

PHYSICAL THERAPY PROVIDED
TO SKILLED NURSING
FACILITY INPATIENTS



OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

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This Report

Entitled "Physical Therapy Provided To Skilled Nursing Facility Inpatients," this study was conducted to evaluate the economies and efficiencies of the types of arrangements used by skilled nursing facilities to provide physical therapy to inpatients.

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PHYSICAL THERAPY PROVIDED
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INPATIENTS

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EXECUTIVE SUMMARY

Skilled Nursing Facilities (SNFs) cannot accept Medicare patients in need of physical therapy (PT) unless they can provide the services directly or make arrangements with outside providers to render the needed services. This inspection analyzed the various arrangements used by SNFs to provide PT and concludes that:

- o Eighty percent of the 241 sampled SNFs used arrangements that are economical and efficient.
- o Twenty percent of sampled SNFs used arrangements that are not economical or efficient, are vulnerable to program abuse, and can place an unnecessary financial burden on the beneficiary.

The key factor contributing to the vulnerability of an arrangement was SNF loss of control over billing. In vulnerable arrangements, billing was split between the SNF and the outside provider or entirely the responsibility of the outside provider. Allowing an outside provider to bill for SNF inpatient services is known as unbundling. Inpatient costs are broken out of SNF operating costs and services are billed by providers other than the SNF. Due to different reimbursement policies, PT payments to outside providers were consistently higher than PT payments resulting from SNF billings. As a result of unbundling, this inspection identified:

- o excessive Medicare payments estimated at \$11 million during fiscal year (FY) 1984;
- o avoidable beneficiary co-payments estimated as \$4 million in FY 1984;
- o the potential for duplicate and triplicate billing;
- o avoidable administrative costs estimated at \$1 million in FY 1984; and
- o inconsistencies in Medicare statutes, regulations, policies and procedures.

In order to prevent excessive program and beneficiary payments, the Health Care Finance Administration (HCFA) should propose legislation that:

- o Prohibits unbundling of PT provided to Medicare patients residing in certified or non-certified beds of a participating SNF.

- o Prohibits unbundling of all covered medical supplies, equipment and non-physician services rendered to Medicare Part A and Part B patients residing in any portion of participating SNF facilities.

HCFA accepted in part the recommendation to prohibit the unbundling of PT from SNF operating costs and will consider extending the legislative proposal to prohibit unbundling or require rebundling of other non-physician services.

Most beds in the majority of participating SNF facilities are not certified by Medicare and are therefore not subject to Medicare statutes, regulations, or policies. Under most circumstances, a Medicare patient residing in a certified, skilled bed is entitled to coverage of all services including PT, under Part A Hospital (or Post-Hospital) Insurance Benefits. A patient residing in a non-skilled, non-certified bed is only entitled to coverage under Medicare for those services covered under Part B Supplemental Medical Insurance Benefits; e.g., PT, durable medical equipment (DME), certain medical supplies, etc.

HCFA does not believe it appropriate to control the unbundling of services provided to Medicare patients residing in non-certified beds. Therefore, the HCFA legislative proposal will require the rebundling of PT services provided only to patients residing in participating beds. We appreciate HCFA's overall receptiveness to this report and its recommendations, but strongly disagree with partial implementation of the reports first recommendation. Partial implementation will not prevent outside PT providers from billing for most Part B services and could result in increased split billing situations which are the most vulnerable and costly to the program. We will continue our dialogue with HCFA and others in the Department in order to resolve this issue.

The text of HCFA's comments on the draft inspection report are appended. Certain revisions to the report were made based on these comments.

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I. OBJECTIVES/METHODOLOGY

Objectives

This inspection focused on SNFs and the types of arrangements they used to provide PT to their Medicare inpatients. The following issues were examined:

- 1) types of arrangements used by SNFs to provide PT;
- 2) economies and efficiencies of the arrangements;
- 3) program and beneficiary vulnerabilities associated with the arrangements; and
- 4) appropriateness of program policies and procedures pertaining to the arrangements.

Methodology

A stratified random sample of 260 SNFs was selected from a universe of 5,125. For each sampled SNF, PT cost data pertaining to FY ending 1984 were reviewed. The type of arrangement used by the SNF to provide PT was categorized. If the SNF had contracted with other Medicare-certified providers such as rehabilitation agencies, home health agencies (HHAs), or hospitals, PT costs reported by that provider for FY 1984 were also reviewed. Medicare PT visit information for FY 1984 was requested from all SNFs selected for the study. Discussions were held with auditing and claims-processing staffs of intermediaries servicing the 260 SNFs. Thirty-one of the 260 SNFs participating in the inspection were visited and in-depth discussions were conducted. See Appendix I for further information regarding sample selection.

Of the 260 SNFs, 19 were dropped from the sample because the facility no longer participated in Medicare, pertinent data could not be obtained, or there was no Medicare utilization in FY 1984. Therefore, the analysis is based on the remaining 241 SNFs.

Data

Of the SNF cost reports reviewed, 11 percent were field audited by the fiscal intermediary, 44 percent were desk reviewed, 18 percent were settled without the submission and/or review of the full cost report, and 27 percent were unsettled during the time of the review. Appendix I contains further explanation regarding these data.

II. BACKGROUND

Most beds in the majority of participating SNF facilities are not certified by Medicare. Under most circumstances, a Medicare patient residing in a skilled, certified bed is entitled to coverage of all services including PT, under Part A Hospital (or Post-Hospital) Insurance Benefits. A patient residing in a non-skilled, non-certified bed is only entitled to coverage under Medicare for those services covered under Part B Supplemental Medical Insurance Benefits, e.g., PT, DME, certain medical supplies, etc.

