

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

Monitoring Part B Therapy for SNF Patients



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 2000
OEI-09-99-00550**

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's San Francisco regional office prepared this report under the direction of Paul A. Gottlober, Regional Inspector General. Principal OEI staff included:

REGION

Steven P. Zerebecki, *Lead Analyst*
Robert Gibbons, *Program Analyst*
Deborah Harvey, *Program Analyst*
Tom Purvis, *Program Analyst*

HEADQUARTERS

Susan Burbach, *Program Specialist*

To obtain copies of this report, please call the San Francisco Regional Office at (415)437-7900.
Reports are also available on the World Wide Web at our home page address:

<http://www.dhhs.gov/progorg/oei>

June Gibbs Brown
Inspector General

Monitoring Part B Therapy for Skilled Nursing Facilities Patients (OEI-09-99-00550)

Michael M. Hash
Acting Administrator
Health Care Financing Administration

We are continuing to monitor the effects of the *Balanced Budget Act* of 1997 (BBA) and the *Balanced Budget Refinement Act* of 1999 (BBRA) on therapy provided to Medicare beneficiaries in skilled nursing facilities (SNFs). As you are aware, the BBRA suspended the Medicare reimbursement caps on Part B physical, occupational, and speech therapy that were imposed by the BBA. In addition, the BBRA mandates that the Department of Health and Human Services conduct focused medical reviews on Part B therapy and provide reports to Congress in the years 2001 and 2002. We continue to gather and analyze information and data that will assist the Health Care Financing Administration (HCFA) in responding to the congressional mandate.

SUMMARY

The implementation of monetary caps on therapy in SNFs coincided with a dramatic decrease in Part B therapy charges during 1999. However, preliminary reports indicate that we should expect a rebound in SNF Part B therapy charges in 2000 and 2001, based in part on the moratorium on the caps and persistent shortcomings in contractor oversight of billing practices and medical necessity of Part B therapy. We recommended that HCFA immediately ensure that the fiscal intermediaries conduct adequate medical reviews of Part B therapy in SNFs while improving therapy providers' understanding of billing procedures and the medical necessity guidelines.

BACKGROUND

Recent Office of Inspector General Work

In August 1999, the Office of Inspector General released two reports concerning physical and occupational therapy rendered to Medicare patients in SNFs. We found that during the 12-month period before the implementation of the SNF prospective payment system, Medicare paid nursing homes approximately \$811 million for medically unnecessary therapy, \$145 million for therapy provided by staff with inappropriate skills, and \$331 million for undocumented therapy. These payments represent 22 percent of the \$5.8 billion Medicare paid for Part A and B therapy in the 12-month period. During the same 12 months, nursing home mark-ups of occupational therapy exceeded \$342 million. For Part B alone, \$74 million was improperly billed for physical therapy that was medically unnecessary or provided by inappropriately skilled staff.

In October 1999, we responded to a request from HCFA to analyze Medicare claims data and determine how the Part B caps would have affected beneficiaries in 1998, 1 year prior to implementation of the caps. We concluded that between 22.4 and 29.1 percent of the beneficiaries who received SNF Part B therapy in 1998 would have exceeded the caps (i.e., a \$1500 limit for occupational therapy and a \$1500 combined limit for physical and speech therapy). We found that patients in proprietary, free-standing, or chain-owned SNFs would be more likely to exceed the caps than patients in nonprofit, independently-owned, or hospital-based SNFs. In addition, we found that patients with hip fractures or strokes would be more likely to exceed the caps.

Current Office of Inspector General Work

Based on the findings of our 1999 studies and the BBRA provisions concerning Medicare therapy, we continue to monitor services for SNF beneficiaries. In consultation with HCFA, we are:

- analyzing data collected during our on-site medical record reviews of a random sample of SNF beneficiaries who received therapy in 1999,
- comparing paid claims data for SNF therapy in 1998 and 1999,
- assessing Medicare fiscal intermediaries' (FI) involvement in medical reviews of SNF therapy,
- surveying a random sample of SNF administrators to assess the effects of the 1999 therapy caps on their patients and facilities, and
- comparing the payment policies of Medicare to non-Medicare payers.

