DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

May 28, 2008

Report Number: A-06-07-00046

Mr. Cory Taliaserro
Administrator
Four Seasons Nursing Home
1212 Four Seasons Drive
Durant, Oklahoma 74701

Dear Mr. Taliaserro:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Skilled Services at Four Seasons Nursing Center of Durant, Oklahoma." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me, or contact Cheryl Blackmon, Audit Manager, at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. Please refer to report number A-06-07-00046 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SKILLED SERVICES AT FOUR SEASONS NURSING CENTER OF DURANT, OKLAHOMA

Daniel R. Levinson
Inspector General

(May 2008)
A-06-07-00046

Office of Inspector General

http://oig.hhs.gov

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare pays skilled nursing facilities (SNF) a daily rate to cover skilled services (e.g., rehabilitation therapy, infusion therapy, and nursing) provided to Medicare patients during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to place patients into specific payment groups, known as Resource Utilization Groups (RUG), based on the patients' care and resource needs. Each RUG corresponds to a combination, or bundle, of services; e.g., skilled nursing services, daily physical therapy, and ancillary services.

SNFs periodically assess each patient's clinical progress. If a patient's condition changes substantially, the patient could be assigned a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim may have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

OBJECTIVE

Our objective was to determine whether the services on rehabilitation claims paid to Four Seasons Nursing Center (Four Seasons) in Durant, Oklahoma, were medically necessary, adequately supported by medical documentation, and properly billed.

SUMMARY OF FINDINGS

Of the 100 rehabilitation claims sampled, which included 165 RUGS, the medical reviewers determined that 127 RUGs included medically unnecessary, inadequately documented, or improperly billed services. Specifically, the medical reviewers recommended that:

- 39 RUGs be denied, 81 RUGs be downcoded, and 3 RUGs be partially denied and partially downcoded because services were not medically necessary at the intense level provided at an SNF or at the RUG level claimed;

- 1 RUG be downcoded and 1 RUG be denied because services were not supported by adequate documentation; and

- 2 RUGS be downcoded because Four Seasons did not properly bill for skilled services.

These errors occurred because Four Seasons misapplied Medicare medical necessity requirements and did not have adequate controls in place to ensure that (1) all Medicare claims were supported with sufficient medical documentation and (2) services were properly billed. As

a result, we estimate that Medicare overpaid Four Seasons at least $791,530 for services that did not meet Medicare requirements.

Additionally, medical reviewers recommended that 18 RUGs be downcoded because they could not determine whether Four Seasons had included time spent on initial evaluation minutes in the actual number of therapy minutes provided to patients. Therefore, patients could have been incorrectly assigned to higher paying RUGs. As a result, we estimate that Medicare potentially overpaid Four Seasons an additional $90,567. We set aside the $90,567 for adjudication by CMS.

RECOMMENDATIONS

We recommend that Four Seasons:

- refund to the Medicare program $791,530 in overpayments,
- work with CMS to resolve the potential overpayments set aside totaling approximately $90,567,
- ensure that future claims with skilled services comply with Medicare requirements for medical necessity,
- strengthen its procedures to ensure that all Medicare claims are supported by adequate medical documentation,
- strengthen its procedures to ensure that all Medicare claims are properly billed, and
- work with the fiscal intermediary to determine the amount of any overpayments made subsequent to our audit period.

FOUR SEASONS COMMENTS

In supplementary information to its comments on our draft report, Four Seasons agreed that 11 of the claims the medical personnel reviewed contained errors. However, Four Seasons disagreed that the remaining claims contained errors and disagreed with various aspects of the review, including issues related to medical necessity determinations and medical documentation. The full text of Four Seasons's comments (excluding privacy information) is included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We rely on the knowledge and expertise of our medical reviewers and stand by our findings and recommendations. Thus, we continue to believe that Four Seasons should refund $791,530 and work with CMS to resolve the potential overpayments set aside totaling approximately $90,567.

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INTRODUCTION

BACKGROUND

Medicare Prospective Payment System for Skilled Nursing Facilities

The Balanced Budget Act of 1997 mandated the implementation of a prospective payment system for skilled nursing facility (SNF) services furnished to beneficiaries under Part A of the Medicare program. SNFs provide daily services that include speech, occupational, and physical therapies; intravenous feedings or medications; and transfusions. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals for a condition previously treated at a hospital.

