

**Memorandum**

JAN 31 2001

Date *Michael Mangano*  
From Michael Mangano  
Acting Inspector General

Subject Review of Rehability Health Services, Incorporated's Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998 (A-06-99-00057)

To Michael McMullan  
Acting Principal Deputy Administrator  
Health Care Financing Administration

This memorandum is to alert you to the issuance on January 31, 2001 of our final report, "Review of Rehability Health Services, Incorporated's Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998." A copy of the report is attached. The objective of this audit was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed by Rehability Health Services, Incorporated's (RHS) Rehability Center - Texas in accordance with Medicare eligibility and reimbursement requirements.

Our review of RHS outpatient rehabilitation service claims showed that a significant amount of the services claimed by the provider did not meet Medicare eligibility and reimbursement requirements. Specifically, sampled claims included units of outpatient physical therapy, occupational therapy, or speech pathology services which fiscal intermediary (FI) medical reviewers determined were not reasonable and necessary, authorized by a physician, and/or supported by medical records. There were also sampled claims for which medical records were not located by RHS. These claims were considered errors in accordance with our sampling methodology. As a result, the RHS' Medicare outpatient rehabilitation charges were overstated for the fiscal year ended September 30, 1998. Based on a statistical sample, we estimate that RHS was paid at least \$3,097,201 for services that did not meet Medicare eligibility and reimbursement requirements. We will provide the results of our review to Mutual of Omaha Insurance Company, the FI, so that it can apply the appropriate adjustment during the settlement of RHS' Rehability Center - Texas Fiscal Year 1998 Medicare cost report and recover the overpayment of at least \$3,097,201.

The assets of RHS, a subsidiary of Mariner Post-Acute Network (MPAN), were sold exclusive of Medicare accounts receivable, provider numbers and liabilities. In addition, because RHS operations terminated effective July 1999, MPAN is responsible for Medicare liabilities. In its November 9, 2000 response to our draft report, MPAN stated it did not have a basis to dispute calculations, but it had reviewed a number of the claim determinations and disagreed with the reviewer's conclusions. The MPAN stated it intended

Page 2 - Michael McMullan

to pursue its appeal rights with respect to the denials of individual claims, or services that were included on those claims after our report was finalized. The MPAN also believed additional records had been located, but because it did not know the claims being sought, it did not know if these records included any of the missing claims.

The MPAN's response did not specify which claim determinations it disagreed with, and the reasons or basis for such disagreement. During the course of the audit, the Office of Inspector General provided RHS home office and MPAN officials with sufficient information and a reasonable period of time to locate records associated with sampled claims. We believe that our final audit determinations are valid, and in accordance with Medicare requirements. The basis for our position is further discussed on page 7 of the attached report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, (214) 767-8414.

For information contact:

Gordon Sato

Regional Inspector General

for Audit Services, Region VI

(214) 767-8414

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF REHABILITY HEALTH  
SERVICES, INCORPORATED'S  
OUTPATIENT REHABILITATION  
FACILITY PROGRAM IN TEXAS  
FOR THE FISCAL YEAR ENDED  
SEPTEMBER 30, 1998**



**Inspector General**

**JANUARY 2001  
A-06-99-00057**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

Region VI  
1100 Commerce Street  
Room 6B6  
Dallas, Texas 75242

CIN: A-06-99-00057

Mr. Chris Winkle  
Chairman, President and Chief Executive Officer  
Mariner Post-Acute Network  
One Ravina Drive, Suite 1500  
Atlanta, Georgia 30346

Dear Mr. Winkle:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Rehabilitation Health Services, Incorporated's Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

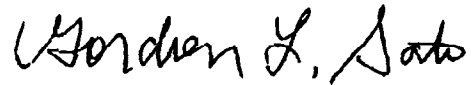
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Page 2 - Mr. Chris Winkle

To facilitate identification, please refer to Common Identification Number A-06-99-00057 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Gordon L. Sato". The signature is written in a cursive style with a large initial "G".

