

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SKILLED NURSING FACILITY
BILLING FOR CHANGES IN
THERAPY: IMPROVEMENTS
ARE NEEDED**



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EXECUTIVE SUMMARY: SKILLED NURSING FACILITY BILLING FOR CHANGES IN THERAPY: IMPROVEMENTS ARE NEEDED OEI-02-13-00611

WHY WE DID THIS STUDY

In fiscal years 2011 and 2012, the Centers for Medicare & Medicaid Services (CMS) implemented new policies to address concerns that billing by skilled nursing facilities (SNFs) did not adequately reflect changes in the amount of therapy that a beneficiary receives during a SNF stay. Specifically, CMS introduced new types of assessments that capture changes in a beneficiary's therapy more quickly. This report provides information about SNF billing for changes in therapy under these new policies.

HOW WE DID THIS STUDY

We used SNF claims to analyze billing for changes in therapy from fiscal years 2010 through 2013. We also determined whether, under the new policies, SNFs used assessments differently when decreasing therapy than when increasing it. Lastly, we determined the extent to which SNFs used the new assessments incorrectly.

WHAT WE FOUND

CMS introduced three types of therapy assessments to more quickly capture when beneficiaries start therapy, end therapy, and decrease or increase therapy. However, we found that SNF billing for changes in therapy increased only slightly. In addition, SNFs used assessments very differently when decreasing therapy than when increasing it, costing Medicare \$143 million over 2 years. Further, SNFs frequently used the new start-of-therapy assessment incorrectly. For example, SNFs often used a start-of-therapy assessment but billed for no therapy during the stay.

WHAT WE RECOMMEND

CMS's new policies are complex and create challenges for effective oversight. To better ensure that beneficiaries are receiving the amount of therapy they need, and that Medicare is paying appropriately, CMS should accelerate its efforts to implement a new method for paying for therapy. A new payment method may eliminate the need for the new assessments by basing payments on beneficiary characteristics rather than on the amount of therapy provided. In the meantime, CMS should mitigate the problems with the new therapy assessments by (1) reducing the financial incentive for SNFs to use assessments differently when decreasing and increasing therapy and (2) strengthening the oversight of SNF billing for changes in therapy. CMS concurred with both of our recommendations.

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OBJECTIVE

To describe billing by skilled nursing facilities (SNFs) for changes in therapy under new Medicare policies.

BACKGROUND

SNFs provide skilled nursing care, therapy, and other services to Medicare beneficiaries who meet certain conditions. In 2012, Medicare spent \$27.6 billion for nearly 2 million Medicare beneficiaries to receive these services.¹

In fiscal years (FYs) 2011 and 2012, the Centers for Medicare & Medicaid Services (CMS) implemented new policies to address concerns that SNF billing did not adequately reflect changes in therapy that occurred during a beneficiary's stay. In particular, CMS introduced three types of assessments to capture when beneficiaries start therapy, end therapy, and decrease or increase therapy. CMS made these changes to help ensure that SNFs are paid appropriately both when they increase therapy and when they decrease therapy.

This technical report is a companion to another report that examines the extent to which SNF billing and beneficiary characteristics changed from FYs 2011 to 2013.²

The SNF Payment System

During a beneficiary's Part A stay, the SNF periodically assesses the beneficiary to classify him or her into a resource utilization group (RUG). The particular RUG determines how much Medicare pays each day for the beneficiary's care.³

CMS divides the 66 RUGs into nontherapy RUGs and therapy RUGs. Therapy RUGs are for beneficiaries who need physical therapy, speech therapy, or occupational therapy—typically, to recover from an event such as a hip fracture or a stroke.

¹ The Centers for Medicare & Medicaid Services (CMS), *The Medicare and Medicaid Statistical Supplement*, 2013 Edition, Tables 6.1 and 6.4. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html> on March 19, 2014.

² Office of Inspector General (OIG), *The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated*, OEI-02-13-00610, forthcoming.

³ CMS, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, ver. 3.0 (RAI), May 2013, § 1.3.

The therapy RUGs are divided into five levels of therapy: ultra high, very high, high, medium, and low. A SNF categorizes a beneficiary into one of these levels primarily based on the amount of therapy that the beneficiary receives during a 7-day assessment period.⁴ For example, if a beneficiary received 45 minutes of therapy during the assessment period, he or she is typically categorized into a low-therapy RUG, whereas if a beneficiary received 720 minutes, he or she is typically categorized into an ultra-high-therapy RUG. SNFs are typically paid more for higher levels of therapy.