Under the prospective payment system, Medicare pays SNFs a daily rate to cover services provided to a patient during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to place patients into a specific payment group, known as a Resource Utilization Group (RUG), based on the patients' care and resource needs. Each RUG corresponds to a combination, or bundle, of services; e.g., skilled nursing services, daily physical therapy, and ancillary services.

Federal regulations require SNFs to complete MDSs on the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of a patient's stay. If a patient's condition changes substantially, the patient could be assigned a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim could have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

Resource Utilization Groups

At the time of our review, Medicare grouped RUGs into seven major service categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function. The rehabilitation services category is further divided into five levels that comprise 14 RUGs: ultra high (3 RUGs), very high (3 RUGs), high (3 RUGs), medium (3 RUGs), and low (2 RUGs). Each RUG is associated with a per diem payment rate.

Medicare Program Safeguard Contractors

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, in part to strengthen CMS's ability to deter fraud and abuse in the Medicare program. In accordance with this legislation, CMS created program safeguard contractors (PSC) to perform medical reviews, cost report audits, data analysis, provider education, and fraud detection and prevention. IntegriGuard is one of 12 companies nationwide designated as a PSC by CMS.

Four Seasons Nursing Center

Located in Durant, Oklahoma, Four Seasons Nursing Center (Four Seasons) is a nursing home with a Medicare-certified skilled nursing unit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the services on rehabilitation claims paid to Four Seasons were medically necessary, adequately supported by medical documentation, and properly billed.

Scope

We selected Four Seasons for our review because the nursing home had the highest number of patient days in the ultra-high rehabilitation RUG category – more than any other Oklahoma nursing home submitting Medicare claims during calendar year 2002.

From January 1 through December 31, 2002, Four Seasons submitted 411 Medicare claims totaling $1,767,234. For our audit, we selected only paid claims that included at least one rehabilitation service period, a total of 394 claims with payments totaling $1,735,939. From these 394 claims, we selected an unrestricted random sample of 100 claims totaling $484,235.

Our review of internal controls focused on gaining an understanding of Four Seasons's policies and procedures for (1) assessing patient care needs and completing their MDSs, (2) billing for Medicare services, and (3) maintaining medical records.

We performed our fieldwork at Four Seasons in Durant, Oklahoma.

Methodology

To accomplish our objective, we:

- reviewed the applicable laws, regulations, and guidance concerning the Medicare payment process for SNFs;

- interviewed Four Seasons officials and reviewed the Four Seasons policies and procedures that focused on (1) assessing patient care needs and completing their MDSs, (2) billing for Medicare services, and (3) maintaining medical records;

- obtained Four Seasons's medical records for the 100 sample claims;

- forwarded the medical records for the sample claims to IntegriGuard's medical reviewers to determine whether the claimed services were medically necessary, supported by adequate documentation, and properly billed;

- obtained the medical review results on the sample claims and calculated the overpayment amounts; and

- estimated total Medicare overpayments based on our sample results.

Appendix A includes our sampling methodology and the resulting projection of overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 100 rehabilitation claims sampled, which included 165 RUGS, the medical reviewers determined that 127 RUGs included medically unnecessary, inadequately documented, or improperly billed services. Specifically, the medical reviewers recommended that:

- 39 RUGs be denied, 81 RUGs be downcoded, and 3 RUGs be partially denied and partially downcoded because services were not medically necessary at the intense level provided at an SNF or at the RUG level claimed;

- 1 RUG be downcoded and 1 RUG be denied because services were not supported by adequate documentation; and

- 2 RUGS be downcoded because Four Seasons did not properly bill for skilled services.

These errors occurred because Four Seasons misapplied Medicare medical necessity requirements and did not have adequate controls in place to ensure that (1) all Medicare claims were supported with sufficient medical documentation and (2) services were properly billed. As a result, we estimate that Medicare overpaid Four Seasons at least $791,530 for services that did not meet Medicare requirements.

Additionally, medical reviewers recommended that 18 RUGs be downcoded because they could not determine whether Four Seasons had included time spent on initial evaluation minutes in the total number of therapy minutes provided to patients. If the initial evaluation minutes were included in the total, patients could have been incorrectly assigned higher paying RUGs. As a result, we estimate that Medicare potentially overpaid Four Seasons an additional $90,567. We set aside the $90,567 for adjudication by CMS.

Appendix B contains a more detailed breakdown of the medical reviewers' findings on the 100 sample claims.