We recently completed the comparative analysis of 1998 and 1999 Medicare Part B therapy claims data and the assessment of FIs' medical reviews of SNF therapy. The results of these studies are as follows:

DRAMATIC DECREASE COUPLED WITH UNCERTAINTY ABOUT MEDICARE CLAIMS FOR THERAPY

Claims data indicate a dramatic decrease in therapy charges for 1999. We compared the Medicare Part B therapy charges for SNF patients for Calendar Year 1998 to Calendar Year 1999. By analyzing data from a 1 percent sample of the Medicare Common Working File, we found that Part B therapy charges declined significantly — approximately 75 percent — in 1999. As shown on the next page, not only did therapy charges decrease, but the total number of beneficiaries decreased. This suggests that some patients received less therapy than they might have without the cap, received therapy that was not billed for or was paid for by insurers other than Medicare, or received maintenance therapy from nonskilled nursing home staff that previously would have been billed as skilled therapy. The latter scenario is supported by our

recent interviews with nursing home administrators and by our current on-site reviews of therapy in SNFs. The dramatic decrease may also be explained, in part, by the requirement that, as of January 1999, reimbursement is based on Medicare Part B fee schedules. As more data become available from HCFA, we will conduct a more detailed analysis of the claims for Calendar Year 1999.

Part B Physical, Occupational, and Speech Therapy Total Charges from Skilled Nursing Facilities Comparison of Calendar Year 1998 to Calendar Year 1999			
Year	Total Charges	Total Beneficiaries	Total charges per beneficiary
1998	\$1,840,666,245	619,600	\$2,971
1999	\$451,438,004	532,100	\$848
Percent Change 1998-1999	-75.5%	-14.1%	-71.5%

The permanency of the decrease is uncertain. While the caps and fee schedules appear to have contributed to the dramatic decline in charges, we believe that the suspension of the caps in 2000 and 2001 will result in rising therapy charges and questionable billing practices, similar to those we observed in 1998. We have received preliminary reports that after January 1, 2000 some therapy providers returned to “business as usual,” indicating that the Medicare program may again incur high levels of medically unnecessary and improperly billed and documented therapy claims in 2000 and 2001. In addition, fiscal intermediaries report that while they do not have the resources and guidance from HCFA to conduct adequate medical reviews of Part B therapy, they commonly find medically unnecessary and excessive therapy in SNFs during their general reviews.

FISCAL INTERMEDIARIES: MEDICAL REVIEW OF PART B THERAPY

In preparation for our on-site medical reviews of Part B therapy conducted in SNFs, we assessed the extent to which Medicare FIs are conducting medical reviews of and providing training to providers of Part B therapy. In January and February of 2000, we used a standardized discussion guide to conduct telephone interviews with staff from all 33 Medicare FIs. In addition, we collected and reviewed provider education materials from selected FIs.

Fiscal intermediaries rarely target Part B therapy for focused medical review. Only four FIs have conducted focused medical reviews on therapy in SNFs. The remainder reviewed therapy during general medical reviews of SNFs that were conducted as a result of claims data analysis. Under the SNF prospective payment system (PPS), FIs are required to perform medical reviews of a random sample which represents 1 to 3 percent of all SNF PPS claims. Focused medical review of SNF claims cannot exceed 20 percent of an FI’s total medical review budgeted workload. While FIs are not required by HCFA to focus on SNF Part B therapy claims for medical review, they can include the claims as part of their discretionary focused medical reviews.

Nineteen FIs indicated that they will continue reviewing therapy claims as part of their general oversight of SNFs. Nine FIs remarked that they will not conduct focused medical reviews of Part B therapy unless HCFA directs them to do so. They said that reviews are labor intensive, and HCFA has instructed them to examine only providers with evidence of “egregious” problems. Based on their reviews of SNF PPS claims, however, some FIs contend that focused medical reviews of Part B therapy are warranted.

When they focus on therapy, fiscal intermediaries commonly find medically unnecessary and excessive services in nursing homes. Almost three-fourths of the FIs found medically unnecessary and/or excessive therapy claims during their general reviews. Their findings ranged from the inappropriate billing of “maintenance” therapy to the abusive overutilization of therapy on patients diagnosed with dementia or Alzheimer’s disease. In the latter example, the FIs found that the patients clearly could not benefit from the therapy provided to them. Dementia patients in particular either were not able to complete their courses of therapy or could not benefit from it. As a result, FIs denied these claims.

During their general reviews, several FIs found instances of excessive therapy in nursing homes. In some cases, physicians had written orders for therapy without examining the patients. In other cases, nursing homes were billing for therapy following a “standing order” for all admissions. In these facilities, therapy is routinely conducted without a physician’s examination and/or order and regardless of the patients’ needs. For example, one FI reported receiving complaints from the son of a 100-year-old beneficiary for whom therapy was ordered upon her admission to the nursing home. The letter prompted the FI to conduct a medical review of the more than \$3000 in therapy that the SNF had billed for her. The FI found that the medical record did not contain examinations by the physician who ordered the therapy. The beneficiary had the same functional level for several years prior to her admission (she had not walked in years), did not benefit from the occupational therapy she received, and had no speech or swallowing problems to justify the speech therapy ordered. Following the initial evaluations, the beneficiary told the SNF staff she did not want any further therapy. All claims for her subsequent occupational and speech therapy were denied.