SNFs must conduct scheduled assessments by the 5th, 14th, 30th, 60th and 90th day of a beneficiary's stay.⁵ They have some flexibility in determining when to conduct each of these assessments—for example, in FY 2012, the beneficiary's second scheduled assessment period could begin anytime between Days 7 and 12 of the stay.⁶ However, SNFs typically do not have flexibility in determining when to bill for the RUG. For example, the first scheduled assessment typically determines the RUG for Days 1 through 14 and the second scheduled assessment determines the RUG for Days 15 through 30.

New Policies Regarding SNF Billing for Changes in Therapy

In FYs 2011 and 2012, CMS also introduced three types of beneficiary assessments that capture changes in a beneficiary's therapy more timely than scheduled assessments. The new assessments are designed to better align SNF billing—and Medicare payments—with changes in therapy during a beneficiary's stay.

Start-of-Therapy Assessments. In FY 2011, CMS introduced the start-of-therapy assessment.⁷ Prior to FY 2011, SNFs were allowed to bill for a therapy RUG—starting on the first day of the stay—on the basis of therapy that had been scheduled but not yet provided. Since FY 2011, this has not been allowed. Instead, if the beneficiary begins receiving therapy after the first scheduled assessment, SNFs may use a start-of-therapy assessment to begin billing for a therapy RUG, rather than waiting for the next scheduled assessment.

End-of-Therapy Assessments. In FY 2011, CMS also created a stricter policy for billing when a beneficiary's therapy is discontinued.⁸

⁴ CMS, *RAI*, § 6.6.

⁵ 42 CFR § 413.343(b) and CMS, *RAI*, § 2.8.

⁶ Throughout this report, we refer to the assessment periods that SNFs use to determine a beneficiary's therapy level. These assessment periods are 7 days long.

⁷ 74 Fed. Reg. 40288, 40346–40349 (Aug. 11, 2009), 74 Fed. Reg. 22208, 22244–22246 (May 12, 2009), and CMS, *RAI*, § 2.8.

⁸ 74 Fed. Reg. 40347–40348 (Aug. 11, 2009) and CMS, *RAI*, § 2.8.

Previously, SNFs could wait 8 to 10 days after therapy was discontinued to conduct an end-of-therapy assessment. Since FY 2011, however, SNFs have been required to conduct this assessment within 3 days of the end of therapy and to begin billing for the nontherapy RUG on the first day after therapy has been discontinued.

Change-of-Therapy Assessments. Since FY 2012, when a beneficiary is receiving therapy, the SNF has been required to review the beneficiary's therapy level every 7 days throughout the stay.⁹ If the therapy level changes, the SNF must conduct a change-of-therapy assessment to begin billing for the new RUG. This billing goes into effect on the first day of the 7-day assessment period.

When a change-of-therapy assessment overlaps with a scheduled assessment, SNFs conduct what is called a "combined change-of-therapy assessment."¹⁰ For example, a SNF conducts such an assessment when the change-of-therapy assessment period begins any day between Day 7 and Day 12, because the scheduled assessment period could also begin on these days.

In addition, a SNF can sometimes choose between a scheduled assessment and a combined change-of-therapy assessment by carefully timing the beneficiary's assessments.¹¹ Using a scheduled assessment delays when a SNF can begin billing for the therapy change. In contrast, using a combined change-of-therapy assessment allows the SNF to bill more timely for the therapy change. Because the choice between the two types of assessments determines when the SNF begins billing for the new therapy RUG, it affects how much Medicare pays the SNF for the beneficiary's stay. CMS currently does not specify which assessment SNFs should use in these circumstances.

METHODOLOGY

We based this study on an analysis of paid Part A SNF claims from the National Claims History file with dates of service in FYs 2010 through 2013.

Analysis of SNF billing for changes in therapy. We analyzed all billing for changes in therapy, regardless of the type of assessment used. We

⁹ 74 Fed. Reg. 48486, 48518, and 48526 (Aug. 8, 2011).

¹⁰ CMS, *RAI*, § 2.10. When the assessment periods do not overlap, SNFs conduct a stand-alone change-of-therapy assessment.

¹¹ CMS, *RAI*, §§ 2.8 and 2.10.

conducted this analysis by looking at the RUGs on SNF claims for beneficiaries' stays.