Prior to 1972, SNF Medicare inpatients not entitled to Medicare Part A benefits could not receive Part B benefits covering PT unless a second certified Medicare provider treated them on an outpatient basis, presumably off the premises of the SNF. A 1972 amendment to Medicare authorized SNFs to directly furnish PT services to Part B covered inpatients who required PT, or make arrangements with another provider of PT to treat their patients. This amendment created inpatient Part B PT coverage, but also allowed outside providers of PT to treat both Part A and Part B inpatients of the SNFs. Billing for PT services was negotiable, to be billed by the SNF or outside PT provider. Medicare reimbursement was made to the provider billing for PT services.

When the term PT is used in the report, it refers to PT services that meet Medicare coverage guidelines. When the terms SNF or SNF inpatients are used they refer to the entire facility or all Medicare Part A and Part B patients residing in the facility, both those in certified and non-certified beds.

III. FINDINGS

Types of Arrangements

- o The majority of sampled SNFs, 64 percent, used contractual arrangements to provide PT. Arrangements were most often made with registered physical therapists (RPTs) who may or may not have been Medicare-certified independent physical therapists (IPTs). Twenty-seven percent used salaried employees to provide PT and 9 percent of the SNFs had no-arrangement agreements with outside PT providers.
- o Billing for PT services was either done by the SNF, the outsider provider, or split between the two. The amount of Medicare payment for PT ser-

VICES depended on the type of provider billing, and the applicable reimbursement mechanisms, and program safeguards specific to that provider.

Based on analysis, it was found that sampled SNFs used three types of arrangements to provide PT to their inpatients. They were:

- 1) Direct Arrangement - The SNF employed salaried physical therapists to provide PT; all billing was done by the SNF. Payment was made to the SNF and all PT services were "bundled" or included in the SNF's operating costs.
- 2) Contractual Arrangement - The SNF contracted with an outside provider. Billing for Part A covered PT services was done by the SNF and payment made to the SNF. Part B Billing may or may not have been done by the SNF. If the SNF did not bill for Part B PT services, the outside PT provider billed, creating a situation where PT services were partially "unbundled" or split out from SNF operating costs. Reimbursement was made to the provider billing for PT services.
- 3) No-Arrangement - No contractual arrangement existed between the SNF and outside PT provider. The SNF generally leased space to the outside provider who then treated SNF inpatients. The SNF did not bill for either Part A or B PT services. All billing was done by and reimbursement made to the outside PT provider under Part B. Services were completely "unbundled" from SNF operating costs.

Arrangements were made with a variety of Medicare certified and non-certified providers of PT. The following is a list of providers that SNFs may use to provide PT to their inpatients.

Medicare Certified Providers of PT Services

- 1) Hospital Outpatient Departments (HOPDs)
- 2) SNFs
- 3) HHAs
- 4) Certified Rehabilitation Agencies (CRAs)
- 5) Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- 6) IPTs
- 7) Public Health Clinics

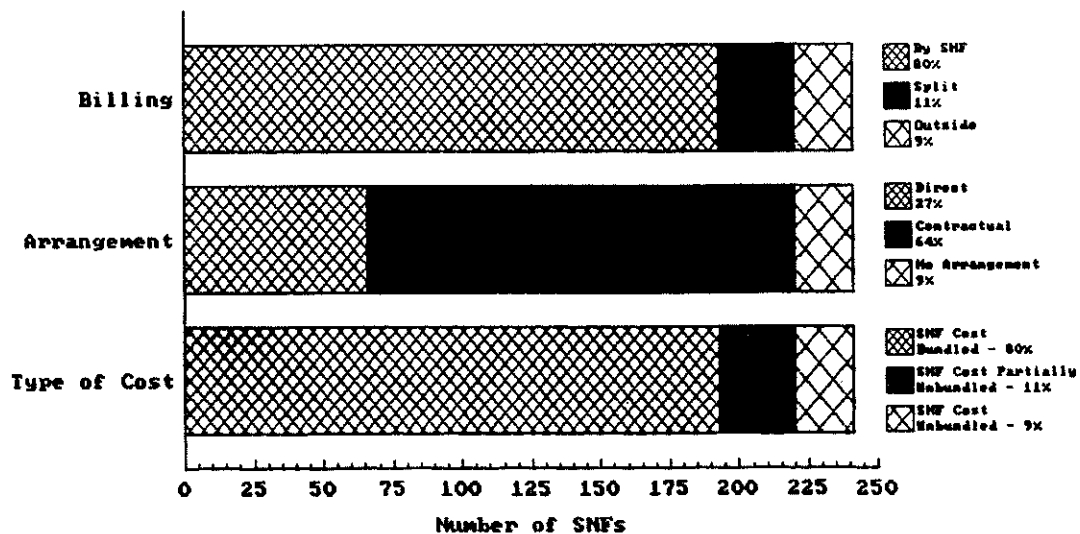
Others Under Contract with Certified Providers

- 1) Non-Medicare-Certified Rehabilitation Agencies (NCRAs)
- 2) RPTs (unlike IPTs not necessarily certified by Medicare)
- 3) PT Assistants
- 4) PT Aides
- 5) Physician Groups

For the majority of SNFs the selection of a particular arrangement did not appear to be influenced by demographics such as bed size or geographic location. There was a tendency for large, urban facilities with higher utilization to provide PT directly; however, SNFs of equal size also had contractual arrangements with outside providers. SNFs using no-arrangement agreements were found in 8 of the 19 States represented in the sample.

