



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

NOV 6 2008

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

Report Number: A-04-05-02010

Claudio Valero, President  
Action Rehabilitation Center  
311 SW. 27<sup>th</sup> Avenue  
Miami, Florida 33135

Dear Mr. Valero:

Enclosed is the U.S. 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 Action Rehabilitation Center, Inc." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me (404) 562-7750, or contact Andrew Funtal, Audit Manager, at (404) 562-7762 or through e-mail at [Andrew.Funtal@oig.hhs.gov](mailto:Andrew.Funtal@oig.hhs.gov). Please refer to report number A-05-02010 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Peter J. Barbera".

Peter J. Barbera  
Regional Inspector General  
for Audit Services

Enclosure

Page 2 – Claudio Valero

**Direct Reply to HHS Action Official:**

Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF THE  
COMPREHENSIVE OUTPATIENT  
REHABILITATION FACILITY  
THERAPY SERVICES  
PROVIDED BY ACTION  
REHABILITATION CENTER, INC.**



Daniel R. Levinson  
Inspector General

November 2008  
A-04-05-02010

# *Office of Inspector General*

<http://oig.hhs.gov>

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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.

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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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## **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**

Comprehensive outpatient rehabilitation facilities (CORF) provide 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 (BBA) of 1997 (sections 4523 (d) and 4541) amended the Social Security Act and required payment for hospital outpatient services, including services furnished by CORFs, to be made under a prospective payment system.

Action Rehabilitation Center, Inc. (Action) is a CORF located in Coral Gables, Florida. With the assistance of a program safeguard contractor (PSC), we reviewed selected claims Action submitted and Medicare paid. The claims selected for review included multiple physical and occupational therapy services with dates of service from January 1, 2003, through December 31, 2003 (calendar year 2003). In total, Action received \$2,038,498 for 2,083 claims during the period of our review.

### **OBJECTIVE**

Our objective was to determine whether services Action provided for physical therapy, speech language pathology, and occupational therapy during calendar year (CY) 2003 met Medicare reimbursement requirements.

### **SUMMARY OF FINDINGS**

Of the approximately \$2 million in Medicare funds Action received in CY 2003, we estimate that \$727,569 was for therapy services that did not meet Medicare reimbursement requirements.

From our random sample of 100 claims containing 4,786 CORF therapy services totaling \$100,283 the PSCs identified 94 claims for 1,789 services totaling \$40,164 that did not meet Medicare reimbursement requirements because:

- 315 services totaling \$6,754 were provided under unapproved or incomplete plans of care;
- 538 services totaling \$13,068 did not meet documentation standards;
- 905 services totaling \$19,699 did not meet Medicare duration of therapy requirements; and
- 31 services totaling \$643 were not medically necessary.

Although Action had written policies and procedures that, if followed, would have precluded some of the errors the medical reviewers identified, it did not always follow its own policies and procedures for ensuring that therapy services were provided in accordance with Medicare reimbursement requirements.

In addition, Action's written policies and procedures did not address Medicare requirements for duration of therapy services and termination of Medicare coverage when patients reached their rehabilitation goals.

## **RECOMMENDATIONS**

We recommend that Action:

- refund to the Medicare program an estimated \$727,569 in payments for services Action billed for CY 2003 that did not meet Medicare reimbursement requirements;
- follow its policies and procedures to ensure therapy services are provided under an approved and complete plan of care and are adequately documented;
- update its policies and procedures to address Medicare requirements for duration of therapy services and medical necessity; and
- identify and submit adjusted claims for services provided subsequent to our audit period that did not meet Medicare reimbursement requirements.

## **ACTION COMMENTS**

### **Disagreement With Audit Findings**

In a written response to our draft report, Action generally disagreed with our findings. Action provided us with additional medical records, notes, and other documentation that Action had compiled for each of the 94 claims we found to contain errors and requested that we review them.

### **First Coast Service Options Probe Medical Review**

Action requested that we take into consideration the probe medical review First Coast Service Options (First Coast) completed in September 2004. The First Coast review found only “12 [percent] in alleged billing errors or deficiencies” while our review found “approximately 40 [percent].”