For each FY, we grouped the claims by stays, using SNF and beneficiary identifiers and SNF admission dates.¹² Each stay was associated with one or more line items in a claim, and each line item indicated the RUG.¹³ We calculated the percentage of stays during which:

- the SNF billed for no therapy;
- the SNF billed for the same level of therapy; or
- the SNF billed for changes in therapy.

Next, for each FY, we determined the percentage of stays in which the SNF billed for the following types of therapy changes:

- a change in the level of therapy,
- a therapy RUG followed by a nontherapy RUG, or
- a nontherapy RUG followed by a therapy RUG.¹⁴

Analysis of SNFs' use of assessments for decreases and increases in therapy. Beginning in FY 2012, SNFs could change therapy levels using either scheduled assessments or change-of-therapy assessments. We determined whether SNFs' use of these assessments differed when they decreased the therapy level compared to when they increased it. In this analysis, we included scheduled assessments and combined change-of-therapy assessments because a SNF can sometimes choose one or the other by carefully timing the beneficiary's assessments; this decision determines when the SNF begins billing for the new therapy RUG.¹⁵

We also determined how much SNFs' use of scheduled assessments—as opposed to combined change-of-therapy assessments—cost Medicare. Using a scheduled assessment delays when a SNF begins billing for the therapy change. In contrast, using a combined change-of-therapy

¹² The number of stays per year ranged from 2.40 million in FY 2013 to 2.46 million in FY 2011.

¹³ We extracted the RUG from the first three characters of the Health Insurance Prospective Payment System (HIPPS) code on the claim line item. The remaining two characters in the HIPPS code indicate the type of assessment that the SNF used to determine the beneficiary's RUG.

¹⁴ SNFs may bill for more than one type of therapy change during a stay.

¹⁵ We excluded stand-alone change-of-therapy assessments from this analysis because SNFs have no flexibility as to whether or when to conduct these assessments. After change-of-therapy assessments were introduced in FY 2012, SNFs changed beneficiaries' therapy levels approximately 900,000 times a year and used scheduled assessments and combined change-of-therapy assessments for 57 percent of these changes.

assessment results in more timely billing. We calculated the cost to Medicare of using scheduled assessments as the difference between what Medicare actually paid when SNFs used scheduled assessments to change therapy levels and what Medicare would have paid if SNFs had used combined change-of-therapy assessments. We did these analyses separately for FYs 2012 and 2013.

Analysis of how often SNFs used the new therapy assessments incorrectly.

We determined how often SNFs used each of the three types of therapy assessments incorrectly. We considered a SNF's use of an assessment to be incorrect if the assessment type reported on the claim clearly contradicted the RUGs on the SNF's claim.

Specifically, we considered the use of a start-of-therapy assessment to be incorrect if the SNF did not bill for a nontherapy RUG immediately followed by a therapy RUG. We considered the use of an end-of-therapy assessment to be incorrect if the SNF did not bill for a therapy RUG immediately followed by a nontherapy RUG. Lastly, we considered the use of a change-of-therapy assessment to be incorrect if the SNF billed for the same level of therapy throughout the stay. We did this analysis separately for each FY.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Under CMS's new policies, SNFs slightly increased their billing for changes in therapy

In FYs 2011 and 2012, CMS implemented new policies requiring SNFs to bill for changes in therapy more quickly. In particular, CMS introduced three types of therapy assessments to capture when beneficiaries start therapy, end therapy, and decrease or increase therapy. However, SNF billing for changes in therapy increased only slightly under CMS's new policies, from 27 percent of SNF stays in FY 2010 to 31 percent in FY 2013.¹⁶ Table 1 shows this slight increase in billing for changes in therapy, as well as the percentage of stays in which SNFs billed for the same level of therapy or for no therapy at all during the beneficiary's stay.

Table 1: Percentage of SNF Stays by Type of Billing, by Fiscal Year

Type of Billing During SNF Stay	Percentage of SNF Stays			
	FY 2010	FY 2011	FY 2012	FY 2013
Billed for changes in therapy	27%	29%	31%	31%
Billed for same level of therapy	64%	59%	58%	59%
Billed for no therapy	9%	12%	11%	10%
Totals*	100%	100%	100%	100%

* Columns do not sum to totals due to rounding.

Source: OIG analysis of SNF claims, 2015.