Most fiscal intermediaries had no role in ensuring that providers complied with the Part B therapy caps. Four FIs had systems in place to identify beneficiaries who had claims in excess of the \$1500 therapy caps in 1999. No other FIs were monitoring the caps, and none had identified providers who had billed in excess of the caps. Some FIs mentioned that they were acting in compliance with HCFA’s program memorandum dated October 1998. The guidance indicated that SNFs were to monitor billing themselves and to ensure that they did not submit therapy claims that exceeded the per beneficiary caps.

Three FIs identified providers who had billed in excess of the therapy caps in 1999. Based on

HCFA's guidance,¹ however, they are not planning to seek reimbursement for the overpayments. One FI had implemented edits in its payment system and had denied claims that were in excess of the caps. Another FI was in the process of identifying the beneficiaries who had received services in excess of the caps, but ceased its efforts when the moratorium on the caps was announced. This FI identified approximately 15,000 beneficiaries who had received therapy in excess of the caps. The third FI identified only one beneficiary who had received therapy in excess of the caps.

While most FIs have informed providers that the caps on therapy have been suspended, few offer specific training on billing practices for Part B therapy. All but two FIs have informed their providers that the caps on Part B therapy have been suspended until 2002. Most issued provider bulletins in January or February 2000. Several FIs notified their providers via their monthly newsletters.

Less than half of the FIs have offered or plan to offer training programs to SNFs on billing practices for Part B therapy. Of the 14 FIs who have offered training in the past, most held occasional workshops that focused on PPS for SNFs and included information about Part B therapy billing. Several FIs mentioned that they conduct training programs on an ad hoc basis: when providers request the training, when billing problems arise, or when a SNF becomes a Medicare provider.

CONCLUSIONS

Based on our interviews with the 33 Medicare fiscal intermediaries and previous Office of Inspector General work showing medically unnecessary and improperly documented therapy services, it is clear to us that problems still exist with Medicare Part B therapy provided in SNFs. We are concerned about the need for proper billing of Part B therapy provided in SNFs as well as improved quality of care and patient safety. Our interviews with the FIs and our current field work in SNFs have increased our concern about the need for medical reviews of Part B therapy.

Therefore, we recommend that HCFA:

- 1. immediately ensure that fiscal intermediaries conduct adequate focused medical reviews of Part B therapy in SNFs and**
- 2. continue to work to improve SNFs' and therapy providers' understanding of proper billing procedures and the medical necessity guidelines for Part B therapy in SNFs.**

While these recommendations are consistent with those from our 1999 reports on therapy, based on our ongoing work we wish to re-emphasize their urgency and elaborate on their implementation. The recommendations could be accomplished by promptly issuing the additional medical review guidelines for Part B physical, occupational, and speech therapy services that were

¹ In its December 1999 *Program Memorandum to Intermediaries/Carriers* (Transmittal AB-99-101), HCFA cautioned FIs to "be judicious in your use of resources" to ensure that providers complied with the 1999 caps on therapy.

mentioned in the December 1999 program memorandum to the FIs. In addition, HCFA could instruct all FIs to: a) provide SNFs and therapy providers with adequate training on Part B billing procedures and b) reemphasize to SNFs and therapy providers the importance of the medical necessity guidelines for physical, occupational, and speech therapy.

We understand that HCFA has entered into a program safeguard contract for therapy. According to HCFA, one of the contractor's responsibilities will be to develop protocols for future medical reviews of Part B therapy in SNFs. While we fully support a program safeguard initiative, the initiative does not address the immediate program vulnerabilities described in this report and our 1999 reports. Focused medical reviews, conducted by the intermediaries, would help safeguard the program until the program safeguard contractor has developed, and HCFA has implemented, a refined protocol for future reviews. We therefore urge HCFA to utilize its current resources to conduct immediate medical reviews of Part B therapy.

We hope that you find this information and our conclusions useful.

AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

2000 OCT -3 AM 11:44
RECEIVED
OFFICE OF INSPECTOR
GENERAL

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
OCIG	<input type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	10-3

DATE: SEP 29 2000

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash *Michael M. Hash*
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Monitoring of Part B Therapy Services to Skilled Nursing Facility Patients," (OEI-09-99-00550).