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Disagreement With Audit Findings**

In view of the disagreement expressed by Action, we requested that the PSC medical reviewers consider the additional documents Action included with its comments and provide us with a response. Based on the PSC's review of Action's comments and additional documentation, the medical reviewers concluded that they would partially reverse their original determinations on some of the services originally found to be in error. Accordingly, we adjusted our findings and recommendations.

### **First Coast Service Options Probe Medical Review**

We reviewed the documentation provided by Action relative to the First Coast probe medical review and found that the First Coast review was dissimilar from the PSC medical review, discussed in this report, for the following three reasons: The First Coast medical review (1) covered only a 6-month period, (2) covered only 40 claims containing 382 services, and (3) was limited to CPT code 97124 (massage therapy). Conversely, the PSC medical review (1) covered a one-year period, (2) covered 100 claims containing 4,786 services, and (3) included 12 different CPT codes. Therefore, the First Coast review does not constitute an appropriate basis for comparison with the PSC review.

The complete text of Action's comments is included as Appendix C.

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## **INTRODUCTION**

### **BACKGROUND**

#### **Comprehensive Outpatient Rehabilitation Facility**

Comprehensive outpatient rehabilitation facilities (CORF) provide 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 (Section 1861 (cc) (2) (B) of the Social Security Act (the Act)). Additional covered CORF services include occupational and speech pathology services ("Medicare Benefit Policy Manual," Chapter 12, Section 20.2).

#### **Comprehensive Outpatient Rehabilitation Facility Legislation**

Section 1861 (cc) (2) of 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 (BBA) of 1997 (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 prospective payment system for CORF services furnished on or after January 1, 1999.

#### **Comprehensive Outpatient Rehabilitation Facility Prospective Payment System**

The BBA added section 1834 (k)(3) to the Act, which required all services furnished by CORFs to 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.

#### **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).

#### **Action Rehabilitation Center, Inc.**

Action Rehabilitation Center, Inc. (Action) became a Medicare-certified CORF in November 1998 and is located in Coral Gables, Florida. The FI for Action is First Coast Service Options, Inc. (First Coast), located in Jacksonville, Florida.

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

### **Objective**

Our objective was to determine whether services Action provided for physical therapy, speech language pathology, and occupational therapy during calendar year (CY) 2003 met Medicare reimbursement requirements.

### **Scope**

Our review covered service dates for CY 2003. For this period, Action received Medicare payments of \$2,038,498 for 2,083 claims.

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

We conducted fieldwork at Action in Coral Gables, Florida. The program safeguard contractor (PSC) performed medical review functions.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable laws, regulations, Medicare guidelines, and FI guidance for CORF therapy services;
- used CMS's Data Extract System user interface to retrieve all Action claim information for the period of our audit;
- selected a simple random sample of 100 paid claims containing 4,786 services totaling \$100,283 (Appendix A);
- worked with PSC staff to develop a payment error matrix;
- obtained supporting medical and billing records from Action for each sampled claim;
- contracted with the PSC to review all medical and billing records to determine whether the CORF therapy services rendered by Action met Medicare reimbursement requirements;
- reviewed Action's written policies and procedures manual to determine whether policies existed to prevent the errors that the medical reviewers identified;

- utilized an appraisal program to estimate overpayments to Action (Appendix B ); and
- met with members of Action management to provide them with the preliminary results of our review.

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 objective.

### **FINDINGS AND RECOMMENDATIONS**

Of the approximately \$2 million in Medicare funds Action received in CY 2003, we estimate that \$727,569 was for therapy services that did not meet Medicare reimbursement requirements.

From our random sample of 100 claims containing 4,786 CORF therapy services totaling \$100,283 the PSCs identified 94 claims for 1,789 services totaling \$40,164 that did not meet Medicare reimbursement requirements because:

- 315 services totaling \$6,754 were rendered under unapproved or incomplete plans of care;
- 538 services totaling \$13,068 did not meet documentation standards;
- 905 services totaling \$19,699 did not meet Medicare duration of therapy requirements; and
- 31 services totaling \$643 were not medically necessary.

Although Action had written policies and procedures that, if followed, would have precluded some of the errors the medical reviewers identified, it did not always follow its own policies and procedures for ensuring that therapy services were provided in accordance with Medicare reimbursement requirements.