SKILLED SERVICES NOT MEDICALLY NECESSARY

Medicare Requirements

General medical necessity requirements are contained in Title XVIII of the Social Security Act (the Act), section 1862(a)(1)(A), which states that no payment may be made under Part A or Part B of Medicare for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or for improving the functioning of a malformed body member.

Pursuant to 42 CFR § 424.20, SNF patients should be correctly assigned to the RUG category that represents the required level of care.

Pursuant to 42 CFR § 409.31(b), Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily; (2) the beneficiary needs care for a condition previously treated in a hospital or critical access hospital; and (3) the skilled services, as a practical matter, can be provided only in an SNF on an inpatient basis.

According to section 230.3 of the CMS "Skilled Nursing Facility Manual," for physical and occupational therapy and speech pathology to be reasonable and necessary, there must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time.

According to section 3159 of the "Medicare Part A Intermediary Manual," custodial care is excluded from coverage. Custodial care is essentially "personal care that does not require the continuing attention of trained medical or paramedical personnel." For example, custodial care involves assisting an individual in the activities of daily living, such as walking, getting in and out of bed, bathing, dressing, and eating. Additionally, 42 CFR § 411.15(g) also excludes custodial care from coverage, except as necessary for the palliation or management of terminal illness.

Skilled Services Not Medically Necessary

The medical reviewers recommended that 39 RUGs be denied, 81 RUGs be downcoded, and 3 RUGS be partially denied and partially downcoded because services were not medically necessary at the intense level provided at an SNF or at the RUG level claimed.

The following two examples illustrate the reasons why medical reviewers recommended that RUGS be either denied or partially denied:

- A 77-year-old patient was admitted to Four Seasons after being hospitalized for lower lobe pneumonia with respiratory distress. The reviewers found that the patient did not meet the criteria for coverage for the RUG category billed. Therapy services were not reasonable and necessary because the patient's condition was not expected

to improve significantly within a reasonable and generally predictable period of time. According to the medical reviewers, skilled nursing staff was not needed to perform range of motion, rolling, turning, and repositioning duties for the patient. In addition, documentation did not support the use of a therapist for the patient's basic custodial needs. Tasks performed by the patient required only routine nursing care, and the patient did not need rehabilitation services. Therefore, the medical reviewers recommended downcoding the claim.

- An 86-year-old male patient was admitted to Four Seasons following an acute hospital stay. The patient was accompanied by his wife because of his inability to speak. According to the patient's wife, he had difficulty swallowing during the previous month due to the progression of his Parkinson's disease. The patient had a history of psychosis, seizures, and mental impairment. When the patient was discharged from the hospital, his diagnoses included dehydration, dementia, anorexia, Parkinson's disease, and macrocytic anemia. The discharge summary documented his activities as "orders for passive physical therapy."

  Documentation did not support the patient's need for daily skilled physical and occupational services or daily skilled nursing. At the time of admission, the patient required assistance for all activities of daily living (ADL), including bed/chair positioning, transfers, and feeding. In addition, he was unable to communicate his needs. The monitoring of a safe environment and assistance with ADLs did not require the skills of a therapist. The patient was unable to participate meaningfully in a rehabilitation therapy program because of debilitating conditions and cognitive impairment. Further, the patient's condition was not expected to improve, and his needs were for custodial care, which is not provided by Medicare. As a result, medical reviewers denied the claim.

Medical Necessity Requirements Misapplied

The medical reviewers determined that Four Seasons provided services that did not meet Medicare requirements for medical necessity. Based on the medical expertise of the medical reviewers, we conclude that Four Seasons misapplied Medicare medical necessity requirements.

SKILLED SERVICES NOT SUPPORTED BY ADEQUATE DOCUMENTATION

Medicare Requirements

Title XVIII of the Act, section 1819(b)(6)(C), states that SNFs must maintain clinical records that adequately support the services provided to all SNF patients.

Skilled Services Not Supported by Adequate Medical Documentation

The medical reviewers recommended that one RUG be downcoded and one RUG be denied because the services were not supported by adequate documentation. For the downcoded RUG, occupational therapy could not be supported because the services lacked a therapy log. For the

denied RUG, skilled services could not be supported because the patient's files lacked occupational therapy logs, and speech therapy could not be supported because the patient's prior level of functioning could not be determined. Moreover, time spent on therapy documented in the medical records did not support the level of the therapy services required for the RUG.