Contractual arrangements were most often made with RPTs/IPTs followed by NCRAs, HOPDs, CRAs, and HHAs. No-arrangement agreements most often existed between SNFs and CRAs followed by HOPDs, RPT/IPTs, and HHAs.

SNF control over the billing determined if PT services were "bundled" (included in) or "unbundled" (excluded) from SNF operating costs. Subsequent reimbursement of PT services varied depending on the arrangement being used. The following chart indicates the percentage of SNFs using each type of arrangement, shows the variation in billing for PT services, and indicates bundling or unbundling within each arrangement.



As the chart indicates, all the SNFs using direct arrangements and the majority of those who entered into contractual arrangements with outside providers of PT maintained control over the billing. Billing was done by and Medicare reimbursement was made to the primary provider, the SNF. All PT services were "bundled." A portion of those using contractual arrangements split the billing; the SNF billed for Part A PT services rendered and the outside provider billed for Part B PT services. Reimbursement was made accordingly. In these instances PT services were partially "unbundled." Those SNFs with no-arrangement agreements relinquished all control over billing; all reimbursement was made to the outside provider and all PT services were "unbundled."

The type of arrangement between a SNF and a PT provider, the type of PT provider, and the entity billing determine the Medicare reimbursement mechanisms, safeguards and program policies that apply to specific situations. The chart below demonstrates the variation in the methodology and controls on reimbursement, depending on the type of provider billing for PT.

<u>Medicare Provider Billing</u>	<u>Reimbursement Method</u>	<u>Limit</u>	<u>Coverage</u>
SNF	Reasonable Cost - Interim Payment	Salary Equivalency Guidelines- if Physical therapist is not salaried	Part A and/or B
CRA	Reasonable Cost - Interim Payment	"	Part B
HOPD	Reasonable Cost - Interim Payment	"	Part B
CORF	Reasonable Cost - Interim Payment	"	Part B
IPT	Reasonable Charge	\$500 Charge Limit Per Beneficiary, Per Year	Part B
HHA	Reasonable Cost Per Visit - Interim Payment	Capped Cost Per Visit	Part B

As the chart indicates, Medicare reimbursement to providers of PT is based on the lower of reasonable cost or charge. Providers reimbursed on cost submit a cost report to an intermediary at the end of their FY; final Medicare settlement is made at that time. Interim payments are made to the provider at regular intervals during the year. Providers reimbursed based on reasonable charge are paid on a claim-by-claim basis by the carrier. There are exceptions to the above reimbursement mechanisms which are discussed in the appendix.

Economies and Efficiencies

- o The most economical and efficient arrangement used by SNFs to provide PT to inpatients was to provide it directly using salaried employees, or through contractual arrangements where billing was done by and reimbursement made to the primary provider, the SNF. Eighty percent of sampled SNFs used this "bundled" arrangement.
- o Twenty percent of the sampled SNFs did not maintain full control over billing and "unbundled" PT services to some extent.
- o The "unbundling" of PT caused inconsistent program payments for SNF inpatient PT services. Payments per visit ranged from an average of \$16.21 if billed by SNFs, to an average of \$47.81 if billed by outside providers. This resulted in excessive Medicare payments estimated at \$11 million in FY 1984 and excessive beneficiary co-payments estimated at \$4 million during FY 1984.

Bundling occurs when the primary provider, the SNF, bills for all PT services rendered to Medicare-entitled inpatients, and reimbursement for all expenses, including contractual and overhead costs, is made to the SNF through the cost report. Bundling of PT services occurs in direct arrangements and contractual arrangements where the SNF maintains control over all Part A and Part B PT billing.

Partial unbundling of PT services occurs when billing for Part A and Part B services is split, the SNF bills for Part A PT services and the outside provider bills for Part B PT services. This situation was present in a small percentage of contractual arrangements. (See chart on page four). Complete unbundling occurs when the outside provider bills for all PT services rendered to SNF inpatients. This situation is always present in no-arrangement agreements.

Unbundling caused inconsistent program payments to be made for PT rendered to SNF inpatients. This is because each provider is subject to different reimbursement mechanisms, cost limits, program policies, and regulations.

SNFs bill for PT services covered under Part A or Part B of the Medicare Program depending on established coverage guidelines. Outside providers of PT billing Medicare are considered Part B outpatient PT providers and can only bill under Part B of the program. PT services covered under Part A if billed by a SNF, would be deemed covered under Part B if billed by the outside provider.

The inconsistency in payment levels is demonstrated by comparing SNF unit costs with outside PT provider costs.

	SNF	CRA	HHA	CRA-SNF	HHA-SNF
Average Part A Cost/Visit	\$24.91	\$44.51	\$47.81	\$19.60	\$22.90
Average Part B Cost/Visit	\$16.21	\$44.51	\$47.81	\$28.30	\$31.60

As the chart demonstrates, the average cost per Part A visit paid to the primary provider, the SNF, is between \$19.60 and \$22.90 less than if Medicare paid the outside PT provider for the same service. The range of Part B visits is similar with SNF costs running \$28.30 - \$31.60 lower than outside provider costs. See Appendix I for the methodology used to calculate the unit cost figures.

It is estimated that \$11 million could have been saved in 1984 if billing for PT services had been done entirely by SNFs rather than CRAs and HHAs.