In addition, Action's written policies and procedures did not address Medicare requirements for duration of therapy services and termination of Medicare coverage when patients reached their rehabilitation goals.

## **MEDICARE REQUIREMENTS AND FISCAL INTERMEDIARY GUIDANCE**

Federal regulations contain the Medicare requirements for CORF services. In addition, FI guidance specifies that CORF services must be furnished under an approved and complete plan of care, be adequately documented, meet Medicare duration requirements, and be medically necessary.

**Approved and Complete Plan of Care** – Medicare guidance states: “The plan of treatment must contain the diagnosis, type, amount, frequency, and duration of services to be performed and the anticipated rehabilitation goals” (“Medicare Outpatient Physical Therapy/CORF Manual,” Pub. No. 9, Chapter II, Section 252(E)). Additionally, the FI Local Coverage Determination Database (LCD) for Therapy and Rehabilitation Services (L6196) states: “The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan.”

**Documentation** – Medicare guidance states: (1) “The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, should be recorded” (“Medicare Intermediary Manual,” Pub. No. 13, part 3, section 3653(I)). (2) “Progress notes are to be maintained in the patient's record” (LCD for Therapy and Rehabilitation Services (L1125)). (3) “Therapy services must relate directly and specifically to a written treatment plan. The plan must be established before treatment is begun” (LCD for Therapy and Rehabilitation Services (L6196)).

**Duration of Therapy Services Performed** – Medicare guidance provides that: “Providers should not bill for services performed for [less than] 8 minutes.” Additionally, they state: “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. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed” (“Medicare Intermediary Manual,” Pub. No. 13, part 3, section 3653(I)).

**Medical Necessity** – Medicare guidance states: “When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends for that aspect of the plan of treatment” (“Medicare Outpatient Physical Therapy/CORF Manual,” Pub. 9, Chapter II, Section 252(E)).

## **SERVICES PROVIDED BY ACTION DID NOT MEET MEDICARE REQUIREMENTS**

The medical reviewers determined that 94 out of the 100 sampled claims contained 1,789 services totaling \$40,164 that did not meet Medicare reimbursement requirements:

- For 315 therapy services, the scope of services provided did not comply with the written plan of care. For example, Action billed 5 service units of therapeutic

activities that were not required by the plan of care. Also, Action billed therapy services for which neither the plan of care nor the certification was signed or dated. As a result of these and other similar issues, Action received \$6,754 in unallowable payments.

- For 538 therapy services, the services provided did not meet documentation standards. For example, for some therapy services, Action did not document the beginning and ending time of the treatment on the note describing the treatment, as required by Medicare Intermediary Manual,” Pub. No. 13, part 3, section 3653(I). Consequently, the duration of therapy is unknown. In addition, Action billed for therapy services that did not have supporting documentation such as progress notes or an initial plan of care. As a result of these and other similar issues, Action received \$13,068 in unallowable payments.
- For 905 therapy services, the duration of therapy services claimed as one unit of service did not fall within the required range of “greater than or equal to 8 minutes and less than 23 minutes.” In one case, Action billed therapy services that did not meet Medicare duration of therapy requirements because the duration of therapy was only 7 minutes. In another case, Action billed two units of therapeutic exercise but documented 8 minutes (or one unit) of total treatment time for this service. As a result of these and other similar issues, Action received \$19,699 in unallowable payments.
- For 31 therapy services, documentation did not support medical necessity. For example, although an Occupational Therapist documented that the patient’s required level of assistance was “Independent,” which indicates that the patient’s treatment goals had been met, this patient’s services were billed to Medicare. As a result of this and other similar issues, Action received \$643 in unallowable payments.

## **POLICIES AND PROCEDURES NEED IMPROVEMENT**

Medical reviewers determined that Action did not always follow Medicare requirements or FI guidance. Action had policies and procedures for ensuring that therapy services both were provided under an approved and complete plan of care and were adequately documented. If Action had followed these policies and procedures, it would have precluded some of the errors identified by the medical reviewers.

In addition, Action’s policies and procedures did not address Medicare requirements for duration of therapy services or for termination of Medicare coverage when patients reached their rehabilitation goals.