Procedures Did Not Ensure Adequate Medical Documentation of Claims

Four Seasons officials stated that they had procedures to ensure that patients' medical records were complete. The officials explained that the therapy director performed random chart audits and the facility hired a consultant to review the skilled nursing records. However, these procedures failed to ensure that all medical documentation was included in patients' medical files. As a result, Medicare overpaid Four Seasons for services that were not supported by medical documentation.

IMPROPERLY BILLED SKILLED SERVICES

Medicare Requirements

Pursuant to 42 CFR § 424.20, SNF patients should be correctly assigned to the RUG category that represents the required level of care.

CMS's "Long-Term Care Resident Assessment Instrument User's Manual" states that, when completing MDSs, SNFs should report only the actual time spent providing therapy to patients.

Improperly Billed Skilled Services

The medical reviewers recommended that two RUGS be downcoded because Four Seasons did not properly bill for skilled services. According to the medical reviewers, therapy documented in the patients' medical records did not equal the number of minutes that would support the RUG levels billed. For example, one patient was assigned an ultra-high rehabilitation RUG after 720 minutes of therapy was reported on the MDS. After reviewing the patient's medical file, the reviewers determined that Four Seasons had provided only 705 minutes of therapy, which would have qualified the patient for a lower-paying RUG. Therefore, Four Seasons erroneously billed for services that were not provided.

Procedures Did Not Ensure Proper Billing of Claims

According to a Four Seasons official, the number of minutes of therapy provided should equal the number of therapy minutes reported on patients' MDSs. In addition, the official stated that if the number of therapy minutes reported on MDSs was incorrect, it was due to an input error. These errors occurred because Four Seasons did not have procedures in place to ensure that claims were properly billed.

INITIAL EVALUATION MINUTES NOT SEPARATED FROM ACTUAL THERAPY MINUTES

Medicare Requirements

Pursuant to 64 Federal Register (July 30, 1999), the time required to perform the formal initial evaluation and develop the treatment goals and the plan of treatment may not be counted as minutes of therapy received by the beneficiary. Further, CMS's "Long-Term Care Resident Assessment Instrument User's Manual" states that the time spent initially evaluating patients for therapy should not be reported on the MDS. If the time is reported, a patient could be placed in a higher-paying RUG category.

Pursuant to 42 CFR § 424.20, SNF patients should be correctly assigned to the RUG category that represents the required level of care.

Initial Evaluation Minutes Not Separated From Actual Therapy Minutes

The medical reviewers could not determine whether the time associated with conducting initial evaluations on patients was included in the total time recorded for therapy services that supported 18 RUGs. If the time spent conducting initial evaluations on patients was reported as therapy services, patients could be placed in higher-paying RUG categories. Therefore, the medical reviewers recommended that 18 RUGs be downcoded. According to Durant officials, the time spent conducting initial evaluations on patients was not included as therapy services. The estimated amount of these potential errors totaled approximately $90,567, which we set aside for adjudication by CMS.

CONCLUSION

For the period January 1 through December 31, 2002, we estimate that Medicare overpaid Four Seasons at least $791,530 for services that were medically unnecessary, inadequately documented, or improperly billed. Further, we set aside $90,567 for adjudication by CMS because medical reviewers could not determine whether initial evaluation minutes were separated from actual therapy minutes.

RECOMMENDATIONS

We recommend that Four Seasons:

- refund to the Medicare program $791,530 in overpayments,
- work with CMS to resolve the potential overpayments set aside totaling approximately $90,567,
- ensure that future claims with skilled services comply with Medicare requirements for medical necessity,

- strengthen its procedures to ensure that all Medicare claims are supported by adequate medical documentation,

- strengthen its procedures to ensure that all Medicare claims are properly billed, and

- work with the fiscal intermediary to determine the amount of any overpayments made subsequent to our audit period.

FOUR SEASONS COMMENTS

In supplementary information to its comments on our draft report, Four Seasons agreed that 11 of the claims the medical personnel reviewed contained errors. However, Four Seasons disagreed that the remaining claims contained errors and disagreed with various aspects of the review, including issues related to medical necessity determinations and medical documentation. The full text of Four Seasons's comments (excluding privacy information) is included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We rely on the knowledge and expertise of our medical reviewers and stand by our findings and recommendations. Thus, we continue to believe that Four Seasons should refund $791,530 and work with CMS to resolve the potential overpayments set aside totaling approximately $90,567.