One of the primary factors contributing to the lower SNF PT unit cost is the Medicare salary equivalency guidelines which apply to all Medicare providers using contractual arrangements. The cost of therapies or other services performed by outside providers is limited to:

- 1) amounts equivalent to the salary and other costs that would have been incurred by the if the services had been performed by an employee; plus
- 2) an allowance to compensate for other costs individuals not working as an employee might incur; e.g., travel. Salary equivalencies are established based on the various therapy disciplines; i.e., PT, speech, occupational therapy.

Also, in certain situations this limit may be based on unit of service. In no case may Medicare reimbursement for outside service exceed the amount actually paid to the outside provider.

Although the salary equivalency guidelines applied to SNFs using contractual arrangements, the CRAs and HHAs billing PT usually had salaried physical therapists on staff. Therefore, the guidelines did not apply and CRA and HHA unit costs were considerably higher.

HHAs have higher unit costs than CRAs because of the methodology used to compute the travel allowance for PT services provided by HHAs. Normally, HHA visits are made to patients who are homebound; to get from one "home" to the next, travel is involved. The reimbursement methodology assumed that one "visit" equals one treatment and figures in a travel factor for each "visit" or treatment. In a SNF, several patients may be seen at one site; nevertheless, the travel allowance is still included in each of the "visits" made at the site. Therefore, HHAs receive an incremental travel allowance for each visit. Rehabilitation agencies do not.

Beneficiaries being treated in situations where the unbundling of PT existed were subject to unnecessary or excessive co-payment amounts. PT services covered under Part A are not subject to the 20 percent beneficiary co-payment, and are reimbursed at 100 percent of cost; PT services covered under Part B are subject to both beneficiary deductible (which usually has already been met) and a 20 percent co-payment. Reimbursement is made at 80 percent of cost. Therefore, if PT can be covered under Part A entitlement, it is to the beneficiary's advantage. Also, the lower the charge for a Part B PT service, the lower the co-payment. When PT services are unbundled, billing is split between the SNF and the outside provider, or totally billed by the outside PT provider. All PT services billed by the outside provider can be covered only under Part B.

Therefore, beneficiaries are subject to the co-payment amounts even for those services that would have been covered under Part A had the SNF billed.

Program payments for PT made to outside providers were running higher than payments to SNFs. Therefore, it follows that beneficiary co-payments to outside providers were also higher than those made to SNFs.

The chart below indicates the extent of beneficiary liability depending on who billed for PT services.

SNF Bill Part A	Outside Provider Bill Part B				
<table border="1"><tr><td>PT 1/1/84 - 1/31/84</td></tr><tr><td>10 Visits at \$24.91 = \$249.10</td></tr></table>	PT 1/1/84 - 1/31/84	10 Visits at \$24.91 = \$249.10	<table border="1"><tr><td>PT 1/1/84 - 1/31/84</td></tr><tr><td>10 Visits at \$47.81 = \$478.10</td></tr></table>	PT 1/1/84 - 1/31/84	10 Visits at \$47.81 = \$478.10
PT 1/1/84 - 1/31/84					
10 Visits at \$24.91 = \$249.10					
PT 1/1/84 - 1/31/84					
10 Visits at \$47.81 = \$478.10					
Deductible Met	Deductible Met				
No Co-payment	Co-payment $\$478.10 \times .20 = \95.62				

As the example demonstrates, a beneficiary residing in a SNF paid no co-payments for services if the SNF billed Part A. The beneficiary paid an average of \$95.62 for those same services if the outside provider billed under Part B of the Program.

For purposes of illustration, the example uses unit costs as explained on page 17 of the report instead of actual PT charges on which co-payment amounts are based. However, PT charges generally run higher than actual costs, therefore the example underestimates beneficiary liability to a degree.

It is estimated that in 1984 SNF beneficiaries paid approximately \$4 million in excessive co-payments to CRAs and HHAs because the outside provider billed instead of the SNF. See Appendix I for further explanation.

From an administrative point of view, bundled arrangements are more efficient. Only one set of claims are submitted for services rendered by the SNF, only one cost report is submitted and one settlement made. Claim review, cost report reconciliation and program monitoring in the PT area is easier because in most cases medical records, PT logs, and all support documentation for PT costs claimed are maintained onsite and under the control of the SNF.

In partially unbundled arrangements, two sets of PT claims are submitted and processed, and two cost reports must be audited and reconciled. Support documentation for PT costs claimed are usually under the control of the outside provider. Therefore, documentation must be sought from both sources.

In bundled situations there is a direct, cohesive line of control, and only one set of regulations, policies and reimbursement principles apply to the primary provider, the SNF.

Vulnerabilities

- o The most vulnerable arrangements used by SNFs to provide PT to their inpatients were: contractual arrangements where partial unbundling of PT occurred due to split billing; and no-arrangement agreements where PT services were completely unbundled. Twenty percent of the sampled SNFs unbundled PT services.
- o It is estimated that in FY 1984, \$1 million in administrative costs could have been saved if unbundling of PT had not been allowed.

The following program vulnerabilities are inherent in contractual or no arrangements where there are two Medicare providers billing, the primary provider (SNF) and/or an outside PT provider.

- 1) The potential for duplicate billing exists. Duplicate-billing edits used by Medicare payors are not effective when split billing occurs and the SNF and the outside provider do not submit claims to the same fiscal intermediary. If the outside PT provider is an IPT, claims are submitted to the Medicare carrier.
- 2) The potential for triplicate billing also exists. A physical therapist could be under contract to an outside provider serviced by Intermediary A; the outside provider in turn contracts with a SNF

serviced by Intermediary B. If the physical therapist is also an IPT, payment could be made through assignment by the carrier to the IPT and by Intermediaries A and B to both the SNF and the outside provider (the employer of the IPT).