Gordon L. Sato  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Dr. James R. Farris, MD  
Regional Administrator  
Health Care Financing Administration  
1301 Young Street, Room 714  
Dallas, TX 75202

## **EXECUTIVE SUMMARY**

### **Background**

The Medicare program reimburses outpatient rehabilitation facilities (ORF) the lesser of reasonable costs or customary charges associated with providing outpatient physical therapy, occupational therapy, and speech pathology services. Medicare requirements provide that the patient, to be eligible for coverage, must be under the care of a physician and the services must be rendered in accordance with an established treatment plan. These guidelines stipulate that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered only by (or under the supervision of) a skilled therapist.

The Reability Health Services, Incorporated (RHS) operated numerous rehabilitation agencies throughout the nation, including one in Texas, during the fiscal year ended September 30, 1998. Effective July 1999, the assets of RHS, a subsidiary of Mariner Post-Acute Network (MPAN), were sold by MPAN exclusive of Medicare accounts receivable, provider numbers, and liabilities and RHS' operations were terminated nationwide. Thus, MPAN retained responsibility for Medicare liabilities. On January 18, 2000, MPAN and its affiliates (which included RHS) filed for Chapter 11 Bankruptcy.

### **Objective**

The objective of the audit was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed by RHS' Reability Center - Texas in accordance with Medicare eligibility and reimbursement requirements.

In Fiscal Year (FY) 1998, RHS submitted for reimbursement nearly \$8.8 million in charges for outpatient physical therapy, occupational therapy, and speech pathology services provided in Texas. It received reimbursement of \$5.5 million from the Medicare program for the billed services. To determine whether these services met Medicare eligibility and reimbursement requirements, we reviewed a statistical sample of 100 paid claims containing 1,238 units of service that were provided to 99 Medicare beneficiaries during FY 1998. The RHS submitted charges totaling \$116,865 and received reimbursement of \$72,887 (reimbursed charges) from the Medicare program for the 100 sampled claims.

### **Summary of Findings**

Of the 100 claims sampled, 79 claims and supporting medical records were examined by medical reviewers. These 79 claims included 1,022 units of service, totaling \$62,949 in reimbursed charges. Medical reviewers determined that 54 of the 79 claims included 724 units of service, totaling \$45,383 in reimbursed charges, which did not meet Medicare eligibility and

reimbursement requirements. The services on these 54 claims were denied because they were not:

- reasonable and necessary for the patient's condition (48 claims);
- authorized by a physician (2 claims); and/or
- supported by medical record documentation provided (4 claims).

The remaining 21 of 100 claims sampled consisted of 216 units of service (totaling \$9,938 in reimbursed charges) for which RHS did not provide medical records. In accordance with our sampling plan, all sample items not supported by a medical record were disallowed.

Based on these results, we estimate that RHS was paid at least \$3,097,201 for outpatient physical therapy, occupational therapy, and speech pathology services that did not meet Medicare eligibility and reimbursement requirements.

## **RECOMMENDATION**

We recommend that MPAN, which retained responsibility for RHS Medicare liabilities, repay the \$3,097,201 relating to outpatient physical therapy, occupational therapy, and speech pathology services provided by RHS that did not meet Medicare eligibility and reimbursement requirements. We will provide the results of our review to Mutual of Omaha Insurance Company, the Medicare fiscal intermediary (FI), so that the FI can apply the appropriate adjustment during the settlement of RHS' Reability Center - Texas FY 1998 Medicare cost report and recover the overpayment of at least \$3,097,201. Since RHS is no longer in operation, we are not making any recommendations regarding the establishment of controls to ensure compliance with Medicare requirements.

The MPAN did not agree with the claim determinations and intends to appeal the denied claims or services associated with such claims. The MPAN also believed it has now located additional records that may pertain to the 21 missing claims but stated it could not identify the missing claims because it did not know the claims being sought.