When SNFs billed for changes in therapy, they most commonly billed for a change in the level of therapy. As shown in Table 2, in FY 2013, SNFs billed for a change in the level of therapy during approximately one-quarter of stays. This represents a total increase of 2 percentage points from FY 2010; this increase occurred in FY 2012 when CMS introduced the change-of-therapy assessment.

In contrast, SNFs billed for a therapy RUG followed by a nontherapy RUG far less often than they billed for a change in the level of therapy. Further, billing for this change increased by only 1 percentage point from FYs 2010 to FY 2013; this increase occurred in FY 2011, when CMS introduced the end-of-therapy assessment.

SNFs were least likely to bill for a nontherapy RUG followed by a therapy RUG. However, billing for this change increased from 1 percent of stays in FY 2010 to 5 percent in FY 2013. Most of this increase occurred in FY 2011, when CMS introduced the start-of-therapy assessment.

¹⁶ This analysis was based on the RUGs billed and included billing for all changes in therapy, regardless of the type of assessment used.

Table 2: Percentage of SNF Stays by Type of Billing for Change in Therapy, by Fiscal Year

Type of Billing for Change in Therapy	Percentage of SNF Stays			
	FY 2010	FY 2011	FY 2012	FY 2013
A change in the level of therapy	23%	23%	25%	25%
A therapy RUG followed by a nontherapy RUG	6%	7%	8%	7%
A nontherapy RUG followed by a therapy RUG	1%	4%	5%	5%
Totals*	27%	29%	31%	31%

* Columns do not sum to totals because SNFs may bill for more than one type of therapy change during a stay.
Source: OIG analysis of SNF claims, 2015.

SNFs used assessments very differently when decreasing therapy than when increasing it, costing Medicare \$143 million over 2 years

As of FY 2012, SNFs can sometimes choose between conducting a scheduled assessment or a combined change-of-therapy assessment when a beneficiary’s level of therapy changes. This decision determines when the SNF begins billing for the new therapy RUG. Using a combined change-of-therapy assessment results in more timely billing, whereas using a scheduled assessment delays when SNFs begin billing for the therapy change. For example, as shown in Box 1, when a SNF chose a scheduled assessment when decreasing therapy, this choice delayed billing by 6 days and cost Medicare \$315 more for the stay.

Box 1: Example of a Stay that Cost Medicare More Because a SNF Chose a Scheduled Assessment When Decreasing Therapy

- The SNF began first assessment period on Day 2 and placed beneficiary into a very-high-therapy RUG.
- The SNF began second assessment period on Day 8 and decreased therapy level to high.
- The SNF chose a scheduled assessment by beginning the second assessment period 6 days (rather than 7 days) after the first, so billing for the lower paying RUG did not begin until Day 15.
- If the SNF had chosen a combined change-of-therapy assessment by beginning the second assessment period 7 days after the first, billing would have started on Day 9.
- Medicare paid **\$315** more for this stay because the SNF chose a scheduled assessment instead of a combined change-of-therapy assessment.

Source: OIG analysis of SNF claims, 2015.

SNFs used scheduled assessments and combined change-of-therapy assessments very differently when decreasing and increasing therapy, which resulted in increased costs to Medicare. In particular, SNFs were far more likely to use scheduled assessments when they decreased therapy than when they increased it. The choice of a scheduled assessment—rather than a combined change-of-therapy assessment—when a SNF decreases therapy allows it to delay billing for the lower paying therapy RUG. This practice increased from FY 2012 to FY 2013. See Table 3.

Table 3: Type of Assessment Used When SNFs Decreased and Increased Therapy, by Fiscal Year

Type of Assessment Used to Decrease and Increase Therapy	Percentage of Therapy Level Changes	
	FY 2012	FY 2013
Decreased therapy using:		
Scheduled assessment	86%	89%
Combined change-of-therapy assessment	14%	11%
Totals	100%	100%
Increased therapy using:		
Scheduled assessment	51%	32%
Combined change-of-therapy assessment	49%	68%
Totals	100%	100%

Source: OIG analysis of SNF claims, 2015.

As a result of these billing practices, SNFs' use of scheduled assessments to change therapy levels in FYs 2012 and 2013 cost Medicare \$143 million more than if SNFs had used combined change-of-therapy assessments. See Table 4.