- 3) Medicare Part A histories of beneficiary services are usually not detailed enough to detect improprieties without performing medical record review.
- 4) Beneficiary intermediary notices do not indicate if PT was paid. Therefore, beneficiaries cannot alert authorities if services were paid for but not received.
- 5) The potential exists for excessive and duplicative overhead costs claimed by both the SNF and the outside provider. Availability of auditing funds prohibits intermediaries from auditing PT costs in most instances. Therefore, these improprieties would not be detected.
- 6) Unnecessary survey and certification expenses exist. In lease arrangements, outside PT providers, specifically CRAs, operate extension sites where SNF inpatients are treated on leased space within the SNFs. These extension sites must be surveyed to ensure compliance with health and safety requirements. This survey is in addition to the surveys conducted at the SNFs and the RAs' primary sites.

It has been conservatively estimated that the cost of surveying extension sites was approximately \$1 million in FY 1984. If unbundling of PT was not allowed, and outside providers could no longer bill for PT, extension sites would not be profitable and would most likely cease to exist. The need to survey extension sites would also be eliminated.

Inconsistencies in Program Policies and Procedures

The unbundling of PT costs, allowed by the 1972 Medicare amendment, contradicts other existing Medicare statutes, regulations, policies, and practices pertaining to PT coverage, reimbursement, and certification requirements.

Coverage and Provider Responsibilities

- 1) Section 1833(d) of the Social Security Act states that no payment may be made for services under

Part B if the patient is entitled to those services under Part A. Yet, a 1972 amendment to the Act allowed outside Part B providers to receive Part B payment for inpatients of SNFs entitled to Part A PT coverage.

- 2) SNFs must provide PT directly or make arrangements with others to provide it before a patient requiring PT can be admitted to the SNF. SNF regulations at 42 CFR 405.1126 and 405.1121 state that if the SNF has made arrangements with others to provide PT, the SNF must assume professional and administrative responsibility for the services rendered. Section 405.230(b)(5) implies that payment for Part B services will be made to the primary provider, the SNF. However, Section 405.230(b)(7) also states that payment may be made to clinics, rehabilitation agencies or public health agencies on behalf of the individual for outpatient PT services. In addition, outpatient physical therapy (OPT) provider regulations at 42 CFR 405.1716 and 405.1721 allow Part B payments to be made, and also hold the OPT provider administratively and professionally responsible. It appears these regulations are contradictory.

Billing, Reimbursement and Cost Limits

The various reimbursement methods, as explained on page five of the report, are not equitable or consistent.

- 1) Billing practices are inconsistent. DME suppliers are prohibited from billing for supplies and equipment provided to beneficiaries residing in certified SNF beds because SNFs are expected to provide and bill for these services themselves. Yet certified PT providers may still bill for PT services provided to SNF inpatients. (It should be noted that this inconsistency is the direct result of explicit statutory language.)
- 2) The practice of reimbursing the primary provider of services, and holding that provider administratively and professionally responsible is not consistently applied to all providers. For instance, Section 3025.2 of the Medicare Part A Intermediary Manual states that if a hospice or a hospital provides some of its services through a

contracted HHA, Medicare will reimburse only the primary provider, the hospice or hospital. However, if a SNF provides PT services through a contracted HHA, Medicare will pay the HHA for Part B PT services if the SNF decides not to bill.

- 3) Reimbursement to SNFs and CRAs for PT is made based on reasonable cost as documented in a submitted cost report. However, HHAs are reimbursed based on cost per visit and are subject to a cost per visit cap.
- 4) A Medicare beneficiary treated by an IPT is limited to \$500 of PT services per year. Claims submitted by the SNFs reviewed in this inspection contained charges per beneficiary of \$400 - \$750 per month for PT services rendered; however, no limit was placed on the amount of PT services rendered to SNF patients if the SNF billed, no matter who provided the service. (It should be noted that this inconsistency is the result of explicit statutory language.)
- 5) HHAs, not under contract with the SNFs, receive an incremental travel allowance for each PT visit made on-site at a SNF, even though a number of patients were seen during one HHA "visit." Other providers of PT do not receive this incremental travel allowance.
- 6) The salary equivalency guidelines applied to contractual arrangements are effective in controlling SNF PT costs. However, the limit does not apply if PT is rendered directly by salaried SNF employees; nor does it apply to outside PT providers using salaried physical therapists.

Certification Requirements

- 1) CRAs may operate extension sites usually located on leased sites within the SNFs. However, the RAs must also maintain a separate "primary" site, appropriately equipped to treat "walk-in" patients. HHAs, on the other hand, can be certified outpatient physical therapy providers, but are not required to maintain separate, distinct sites.
- 2) CORFs who are certified to provide all of the same services that RAs provide, plus psychological and physician services, are prohibited from operating extension sites.

IV. RECOMMENDATIONS

HCFA should propose legislation that:

- o Prohibits unbundling of PT costs in participating SNF facilities. This can be done either through an unbundling amendment similar to the one affecting hospitals passed with the Prospective Payment System (PPS) package, or by an amendment dictating that SNFs must bill for all PT services rendered to Medicare-entitled SNF inpatients. This would result in a potential program and beneficiary savings of \$16 million annually based on FY 1984 data.

Since prohibiting unbundling of PT is a rather fragmented approach to a problem affecting other services rendered to SNF inpatients, it is ultimately recommended that HCFA propose legislation that:

- o Prohibits unbundling of all Medicare covered medical supplies, equipment or non-physician services rendered to entitled inpatients of SNFs.