## **OVERPAID COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY CLAIMS**

Action received \$40,164 in unallowable payments for therapy services that did not meet Medicare reimbursement requirements. Based on our sample results, we estimated that Action received \$727,569 for services provided during CY 2003 that did not meet Medicare reimbursement requirements. (See Appendix B.)

### **RECOMMENDATIONS**

We recommend that Action:

- refund to the Medicare program the estimated \$727,569 in payments for services billed for CY 2003 that did not meet Medicare reimbursement requirements;
- follow its policies and procedures to ensure therapy services are provided under an approved and complete plan of care and are adequately documented;
- update its policies and procedures to address Medicare requirements for duration of therapy services and medical necessity; and
- identify and submit adjusted claims for services provided subsequent to our audit period that did not meet Medicare reimbursement requirements.

### **ACTION COMMENTS**

#### **Disagreement With Audit Findings**

In a written response to our draft report, Action generally disagreed with our findings. Action provided us with additional medical records, notes, and other documentation that Action had compiled for each of the 94 claims we found to contain errors and requested that we review them.

#### **First Coast Service Options Probe Medical Review**

Action requested that we take into consideration the probe medical review First Coast Service Options (First Coast) completed in September 2004. The First Coast review found only “12 [percent] in alleged billing errors or deficiencies” while our review found “approximately 40 [percent].”

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

#### **Disagreement With Audit Findings**

In view of the disagreement expressed by Action, we requested that the PSC medical reviewers consider the additional documents Action included with its comments and provide us with a response. Based on the PSC’s review of Action’s comments and

additional documentation, the medical reviewers concluded that they would partially reverse their original determinations on some of the services originally found to be in error. Accordingly, we adjusted our findings and recommendations.

### **First Coast Service Options Probe Medical Review**

We reviewed the documentation provided by Action relative to the First Coast probe medical review and found that the First Coast review was dissimilar from the PSC medical review, discussed in this report, for the following three reasons: The First Coast medical review (1) covered only a 6-month period, (2) covered only 40 claims containing 382 services, and (3) was limited to CPT code 97124 (massage therapy). Conversely, the PSC medical review (1) covered a 1-year period, (2) covered 100 claims containing 4,786 services, and (3) included 12 different CPT codes. Therefore, the First Coast review does not constitute an appropriate basis for comparison with the PSC review.

The complete text of Action's comments is included as Appendix C.

# **APPENDIXES**

## **APPENDIX A**

### **SAMPLING METHODOLOGY**

#### **POPULATION**

The population consisted of 2,083 paid claims for comprehensive outpatient rehabilitation facility (CORF) services provided in calendar year 2003, representing \$2,038,498 in therapy benefits the FI paid to Action.

#### **SAMPLING FRAME**

The sampling frame is an Access database table containing the 2,083 paid claims.

#### **SAMPLE UNIT**

The sample 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.

#### **SAMPLE DESIGN**

A simple random sample of paid CORF claims.

#### **SAMPLE SIZE**

The sample consisted of 100 claims, which contained 4,786 CORF therapy services.

#### **ESTIMATION METHODOLOGY**

Using the Office of Inspector General, Office of Audit Services statistical software, we estimated the unallowable payments for services that Action provided during calendar year 2003.

**APPENDIX B**

**SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

<u>Sample Size</u>	<u>Value of Sample</u>	<u>No. of Unallowable Claims</u>	<u>Value of Unallowable Payments</u>
100	\$100,283.44	94	\$40,164

**ESTIMATES OF UNALLOWABLE PAYMENTS**  
**(Limits Calculated for a 90-Percent Confidence Level)**

Point Estimate:	\$836,635
Lower Limit	\$727,569
Upper Limit	\$945,700

**Manuel R. Lopez & Associates, P.A.***Attorneys At Law*

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July 27, 2007

***Via Hand-Delivery***

Peter J. Barbera

Department of Health and Human Services

Office of Inspector General

61 Forsyth Street, S.W. Suite 3T41

Atlanta, GA 30303

c/o Maritza Hawrey

Audit Manager

HHS, OIG, OAS

61 SW 1<sup>st</sup> Avenue

Room 504

Miami, Florida

RE: Action Rehabilitation Center

Report No. A-04-05-02010

Dear Mr. Barbera:

This firm has been retained by Action Rehabilitation Center ("Action") to assist it to respond to the above-referenced report contained in your letter dated June 29, 2007.