APPENDIXES

SAMPLING METHODOLOGY

Population: The population consisted of all paid Medicare claims having at least one rehabilitation service for Four Seasons Nursing Center (Four Seasons) for the period January 1 through December 31, 2002. During this period, Four Seasons submitted 394 claims that included at least one rehabilitation service period, for a total of $1,735,939.

Sample Unit: The sample unit consisted of a paid claim that included at least one rehabilitation service.

Sample Design: We used an unrestricted random sample, selecting 100 sample units for this review.

Value of an Error: If the medical review determined that the services recorded on the claim were not medically necessary, properly billed, or adequately supported by medical documentation, those services were disallowed and that portion paid on the claim was considered an overpayment.

Estimation Methodology: We used the Office of Audit Services's statistical sampling software (RAT-STATS) to estimate the overpayment amounts. For claims that were medically unnecessary, inadequately documented, and improperly billed, we reported the estimate of overpayments at the lower limit of the 90-percent, two-sided confidence interval. For the claims that were set aside for Centers for Medicare and Medicaid Services' adjudication, we reported the estimate of overpayments at the point estimate.

Sample Results for Medically Unnecessary, Inadequately Documented, and Improperly Billed Errors

Population	Sample Size	Value of Sample	Number of Errors	Value of Errors
394	100	$484,235.39	78	$236,577.02

Appraisal:

Point Estimate	Lower Limit at the 90% Confidence Interval	Precision at the 90% Confidence Interval
$932,113	$791,530	$140,583

Sample Results for Potential Overpayment Amounts Set Aside

Population	Sample Size	Value of Sample	Number of Potential Errors	Value of Potential Errors
394	100	$484,235.39	18	$22,986.56

Appraisal:

Point Estimate	Lower Limit at the 90% Confidence Interval	Precision at the 90% Confidence Interval
$90,567	$60,720	$29,847

MEDICAL REVIEW DETERMINATIONS FOR THE 100 SAMPLE CLAIMS

A single claim may have multiple Resource Utilization Groups (RUG), and each RUG may cover a different period and correspond to a different payment rate. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently and make individual decisions on each one. The table below summarizes the medical review determinations for the 100 sample claims summarized by RUG. The total number of RUGs for each determination category and a breakdown of the number of RUGs that the reviewers recommended be allowed, paid at a lower RUG level (downcoded), denied, or partially denied and partially downcoded.

Medical Determination	RUGS Allowed	RUGS Downcoded	RUGS Denied	RUGS Partially Downcoded/ Partially Denied
Allowed RUGs	20			
RUGs adjusted for medical necessity errors		81	39	3
RUGs adjusted for documentation errors		1	1	
RUGs adjusted for billing errors		2		
RUGs adjusted for evaluation minutes		18		
Totals	**20**	**102**	**40**	**3**

Detail of RUGs for the 100 Sample Claims

The table below lists detailed information for the 100 sample claims reviewed and the medical reviewers' recommendation for each claim.

Sample Number	Error Categories[1]	Total No. of RUGs	No. of RUGs Allowed	No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Partially Denied/ Partially Downcoded
1	M	2			2	
2	M	1			1	
3	E	1			1	
4	E	1			1	
5	M	1				1
6	M	2		1	1	
7	M	2			2	
8	M	2			2	
9	M	2			2	
10	M	1		1		
11	M	2		2		
12	M	1			1	
13	E	2	1		1	

14	M	2		1	1	
15	M	1		1		
16	E	1			1	
17	M	2		2		
18	M	3		3		
19	M	1			1	
20	M	1		1		
21	M	2			2	
22	A	2	2			
23	A	3	3			
24	M	1			1	
25	M	1			1	
26	E	2	1		1	
27	A	1	1			
28	M	2			2	
29	M	2		2		
30	M	2		2		
31	M	2			2	
32	M	3			3	
33	M	3		3		
34	M	1			1	
35	M	1			1	
36	M,E	3			2(M),1(E)	
37	M	1			1	
38	M	2			2	
39	M	2		2		
40	M	1			1	
41	E	1			1	
42	M	1			1	
43	M	3			3	
44	M	2			2	
45	M	1			1	
46	M	1			1	
47	M,E	3			2(M),1(E)	
48	M,E	3		2(M)	1(E)	
49	M	1			1	
50	M	1		1		
51	B	2	1		1	
52	M	1			1	
53	M	1			1	
54	D,M	2		1(D)	1(M)	
55	M	3	1		2	
56	A	1	1			
57	M	1			1	
58	M	2		2		
59	M	2			2	
60	M	2		1	1	