Please note the terms SNF and SNF inpatients used above refer to the entire facility and to Medicare patients residing in participating and non-participating beds.

It appears from committee records that Congress, in passing the 1972 amendment which allowed the unbundling of PT from SNF costs, did so because of beneficiary concern. The amendment attempted to rectify the problem of access to needed services and expanded beneficiary coverage of PT. However, in allowing PT services provided to SNF inpatients to be covered under Part B of Medicare, and not addressing who should bill for those services, Congress unintentionally created situations that are detrimental to the Program and the beneficiary, and are not efficient or cost-effective.

The most obvious solution to this problem is to prohibit unbundling of PT costs in participating SNF facilities. However, the problem of unbundling affects other SNF inpatient areas, such as certain medical supplies and equipment costs that are unbundled from routine care expenditures. Several proposals, not necessarily specific to PT, have been made in the past to alleviate or minimize the vulnerabilities, inefficiencies, and unnecessary expenditures caused by unbundling in SNFs. Some of these proposals sought administrative remedies; others, legislative change.

Some previously proposed remedies entailed restricting Part B coverage of items and services provided to SNF inpatients, or strictly enforcing SNF conditions of participation, with non-compliance resulting in decertification. These recommendations were made based on studies done regarding PT, DME, and enteral and urological supplies.

This study again documents the problems with unbundling in SNFs. The bundling provision regarding hospital inpatient services under PPS has set a precedent which should ease the way in passage of a bundling provision in SNFs. This would not affect beneficiary coverage, or certification/decertification issues, nor would it require extensive revision of regulations that are needed to address current program inconsistencies as pointed out on pages 11-13 of this report. It also is in accord with recent SNF legislation contained in the Comprehensive Omnibus Budget Reconciliation Act. Finally, a bundling amendment pertaining to SNFs would facilitate the establishment of an accurate data base for future Diagnostic Related Groups based reimbursement for SNFs.

APPENDIX I

DATA

Obtaining the necessary data for the inspection was difficult. The primary reason was inconsistent reporting requirements pertaining to SNFs and outside PT providers. As explained in the report, providers of PT are subject to different reimbursement mechanisms, program policies and procedures.

In order to analyze the cost-effectiveness of the arrangements it was necessary to find a common unit of measurement. The unit selected was cost per PT visit. However, not all of the 241 sampled SNFs were required to report PT costs, and PT visit information was reported sporadically.

All HHAs, CRAs, and HOPDs providing PT for SNFs in the sample submitted FY 1984 cost reports. However, SNFs with low Medicare utilization, less than 750 Medicare reimbursed patient days in FY 1984, were offered the option of not submitting a cost report. Instead of reconciling actual costs with the amount of interim payment received during the year, the SNFs agreed to accept as final reimbursement the total interim payment amount. Therefore, a complete cost report was not submitted and PT costs could not be identified. Eighteen percent of the sampled SNFs did not submit full cost reports containing PT cost data.

HHAs and CRAs are required to document in the cost reports the total number of Medicare visits rendered in a year. SNFs are not required to report visit information. Therefore, it was necessary to contact the SNFs directly to obtain the needed information. Not all of the SNFs responded to this request. Less than 50 percent of the 241 sampled SNFs provided complete cost and visit information. However, type of arrangement and billing entity was identified for all 241 SNFs.

While the data were incomplete, estimates of unit cost, and excessive payments have been calculated and appear representative.

SAMPLED SELECTION

The sample was selected from a universe of 5,125 SNFs participating in the Medicare program during FY 1983. Two strata, of ten State codes, were used. The first strata was the certainty strata; that is, the 10 State codes in that strata were selected because they represented the top 10 in terms of volume of SNF reimbursement from Medicare.

The second strata consisted of 10 State codes selected at random from the remaining 43 States or jurisdictions (i.e., Washington, D.C.). Using HCFA's Provider Reimbursement Master (PRM) File, SNFs in the 20 selected States were divided into two categories, those with PT charges and those without PT charges. Thirteen SNFs were then selected at random from each State group such that the sample reflected the State's distribution according to amount of PT charges. The sample consisted of 260 SNFs from 19 States. (California was sampled twice because SNFs in California are assigned in two State code categories, "05" or "55.")

Unit Costs

Because of the incomplete data the approach used to compute unit cost for PT was to produce two sets of results, and then combine these results to produce an estimate of potential savings.

The first approach was to estimate the total number of Part A and B PT visits rendered to SNF inpatients, and then associate the costs of these visits. Also, the estimates of the totals were adjusted to take into account terminations found in the sample. Thus, the estimates represent 4,750 SNFs (5,125 x 241/260). The following table gives the total estimated costs and visits for both Part A and Part B.

Table I

<u>Variable</u>	<u>Estimate</u>	<u>Standard</u> <u>Deviation</u>	<u>90% Confidence Interval</u>	
	<u>Total</u>		<u>Lower</u>	<u>Upper</u>
A Visits	3,671,544	932,788	2,137,107	5,205,981
A Costs	\$95,409,665	\$15,063,687	\$70,629,915	\$120,189,414
B Visits	2,900,503	501,602	2,075,367	3,725,638
B Costs	\$36,757,509	\$69,983	\$36,642,387	\$36,872,631

Combining the estimates in Table I with the number of SNFs gives the following estimates of the average visits and costs per SNF.