Table 4: Cost to Medicare Associated With Using Scheduled Assessments, Rather Than Combined Change-of-Therapy Assessments, to Change Therapy Levels

Type of Therapy Change Billed by SNFs	Cost to Medicare (millions)		
	FY 2012	FY 2013	Total
Decrease in therapy	\$90.1	\$108.4	\$198.5
Increase in therapy*	-\$35.2	-\$20.5	-\$55.8
Totals	\$55.9	\$87.8	\$142.8

* Medicare saves money when SNFs delay billing for increasing therapy, but this is far less common than delayed billing for *decreasing* therapy.

Source: OIG analysis of SNF claims, 2015.

SNFs frequently used the start-of-therapy assessments incorrectly

In FY 2013, SNFs used the new therapy assessments in just over one-quarter of SNF stays. As shown in Table 5, SNFs were most likely to use change-of-therapy assessments and least likely to use start-of-therapy assessments.

Table 5: SNFs' Use of the New Therapy Assessments, By Type of Assessment

Type of Assessment Used During Stay	Percentage of SNF Stays		
	FY 2011	FY 2012	FY 2013
Start-of-therapy assessment	5%	4%	3%
End-of-therapy assessment	6%	7%	6%
Change-of-therapy assessment	N/A	17%	19%
Totals*	11%	25%	26%

* Columns do not sum to totals because a SNF may have used more than one type of therapy assessment during a stay.

Source: OIG analysis of SNF claims, 2015.

However, SNFs were most likely to use the start-of-therapy assessments incorrectly.¹⁷ In FY 2011, for 61 percent of the stays in which SNFs used a start-of-therapy assessment, they did not bill for a nontherapy RUG immediately followed by a therapy RUG. For example, SNFs sometimes billed for no therapy RUGs throughout the stay when they used a start-of-therapy assessment. This incorrect use decreased in FY 2013, but remained high at 27 percent. SNFs also used the end-of-therapy and change-of-therapy assessments incorrectly, but to a lesser extent. See Table 6.

Table 6: Incorrect Use of Therapy Assessments, by Assessment Type and Fiscal Year

Type of Therapy Assessment	Percentage of Stays with Incorrect Use		
	FY 2011	FY 2012	FY 2013
Start-of-therapy assessment	61%	35%	27%
End-of-therapy assessment	14%	10%	8%
Change-of-therapy assessment	N/A	4%	4%

Source: OIG analysis of SNF claims, 2015.

¹⁷ We considered a SNF's use of an assessment to be incorrect when the assessment types reported on the claim clearly contradicted the RUGs billed.

CONCLUSION AND RECOMMENDATIONS

CMS introduced three types of therapy assessments to capture when beneficiaries start therapy, end therapy, and decrease or increase therapy. However, under these new policies, SNF billing for changes in therapy increased only slightly. In addition, SNFs used assessments very differently when decreasing therapy than when increasing it, costing Medicare \$143 million in FYs 2012 and 2013. Further, SNFs frequently used the start-of-therapy assessments incorrectly. For example, SNFs often used a start-of-therapy assessment but billed for no therapy during the stay.

CMS's new policies are complex and create challenges for effective oversight. To better ensure that beneficiaries are receiving the amount of therapy they need, and that Medicare is paying appropriately, CMS should accelerate its efforts to implement a new method for paying for therapy. A new payment method may eliminate the need for the new therapy assessments by basing payments on beneficiary characteristics rather than on the amount of therapy provided.

In the meantime, CMS should mitigate the problems with the new policies. We recommend that CMS:

Reduce the financial incentive for SNFs to use assessments differently when decreasing therapy than when increasing it

CMS should modify its policies so that SNFs cannot use assessments differently when decreasing and increasing therapy in a manner that substantially increases Medicare payments. For example, CMS could eliminate SNFs' ability to choose a scheduled assessment over a combined change-of-therapy assessment when changing therapy levels.

Strengthen the oversight of SNF billing for changes in therapy

CMS should instruct its contractors to monitor SNF billing for changes in therapy. Such analyses should identify SNFs that rarely bill for changes in therapy or that frequently use the new therapy assessments incorrectly. The contractors should target these SNFs for education and for claims review to establish whether these SNFs are billing inappropriately. CMS should also instruct its contractors to develop claims processing "edits" (automatic systems processes) to reject claims if therapy assessments are used incorrectly.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our two recommendations.