61	M	2			2	
62	M	1			1	
63	A	1	1			
64	M	1		1		
65	E	1			1	
66	M	3			3	
67	M	2			2	
68	M	1		1		
69	E	1			1	
70	M	2		2		
71	M	2			2	
72	M,E	2			1(M),1(E)	
73	E	1			1	
74	D	1			1	
75	E	2	1		1	
76	M	1		1		
77	E	2	1		1	
78	M	1		1		
79	M	1			1	
80	M	1			1	
81	E	1			1	
82	M	2		1		1
83	M	3			3	
84	A	1	1			
85	E	2	1		1	
86	M	2		2		
87	E	1			1	
88	M	1			1	
89	M	2		1		1
90	M	1			1	
91	M	2			2	
92	M	4	2		2	
93	M	2		2		
94	M	2			2	
95	M	1			1	
96	M	2			2	
97	M	2			2	
98	A	1	1			
99	A	1	1			
100	B	1			1	

[1]**Error Categories:**
- **A** – Allowed
- **M** – Medically unnecessary
- **D** – Inadequate documentation
- **B** – Improper billing
- **E** – Evaluation minutes

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February 16, 2008

Gordon L. Sato,
Regional Inspector General for Audit Services
Lisa Lara, Cheryl Blackmon, Gaye Patrick, John Perkins
Office of the Inspector General Office of Audit Services
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Dallas, Texas 75242

Re: Report Number A-06-07-00046

Dear Mr. Sato and fellow OIG associates:

Four Seasons Nursing Center of Durant, Inc. is grateful to receive the initial report from OIG in regards to the audit of our Skilled Nursing Facility (Report Number A-06-07-00046). Our initial contact from OIG began on August 26, 2004, and we received the initial written response on December 31, 2007. At this time, the audit team requested our response within 30 days; we do greatly appreciate your office for the extension to 60 days. We would like to thank your staff for their professionalism and helpful attitude throughout this entire process. However, in regards to the audit findings, our internal audit team consisting of physical and speech therapists, registered nurse, pharmacist, and CPA have found multiple discrepancies between your reviewers and disagree with your findings.

Four Seasons Nursing Center of Durant, Inc. has always been driven and committed to excellent patient care and excellent patient outcomes. Part of this commitment deals with providing the most comprehensive Physical, Occupational, and Speech Therapy for every patient who requires these services. Over the years, Four Seasons Skilled Facility has built a very strong reputation of providing excellent therapy services. Our facility and its staff have always prided ourselves not only in providing the best care possible to our residents, but also to achieve the best possible compliance record with State and Federal Regulations as evident by our State and Federal survey results. Our patient care, resident and family satisfaction, and our survey results far surpass many facilities in Southeast Oklahoma thus giving us the reputation and trust from our medical community. With this reputation came many referrals from physicians for short-term rehabilitation for their patients who needed in-depth, intensive medical and therapy rehabilitation for a short period of time

(usually less than 60 days), to achieve a higher functional level and increased quality of life. So, Four Seasons Nursing Center of Durant, Inc. became, and is still, a leader in Southeast Oklahoma and surrounding communities for providing excellent intense short-term rehabilitation and meeting the needs of appropriate residents.

In order for Four Seasons Nursing Center of Durant, Inc. to effectively benefit patients and return them to their Prior Level of Function (PLOF), Physical, Occupational, and Speech Therapy must be provided. We are bound by the covenants in the Omnibus Budget Reconciliation Act of 1987 which require extreme "emphasis on a resident's quality of life as well as the quality of care", and "expectations that each resident's ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons".

Southeast Oklahoma has no inpatient rehabilitation hospital. There is no other place to receive intense Rehabilitative care other than a Skilled Nursing Facility. We, at Four Seasons Nursing Center of Durant, Inc. pride ourselves on being the best Skilled Nursing Provider of rehabilitative services in Southeast Oklahoma.

Four Seasons Nursing Center believes in providing our residents with the best care possible and for giving our residents the best chance to reach their highest level of functioning. Our care plan team, consisting of the physician, PT, OT, ST, nurses, Dietician, Social Services, Activities, the family and the resident, meets on a regularly basis to discuss the patient's PLOF, current level of functioning and their goals for care. We also discuss discharge potentials, goals and plans that will best meet the resident's physical, mental, social, and living arrangement needs.