Table II

<u>Variable</u>	<u>Estimate</u>	<u>90% Confidence Interval</u>	
	<u>Total</u>	<u>Lower</u>	<u>Upper</u>
A Visits	773	450	1096
A Costs	\$20,086	\$14,869	\$25,303
B Visits	611	437	784
B Costs	\$ 7,738	\$ 7,714	\$ 7,763

These data give an average cost per A visit of \$25.98 and an average cost per B visit of \$12.66 which does not take into account the type of arrangement or provider billing.

The next step was to take the available data and produce a cost per visit estimate by the type of arrangement and provider billing. The following table gives a breakdown of the 241 non-terminated providers.

Table III

<u>Arrangement</u>	<u>Provider Billing</u> <u>A Service</u>		<u>Provider Billing</u> <u>B Service</u>			
	<u>Num.</u>	<u>%</u>	<u>Num.</u>	<u>%</u>		
Direct	SNF	66	27.4	SNF	66	--
Contract	SNF	154	63.9	SNF	127	82.5
				CRA	3	1.9
				HOPD	16	10.4
				IPT	2	1.3
				NCRA	2	1.3
				HHA	4	2.6
				Total		154
No Arrangement (All Part A services are billed by outside providers as Part B services.)				CRA	12	57.1
				HOPD	6	28.6
				IPT	2	9.5
				HHA	1	4.8
				Total		21
Total		241	100.0		241	--

Of these 241 SNFs, only 117 provided enough information from which average per visit rates could be calculated. The 117 excludes those SNFs which had outlier values. The definition of outlier was any per visit rate (Part A or Part B) greater than \$100 or less than \$1. Excluding the outlier SNFs and the SNFs with missing data makes the data available for analysis extremely sparse. The following table gives the counts of SNFs available for analysis.

Table IV

<u>Arrangement</u>	<u>Provider Billing A Service</u>		<u>Provider Billing B Service</u>	
	<u>Num</u>	<u>%</u>	<u>Num</u>	<u>%</u>
Direct	SNF	32 27.4	SNF	32 --
Contract	SNF	75 64.1	SNF	72 96.0
			CRA	1 1.3
			HHA	2 2.7
			Total	75 100.0
No Arrangement	CRA	10 8.5	CRA	10 100.0
<u>Total</u>		117 100.0		117 ---

Using these data, the cost per Part A and Part B visit based on billing entities was calculated. The type of arrangement caused slight differences in the unit costs, but they did not appear to be significant therefore this factor was ignored. The difference by billing entity appears to be much greater. The following table shows the unit costs by billing entity.

Table V

<u>Billing Entity</u>	<u>Cost Per PT Visit</u>	
	<u>Part A</u>	<u>Part B</u>
SNF	\$24.91	\$16.21
CRA	\$44.51	\$44.51
HHA	\$47.81	\$47.81

Using the SNF as the baseline, the expected savings per visit if the SNF billed was calculated. The following table gives the results of this calculation.

Table VI

<u>Billing Entity</u>	<u>Savings Per PT Visit</u>	
	<u>Part A</u>	<u>Part B</u>
SNF	--	--
CRA	\$19.60	\$28.30
HHA	\$22.90	\$31.60

EXCESSIVE PROGRAM PAYMENTS

Projections of excessive costs are based on the difference between CRA/HHA unit costs and SNF unit costs for Part A and Part B visits. The projected excessive costs paid in FY 1984 are as follows:

Table VII

<u>Billing Entity</u>	<u>% of Sample CRA/HHA Billing Part A/B (TABLE III)</u>	<u>Estimated # of SNFs in Universe</u>		<u>Avg. A/B Visits Per SNF (TABLE II)</u>		<u>SNF-RA/HHA Unit Cost (TABLE VI)</u>	<u>Excessive Payment</u>
CRA (Part A)	5.0%	238	X	773	X	\$19.60 =	\$3,605,890
CRA (Part B)	6.2%	295	X	611	X	\$28.30 =	\$5,100,934
HHA (Part A)	0.4%	20	X	773	X	\$22.90 =	\$ 354,034
HHA (Part B)	2.1%	100	X	611	X	\$31.60 =	\$1,930,760
						<u>Total =</u>	<u>\$10,991,618 *</u>

* Slight discrepancies in figures due to rounding.

<u>Source</u>	<u>Estimate</u>	<u>90% Confidence Interval</u>	
		<u>Lower</u>	<u>Upper</u>
CRA (Part A)	\$3,605,890	\$2,099,160	\$5,112,621
CRA (Part B)	\$5,100,934	\$3,648,295	\$6,545,224
HHA (Part A)	\$ 354,034	\$ 206,100	\$ 501,968
HHA (Part B)	\$1,930,760	\$1,380,920	\$2,218,720
<u>Total</u>	<u>\$10,991,618</u>	<u>\$7,334,475</u>	<u>\$14,378,533</u>

The confidence intervals provided above are approximations and are not exact. This is because two sets of estimates have been made from the same sample (total costs and visits, and average cost per visit) and treated independently.

