVE:

Our objective was to determine whether payments to ABC for physical therapy, speech language pathology, and occupational therapy services were provided in accordance with Medicare reimbursement requirements.

POPULATION:

The universe consisted of 964 paid claims for CORF services provided in calendar year 2002, representing \$2,086,998 in therapy benefits the FI paid to ABC.

SAMPLING UNIT:

The sampling unit is a paid CORF claim for a Medicare beneficiary. A paid claim consists of multiple units of therapy services claimed by the provider for the period covered by the claim.

SAMPLING DESIGN:

An unrestricted random sample of paid CORF claims.

SAMPLE SIZE:

The sample consisted of 100 claims, which contained 9,995 CORF therapy services.

ESTIMATION METHODOLOGY:

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Variable Appraisal Program for unrestricted samples, we projected the excessive payments to ABC resulting from erroneous claims.

APPENDIX B

STATISTICAL SAMPLE INFORMATION

Sample Results

<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Non-Zero Errors</u>	<u>Value of Errors</u>
100	\$208,191	88	\$27,602

Variable Projections

Point Estimate	\$266,084
90 Percent Confidence Interval	
Lower Limit	\$226,673
Upper Limit	\$305,495