As a preliminary matter, we would like you to take into consideration the Probe Medical Review and Education conducted by First Coast Service Options, Inc. completed in September, 2004. It is enclosed for your review. This Probe Review sampled claims during the time period July 1, 2003 through December 31, 2003. It resulted in a minor over payment in the amount of \$1,299.00 as a result of approximately 12% in alleged billing errors or deficiencies. However, your review during the same time period found an overpayment in the amount of \$736,769.00 as a result of approximately 40% in alleged billing errors or deficiencies.

I have had the opportunity to review your report with my clients. We compiled all of the medical records of the subject claims and have enclosed them for your review in order of patient according to the matrix you provided.

c/o Maritza Hawrey  
Audit Manager  
July 27, 2007  
Page 2.

With respect to the specific error codes, Action responds as follows:

**Error Code # 3**

Action respectfully disagrees with the determination. As demonstrated by the enclosed patient files, each and every patient file contains progress notes. The subject files contain Physical Therapy Daily Notes ("Daily Notes") which assess the patient's progress.

**Error Code # 5**

Action respectfully disagrees with the determination. As demonstrated by the enclosed patient files, each and every patient file contains a diagnosis, type, amount, frequency and duration of services to be performed, and the anticipated rehabilitation goals. Each file contains a Plan of Treatment for Outpatient Rehabilitation ("POT"). The goals are listed in section 12. Section 14 sets forth the frequency and duration of treatment and section 20 identifies the objectives of treatment.

**Error Code # 6**

Action respectfully disagrees with this determination. The Daily Notes set forth the treatments as in excess of 15 minutes. Moreover, Medicare Intermediary Manual Chapter VII Section 3653 states that a provider *should not* bill for services less than 8 minutes and that they should be highlighted for review. The Manual does not state that the provider *may not* bill or that those services will not be paid.

**Error Code # 6A**

Action respectfully disagrees with this determination. Adding the minutes from each of the treatments, services and/or session billed equal the total units billed in 15 minute increments. In addition, the subject rules were amended and did not come into effect until after the services were performed and billed.

**Error Code # 7**

Action respectfully disagrees with this determination. Please review the enclosed documents for this claim.

**Error Code # 9**

Action respectfully disagrees with this determination. All Plans of Care are signed. However, it is correct that the physician may not have dated a few of the plans. If necessary, the plans can be amended to add the dates. Your records should show when the patient visited the physician as

c/o Maritza Hawrey  
Audit Manager  
July 27, 2007  
Page 2.

the physician would have billed for that particular visit. In addition, it is recognized that the prescription is only valid for 30 days. All plans are initiated within that time period.

Error Code # 14

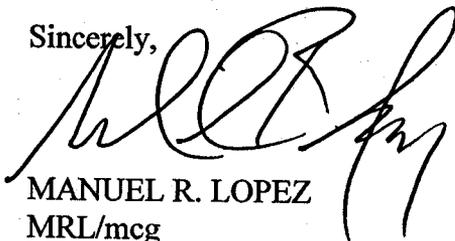
Action respectfully disagrees with this determination. All patient plans set goals which are sought to be met. The services provided seek to meet those goals. No services are provided once the goals are met.

Error Code #19

Action respectfully disagrees with this determination. The Medicare Intermediary Manual specifically states that the length of treatment could be recorded instead of beginning and ending times. The Daily Notes all set forth the length of treatment.

We would like to meet to discuss each file with you and demonstrate how the files are in compliance. If you have any question or require further information, please do not hesitate to contact me.

Sincerely,



MANUEL R. LOPEZ  
MRL/mcg

cc: Action Rehabilitation Center

Enclosures



A CMS CONTRACTED INTERMEDIARY & CARRIER

Program Safeguards Division

**MEDICARE**

September 8, 2004

### Probe Medical Review and Education

**SUBJECT:** Action Rehabilitation Center, Inc.

**Provider #:** 684505

Specialty: Outpatient Rehabilitation

Place of Service: CORF

Review period: July 1, 2003 through December 31, 2004

#### OVERVIEW

A probe medical review was conducted on one (1) sample of forty (40) claims. The claims reviewed encompassed three hundred and eighty two (382) services for thirty-five (37) beneficiaries. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, appropriately coded, medically reasonable and necessary and covered Medicare services.