EXCESSIVE BENEFICIARY CO-PAYMENTS

All PT services covered under Part B are subject to beneficiary co-payments of 20 percent of actual charge. Since charge data were not collected unit cost data were substituted. Part B unit costs are based on 80 percent of the actual cost. To compute excessive beneficiary co-payments it is necessary to determine the full unit cost. Calculations are as follows:

Table VIII

<u>Billing Entity</u>	<u>Cost Per Visit</u>			
	<u>Part A Paid</u>	<u>Actual Part A Cost</u>	<u>Part B Paid</u>	<u>Actual Part B Cost</u>
SNF	\$24.91	\$24.91	\$16.21	\$20.26
CRA	\$44.51	\$55.63	\$44.51	\$55.63
HHA	\$47.81	\$59.76	\$47.81	\$59.76

<u>Billing Entity</u>	<u>% of Sample CRA/HHA Billing Part A</u>	<u>Estimated # of SNFs in Universe</u>	<u>Avg. Part A Visits Per SNF</u>	<u>Actual Part A Cost</u>	<u>20% Co-Payment</u>	<u>Excessive Payment</u>
CRA (Part A)	5.0%	238	X 773	X \$55.63	X .20 =	\$2,046,895
HHA (Part A)	0.4%	20	X 773	X \$59.76	X .20 =	\$ 184,778
Total =						\$2,231,673

If the SNF had billed under Part A, instead of the outside PT provider, who billed under Part B, beneficiaries would not have been subject to the 20 percent co-payment.

<u>Billing Entity</u>	<u>% of Sample CRA/HHA Billing Part B</u>	<u>Estimated # of SNFs in Universe</u>	<u>Avg. Part B Visits Per SNF</u>	<u>Actual Part B Cost</u>	<u>20% Co-Payment</u>	<u>Dif. AS % of SNF Unit Cost</u>	<u>Excessive Payment</u>
CRA (Part B)	6.2%	X 295	X 611	X \$55.63	X .20	X .63	\$1,263,406
HHA (Part B)	2.1%	X 100	X 611	X \$59.76	X .20	X .66	\$ 481,976
Total =							\$1,745,382

The beneficiary is always subject to co-payment for PT Part B services. However since the SNF's unit cost is 63 percent lower than a CRA's and 66 percent lower than an HHA's, beneficiaries would be subject to a proportionately lower co-payment.

TOTAL BENEFICIARY EXCESSIVE PAYMENTS

Part A	\$2,231,673
Part B	\$1,745,382
	<u>\$3,977,055</u>

TOTAL EXCESSIVE PAYMENTS

Program	\$10,991,618
Beneficiary	\$ 3,977,055
Administrative	\$ 1,000,000
	<u>\$15,968,673</u>

It should be noted that the projected amount of excessive payments caused by unbundling could be understated. This is because unit cost information could not be collected on all outside providers billing for PT. HHAs and RAs represent 61.9 percent of all outside providers billing the Program for SNF Part A PT visits and only 42 percent of all outside providers billing for SNF Part B PT visits. Unit cost information for HOPDs, the next largest outside provider billing for PT services, could not be obtained. If HOPD unit costs are higher than SNF unit costs, there are still unknown savings that would result from an amendment prohibiting unbundling.

The amount of excessive beneficiary payments could also be understated since it is based on unit costs as opposed to charges. Co-payment amounts are calculated based on charge, and charges generally run higher than costs. Therefore actual co-payment amounts paid in excess could be higher than the \$4 million projected.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date **DEC 29 1986**
From *Henry F. Desmond*
William L. Roper, M.D.
Administrator

Subject **OIG Draft Report: "Inspection of Physical Therapy Provided to Skilled Nursing Facility (SNF) Inpatients" - OAI 05-85-00005**

To **The Inspector General
Office of the Secretary**

We have reviewed your draft report recommending that HCFA propose legislation which prohibits unbundling of physical therapy from SNF operating costs. We agree with this recommendation, and we will develop a legislative proposal embodying it. We will also examine whether prohibiting unbundling or requiring rebundling of other services would be sensible and result in savings. Depending on the results of this examination, we may extend the legislative proposal to cover other services as well.

The cost savings of the proposal might be lower than estimated by the OIG. Some SNFs may not be able to arrange contracts that are as cost effective as currently contracting SNFs because of factors such as low volume or remoteness of facility. The salary equivalency guidelines do not apply to intermittent, part-time services or unique labor market situations.

Attached are some comments on certain details in the draft report which we are submitting for your consideration.

Attachment

OIG Draft Report
Physical Therapy Provided to SNF Inpatients
OAI 05-85-00005

Additional HCFA comments:

- o Page 2, BACKGROUND, paragraphs 2 and 3--Within an institution, only those beds that are participating in Medicare comprise the SNF. Medicare has no control over the activities of the nonparticipating portion, nor is it likely that a legislative change could establish such control. The scope of the report and recommendations should be limited to patients in participating SNF beds only.
- o Page 5, last entry--The "Coverage" line should be "Part B." An HHA cannot bill under Part A for services to SNF inpatients.
- o Page 8, last full sentence--The phrase "are deemed by the program to be covered" should be changed to "can be covered only."
- o Page 8. When an HHA furnishes services to more than one patient at the same location, actual time must be recorded. If the services are furnished under arrangements to a SNF, the reasonable cost must be based on the actual number of hours of service and the standard travel allowance. In addition, only one travel allowance is allowed for each visit to the facility. Therefore, the methodology for HHA and RA services to patients in a SNF is the same.
- o Page 12, item 2 at top, first paragraph--The last sentence should be deleted. 405.230(b) merely sets forth various possibilities for payment channels; it is not relevant to this issue.
- o Page 12, item 1--The noted inconsistency is the direct result of explicit statutory language.
- o Page 13, item 4-- This also is the result of an explicit statutory provision.
- o Appendix--Beginning with Table III, we are unable to understand the entries for Part A billings by CRA, HOPT, IPT, and HHA. None of these providers can bill under Part A for services furnished to SNF inpatients; they are exclusively Part B.