From your review, you stated that Four Seasons Nursing Center of Durant, Inc. was targeted due to the fact that this facility had the highest number of patients in ultra-high rehabilitation RUG category – more than any nursing home in Oklahoma. While this may seem high to the OIG, we *at* Four Seasons Nursing Center of Durant, Inc. focus on each Medicare's recipient's entitlement to have access to the best care possible. Southern Oklahoma (Durant) is a large medical center for multiple surrounding counties/communities. There are no rehabilitation hospitals close and the patients' physicians want to be able to monitor their patients' care. Therefore, Four Seasons Season's obtains a high number of complex post acute hospital stays. In a Rehab Hospital these same patients would be seen for on average four (4) hours per day. With the current SNF Prospective Payment System, Medicare will only reimburse up to 2.4 hours a day of combined Therapy treatment 5 days per week (assuming the patient is being treated at an Ultra High RUGS category). However, the most common RUGS Therapy code used in the United States (and the most profitable) is Rehab High, which is only 1.06 hours of combined Therapy treatment 5 days per week. To expect providers to provide the same amount of quality Rehabilitative care in 1-2 hours a day that was done in four (4) hours a day, is extremely unrealistic.

Your review goes on to state that 127 RUGS are being recommended to be denied (partial or total) or down coded because they were not medically necessary at the level provided at a SNF. Pursuant to 42CFR 409.3 1, Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily. (2) the beneficiary needs care for a condition previously treated in a hospital, and (3) the skilled services, as a practical matter, can be provided only in a SNF on an inpatient basis. Each claim had physician orders to admit the patient to a SNF, each claim had a condition previously treated in a hospital, and each claim could only be treated in a SNF on an inpatient basis. There are no other types of Medical Facilities in Southeast Oklahoma that can handle the medical complexity and the rehabilitation needs of these patients.

The review goes on to quote 42CFR409.44(c) (2) regarding there must be a reasonable expectation that the patient's condition will improve based on the physician's assessment of the beneficiary's restoration potential and unique medical condition. This is not always true.

In fact, **SNF Manual, HCFA Pub. 12 states:**

"Where a patient's full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities. The key issue is whether the skills of a therapist are needed; the deciding factor is not the patient's potential for recover, but whether the services needed the required skills of a therapist or a non skilled worker."

Also, it was discussed that the "amount, frequency and duration of the services must be reasonable." The therapist and the patients' physician collaborated on patient plan of care and the physician by signature validates the discipline and professional level of care needed (unique skills of Physical, Occupational, and Speech Therapists) to assist increasing their functional independence, dignified well being, and quality of life. Also, the amount, frequency and duration of treatment are always specific to the needs of each patient in order to increase the patients function and quality of life. Therefore, the amount, frequency, and duration of Therapy treatments are reasonable and necessary.

This report shows that Four Seasons Nursing Center of Durant, Inc. was treating very sick patients. These patients will not return to prior level of functioning as quickly or easily as patients who have fewer complications. Furthermore, these patients were very progressed in age which adds to recover time and complexity of care. These patients's complex needs require more extensive treatment and medical care than other patients. All of the patients mentioned in this report were evaluated by a licensed Physical, Occupation, or Speech Therapist. Each patient's care was agreed to by their primary care physician not only prior to their care (700), but also one the first of the following treatment months (701's for continued care). In the Physician's and Therapist's professional opinion, each patient was evaluated and given the proper care necessary for their complex situation.

There were functional gains (or safety issues/decline issues) noted on each and every patient that would not have been possible if skilled therapy services were not provided. Given that the residents were entitled to this benefit, the services were medically appropriate, the physician collaborated with nursing and therapy staff for such services, and the physician properly and timely signed for such services. We believe the claims are appropriate and should not be denied. Furthermore, we have had a secondary review of the documentation. This review team consisted of Physical Therapist, Speech Therapist, Pharmacist, Registered Nurse and CPA. Their review found the services provided met Medicare criteria and guidelines and should not be denied. Therefore, we disagree with your findings and ask your office re-consider your initial response.

We thank you in advance for your time and re-evaluation of your audit findings. We look forward to a reasonable and timely resolution.

Respectfully,

Stefanie Stumpff