All relevant documents and pertinent information such as beneficiary histories and test results were taken into consideration during the review. Also used in this review were the rules, regulations, policies and guidelines documented for Physical and Occupational Medicine and Rehabilitation services established by Centers for Medicare & Medicaid Services (CMS), which were in effect when the services were performed.

The following CPT code with descriptors was reviewed:

- 97124 - Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)

#### FINDINGS:

- Forty (40) claims were reviewed and eight (8) were denied in part or whole
- Three hundred and eighty two (382) services were reviewed.
  - Three hundred and thirty two (332) services were allowed.
  - Fifty (50) services were denied.
- Please see the enclosed diskette for the medical review findings for each beneficiary.
- \$8718.84 was paid to the provider, \$1099.17 was assessed as an overpayment.
  - 12.6% error rate of dollars denied divided by dollars reimbursed.

*First Coast Service Options, Inc.*

Medicare Part A • P.O. Box 44159 • Jacksonville, FL 32203-4159

## NOTABLE FINDINGS:

- Partial denials did not have documentation to support medical necessity past date of services specified in working file of claims.
- Please see the enclosed diskette for the medical review findings for each beneficiary.
- Claims denied in whole did not address massage therapy as part of their plan of care.

## Social Security Act

- SEC. 1862 {42 U.S.C. 1395y} (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services- (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Section 1833 (e), Title XVIII, of the Social Security Act prohibits carriers from making payment when services are in question unless documentation can be provided to support that the services were performed. Section 1833 (e) of the Act places the burden upon the physician and the supplier to furnish such information as may be necessary to determine if payment was due.
- If the medical records do not document that a billed service was provided, payment is denied for the service or, if payment already has been made, repayment will be requested.

## Policy Guidelines

- CMS Publication 100-2, Medicare Benefit Policy Manual, Chapter 12
- CMS Publication 100-8, Program Integrity Manual, Chapter 2 and 3
- Florida Local Medical Review Policy/LCD A97001, Physical Medicine and Rehabilitation
- Florida Local Medical Review Policy/LCD A97003, Occupational Therapy Policy for Rehabilitation Services

## APPLICATION OF LIMITATION OF LIABILITY

### Liability for the resulting overpayment rests with this provider because:

- The Limitation of Liability provisions of Section 1879 of the Social Security Act are applicable when items or services are found to be not reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the function of a malformed body member under Section 1862(a)(1) of the Act and pursuant to an assignment of benefits under Section 1842(b)(3)(B)(ii). This law limits the liability of a provider, beneficiary, or both when the individuals did not know, or could not be expected to know that the services submitted would not be approved under Medicare.
- Section 1870 of the Social Security Act provides regulations for waiver of recovery of overpayments on behalf of individuals. Section 1870(b) of the Act, in pertinent part, states that the excess over the correct

amount cannot be recouped from the provider of services or other person that was without fault with respect to the overpayment.

Based on the findings and conclusions reached in this review, Section 1879 of the Act is applicable for the services, which were not found reasonable and necessary in accordance with Section 1862(a)(1) of the Social Security Act. Section 1879 may serve to limit the liability of the provider, beneficiary, or both.

**FOLLOW-UP ACTIVITIES:**

**Based on the findings of this probe review, the following corrective actions that are indicated by an "X" will be performed:**

- Actual Overpayment. See enclosed correspondence.**
- Education pertinent to the review findings. An analysis of your updated comparative billing report will be performed in 3-6 months. Based on your utilization at that time, additional medical review activity may occur. If additional medical review activity is indicated, you will be notified.**
- Education and Prepayment Review for CPT codes: 97116, 97035, and 97530. You will receive additional correspondence from our office at a later date regarding the submission of documentation for the prepayment review
- Statistically Valid Random Sample Review (SVRS) for CPT codes: 97116, 97035, and 97530. You will receive additional correspondence from our office at a later date regarding the submission of documentation for this review.
- None. No additional action indicated.