Thank you for your report on the utilization of Part B therapy services by Medicare beneficiaries in Skilled Nursing Facilities (SNFs). We look forward to continuing to work with you to ensure Medicare beneficiaries have access to covered therapy services while ensuring that payments are made appropriately.

Since 1993, the Clinton Administration has done more than any previous administration to fight waste, fraud and abuse of the Medicare program, which pays more than \$200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly \$500 million as a result of health-care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent four years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.

We agree with you, that adequate medical reviews of Part B therapy services in SNFs is vital to the solvency of the Medicare program. With the passage of the Health Insurance Accountability and Portability Act and the provision of dedicated funding for program integrity activities, we are better able to conduct adequate medical reviews. Nonetheless, resources are still limited, and HCFA still must use risk assessment to identify how best to use these new resources to maximize the benefits to the program.

Last year HCFA began an aggressive series of steps to ensure that Medicare only pays outpatient therapy providers for medically appropriate, Medicare covered therapy services. Last year alone, Medicare suspended payments to approximately 20 outpatient rehabilitation facilities that had submitted a high volume of fraudulent claims. Many problem facilities and new providers are under intensive medical review to ensure that Medicare pays appropriately.

Page 2 – June Gibbs Brown

We directed intermediaries and carriers to review claims involving SNF PPS and Home Health PPS (once Home Health PPS is in effect) and directed them to take appropriate action “if in the course of data analysis you identify serious problems (egregious over utilization or fraud).”

In addition, as part of our Comprehensive Plan for Program Integrity, we identified program changes made as a result of the Balanced Budget Act as an area requiring attention. We convened groups and developed methods and approaches for dealing with potential program vulnerabilities resulting from new payment systems. We adapted this approach with passage of the Balanced Budget Refinement Act (BBRA) and undertook a similar exercise to identify potential vulnerabilities associated with the elimination of therapy caps. Although the elimination of caps increases the challenges to the program in ensuring proper payment, it does allow beneficiaries access to quality care based on their clinical needs and condition.

We also agree with you that it is vitally important to continue to improve SNFs’ and therapy providers’ understanding of proper billing procedures and medical necessity guidelines for Part B therapy services in SNFs. After passage of the BBRA, we held weekly planning meetings for the purpose of determining a strategy that would realize our goal of paying claims correctly. After careful deliberation, we decided to commit Program Safeguard Contractor (PSC) resources to the important issue of controlling unnecessary spending while ensuring appropriate therapy services. The PSC for the Therapy Review Program will study the delivery of therapy services using interviews, data analysis, medical record reviews, and reviews of local medical review policies, manuals, regulations, and professional literature. On August 14, 2000, HCFA awarded a Therapy Service Task Order to a PSC. As of that date, the PSC began work to collect data and conduct statistical analysis related to therapy services in SNFs. Further, the PSC will build on HCFA’s current education efforts to ensure that providers, claims-processing contractors and other stakeholders understand Medicare policies.

Following this review, the contractor will provide:

- Information on utilization patterns necessary for the BBRA mandated Report to Congress; specifically it will compare paid claims data for all outpatient therapy services in 1998, 1999 and 2000;
- Recommendations for managing medical review of therapy claims, accounting for any procedural problems or changes in data systems revealed in their study;
- Protocols for medical reviews of therapy claims that are based on the best evidence currently available;
- Recommendations for changes in laws, regulations or manuals that would facilitate submission of appropriate claims and appropriate claims review; and
- Educational materials and plans for improving compliance with regulations, guidelines and procedures through education of all stakeholders.

Page 3 – June Gibbs Brown

It is reasonable and appropriate that your study found 4 out of 33 Fiscal Intermediaries (FI's) performing focused medical reviews on Part B therapy in SNFs. We expect these four FIs are in states with a high volume of therapy services with a history of abuse. It is also reasonable that Intermediaries can provide anecdotal reports of random reviews that identify individual claims billed inappropriately. However, the Program Memorandum never suggested that FIs should not recoup overpayments that they discover. In fact, all FIs are required by HCFA regulations to recoup overpayments (See 42 C.F.R. 405.371(a)(2), 405.373(a), 421.100(a)). The FI conferences in 2000 reiterated this requirement and noted the need to pursue more of the overpayments that have been identified in relation to payment caps.

We continue to agree with you that we must maintain efforts to educate providers, contractors, and other stakeholders. The Program Safeguard Contractor, described previously, will address education issues. The Therapy PSC will also be providing educational materials and plans specific to therapy services. Our plans for broad and intense study of therapy services will lead to a successful program of comprehensive therapy service management.

Attachment