CMS concurred with our recommendation to reduce the financial incentive for SNFs to use assessments differently when decreasing therapy than when increasing it. CMS stated that it is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF payment system. We appreciate that CMS is developing alternative methods of paying for therapy and CMS should accelerate these efforts. In the meantime, however, CMS should develop a shorter term solution to this problem with the new policies. For example, CMS could eliminate SNFs' ability to choose a scheduled assessment over a combined change-of-therapy assessment when changing therapy levels.

CMS concurred with our recommendation to strengthen the oversight of SNF billing for changes in therapy. CMS stated that it will work to monitor SNF billing for changes in therapy and to target for education and claims review the SNFs that rarely bill for changes in therapy or that frequently use therapy assessments incorrectly.

For the full text of CMS's comments, see Appendix A.

APPENDIX

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
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DATE: JUN -5 2015

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Skilled Nursing Facility Billing for Changes in Therapy: Improvements are Needed" (OEI-02-13-00611)

The Centers for Medicare and Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to making sure that the Skilled Nursing Facility (SNF) payment model provides appropriate payments for services provided.

SNFs provide care to beneficiaries who need daily skilled care given by, or under the supervision of, skilled nursing or therapy staff. Medicare Part A beneficiaries may qualify for coverage of up to 100 days of SNF services in a benefit period if they have a medically necessary inpatient hospital stay of three consecutive days or more that occurred within a short time period (generally, 30 days) prior to entering the SNF. Currently, Medicare pays for services provided by SNFs under the Medicare Part A benefit on a per diem basis through the SNF Prospective Payment System (PPS). This payment methodology was designed to prospectively reimburse SNFs based on the relative amount of resources needed to treat beneficiaries.

The SNF PPS was expected to control the costs of administering the Medicare Part A SNF benefit. However, the number of Medicare Part A payment days for therapy services in general, and more specifically for ultra-high levels of therapy, continues to rise. A potential cause of this issue is that the Medicare Part A therapy payment under the SNF PPS is based primarily on the amount of therapy provided to the beneficiary regardless of patient condition, which implicitly provides a financial payment incentive for facilities to provide as much therapy to a resident as that resident can tolerate, regardless of the impact of providing this level of therapy on producing positive patient outcomes.

In FY 2011, CMS modified regulations regarding SNFs' use of Start of Therapy Assessments and End of Therapy Assessments to more accurately report and receive reimbursement for the start and end of therapy services to beneficiaries. Previously, SNFs could only start billing for therapy after conducting a scheduled assessment and were required to conduct an end of therapy assessment eight to 10 days after therapy was discontinued. Under the new policies, SNFs may use a Start of Therapy Assessment to begin billing for therapy at the outset of a new therapy regimen and End of Therapy Assessments must be conducted within three days from the last day therapy services were provided. In FY 2012, CMS began requiring SNFs to use Change of

Therapy Assessments to more accurately report on and receive reimbursement for changes in therapy levels provided to beneficiaries. Previously, SNFs generally could only change the level of therapy they were billing after conducting a scheduled assessment. Under the new policies, SNFs must use a Change of Therapy Assessment if appropriate to begin billing for a new therapy level every seven days. In recent updates to SNF payment policies, CMS has worked to balance the need to provide accurate payment for therapy services with the burden that reporting requirements place on providers.

CMS is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF PPS. In an effort to establish a comprehensive approach to SNF payment reform, CMS has initiated the SNF PPS Payment Model Research project. In the first phase of the project, we reviewed past research studies and policy issues related to SNF PPS therapy and options for improving or replacing the current system of paying for SNF therapy services. We are currently using the findings from that research as a guide to identify potential models suitable for further analysis.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Reduce the financial incentive for SNFs to use assessments differently when decreasing and increasing therapy.

HHS Response

CMS concurs with OIG's recommendation. CMS is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF PPS.

OIG Recommendation

Strengthen the oversight of SNF billing for changes in therapy.

HHS Response

CMS concurs with OIG's recommendation. CMS will work to monitor SNF billing for changes in therapy and target SNFs that rarely bill for changes in therapy or frequently use therapy assessments incorrectly for education and claims review.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Bartlett served as the team leader for this study, and Rachel Bryan served as lead analyst. We would also like to acknowledge the contributions of other Office of Evaluation and Inspections regional office staff, including Marissa Baron. Central staff who provided support include Clarence Arnold, Heather Barton, Berivan Demir Neubert, Evan Godfrey, and Christine Moritz.

Office of Inspector General

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