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**A CMS CONTRACTED INTERMEDIARY & CARRIER**

**MEDICARE**

September 24, 2004

Action Rehabilitation Center  
Attn: Financial Officer  
411SW 27<sup>th</sup> Avenue, Suite 200  
Miami, FL 33135

Provider #684505

Dear Provider:

Thank you for your cooperation during the Probe Review conducted for your facility completed September, 2004. Based on this review, the error rate of **12%** has been assessed on the claims reviewed in the sample. Claims will be reopened in accordance with the procedures in 42 CFR 405.841 and have determined that you have been overpaid in the amount of **\$1,099.17**. We hope the following information answers any questions you may have.

### **REASON FOR REVIEW**

This review was conducted because our analysis of your billing data showed that you have a higher utilization index than your peers for services. The comparative billing report (CBR) is attached for your review.

### **HOW THE OVERPAYMENT WAS DETERMINED**

A randomly selected sample of forty claims with dates of services from July 1, 2003 through December 31, 2003 was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Our medical review staff reviewed medical documentation for the selected claims.

Based on the documentation reviewed for the selected claims, it was determined that there were services submitted that were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with the claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). It has been determined that you knew, or should have known, that the services were non-covered based on Local Medical Review Policy in place for these services, and Criteria outlined in Centers for Medicare and Medicaid Services Skilled Nursing Facility Manual. In addition, the decision has been made that you are at fault for the overpayment under the provisions of §1870 of the Act. We projected the findings from the claims that were reviewed to the universe of claims processed during the time frame mentioned above.

### **WHY YOU ARE RESPONSIBLE**

You are responsible for the overpayment if they knew or had reason to know that service(s) were not reasonable and necessary, and/or did not follow correct procedures or use care in billing or receiving payment, and you are found to not to be without fault under §1870 of the Act.

A list of specific claims that have determined to be fully or partially non covered, the specific reasons for denial, identification of denials that fall under section §1879 of the Act and those that do not, the determination as to whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached.

*First Coast Service Options, Inc.*

Medicare Part A • P.O. Box 44159 • Jacksonville, FL 32203-4159

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Liability for the resulting overpayment rests with this provider, as they should have known that a patient would have to exhibit acuity requiring the intensity of this level of care and have reasonable expectation of improvement. Centers for Medicare and Medicaid Services, Medicare Part A bulletins, Medical Policies and statewide Medifest Seminars have provided information related to these requirements. These include the following:

- *CMS Publication 100-2, Medicare Benefit Policy Manual, Chapter 12.*
- *CMS Publication 100-8, Program Integrity Manual, Chapters 2 and 3.*
- *Florida Local Medical Review Policy/LCD A97001, Physical Medicine and Rehabilitation.*
- *Florida Local Medical Review Policy/LCD A97003, Occupational Therapy Policy for Rehabilitation Services.*

### **WHAT YOU SHOULD DO**

You will receive a separate correspondence from Provider Audit and Reimbursement (PARD) as to the actions you will need to take to repay the overpayment amount identified.

### **YOUR RIGHT TO CHALLENGE OUR DECISIONS**

This letter serves as our revised determination of the claims listed following this letter. If you disagree with this determination, you must request an Appeal within one hundred and twenty (120) days from the date you receive this letter (receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act.

#### **For outpatient services:**

Refer to the appeals procedure in the Medicare Intermediary Manual §3888.2. The address for Part A Hearing's is as follows:

Medicare Part A  
Hearings and Appeals  
PO Box 45203  
Jacksonville, FL 32203

#### **For inpatient services:**

Refer to the appeals procedure in your Skilled Nursing Facility Provider Manual §310.3. The address for Reconsideration's is as follows:

Medicare Part A Reconsideration  
PO Box 45053  
Jacksonville, FL 32203

Thank you in advance for your prompt attention to this matter.

Sincerely,



Utilization Audit  
First Coast Service Options

**NOTE: The remaining pages  
have been redacted because  
they contained Personally  
Identifiable Information.**

*First Coast Service Options, Inc.*

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