The OIG considers the auditee's comments to be an essential part of a report's development and MPAN officials were provided with an opportunity to respond to our findings through the issuance of our draft report and a separate transmittal that provided details on the FI medical reviewer's determinations. However, the MPAN chose not to specify which claims it reviewed, or to comment on why it disagreed with FI medical review determinations on any of the 54 claims denied. With regard to the 21 missing claims, MPAN was provided with listings, throughout the audit, which identified the specific RHS service locations associated with the sampled FY 1998 claims and had a 4-month period during the audit to locate the requested records. Therefore, we continue to believe that our findings and recommendations are valid and

that MPAN was provided with adequate information and more than a reasonable amount of time to locate the requested records. The MPAN's comments are included as APPENDIX B to this report.



## TABLE OF CONTENTS

	Page
INTRODUCTION .....	1
BACKGROUND .....	1
OBJECTIVE, SCOPE, AND METHODOLOGY .....	2
FINDINGS AND RECOMMENDATIONS .....	3
Services Not Reasonable and Necessary .....	3
Services Not Authorized by a Physician .....	5
Lack of Documentation in Medical Records .....	5
Medical Records Not Provided .....	5
CONCLUSION .....	6
RECOMMENDATION .....	6
MPAN COMMENTS AND OIG RESPONSE .....	7
APPENDIX A	
Sampling Methodology and Results	
APPENDIX B	
Auditee's Comments	

---

## INTRODUCTION

---

### BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA).

Section 1861(p) of the Act defines outpatient physical therapy services as "...physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency...to an individual as an outpatient." A rehabilitation agency is defined in section 120 of the HCFA Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (the Manual) as a provider of outpatient physical therapy, occupational therapy, and/or speech pathology services. In recent years, the term "rehabilitation agency" has become synonymous with "outpatient rehabilitation facility" or ORF in the Medicare provider community.

Section 1861 of the Act also includes a provision that the outpatient therapy services may be rendered at a facility (such as an ORF), a physical therapist's office, or an individual's home. Although there is no requirement that services be rendered on the ORF premises, providers must maintain a centralized location with adequate space, equipment, and staff to treat patients.

Medicare covers outpatient physical therapy, occupational therapy, and speech pathology services rendered in an ORF setting. The conditions for coverage of ORF services are outlined in sections 270 through 273 of the Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered only by (or under the supervision of) a skilled therapist.

Medicare requires the ORF to demonstrate that the services were: (1) required for the patient's condition; (2) furnished under a treatment plan that has been reviewed by a physician; and (3) furnished while the patient was under the continuous care of a physician. A patient receiving ORF services must be seen by a physician every 30 days, and documentation of the visit must be maintained in the medical record.

Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the ORF submits a cost report to the Medicare FI for final settlement.

The RHS Reability Center - Texas, which has operated under the same Medicare provider number since 1982, operates multiple extension sites throughout Texas, and is part of a large multi-level national chain organization. Its primary clinic site was in Austin, Texas. During the past few years, RHS has been involved in numerous corporate mergers and reorganizations.

During FY 1998, RHS and its related owners' corporations went through multiple mergers, with the last merger occurring in July 1998, making it a subsidiary of the newly formed parent corporation, MPAN. During April 1999, MPAN officials signed an agreement with HealthSouth to sell the assets of RHS exclusive of Medicare accounts receivable, provider numbers, and liabilities. Thus, MPAN retained responsibility for Medicare liabilities. The sale closed on or about June 30, 1999, and also included the sale of assets for 25 other Medicare ORF providers operating clinics in 18 States across the nation. Effective July 1, 1999, RHS' voluntarily withdrew from participation in the Medicare program. On January 18, 2000, MPAN and its affiliates (which included RHS) filed for Chapter 11 Bankruptcy.

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

The objective of this audit was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services were provided and billed by RHS' Reability Center - Texas in accordance with Medicare eligibility and reimbursement requirements. The audit period covered services provided from October 1, 1997 to September 30, 1998.

To meet the objectives of this audit, we:

- obtained Provider Statistical and Reimbursement (PS&R) data from the FI to establish the universe of RHS Reability Center - Texas paid claims;
- requested supporting medical records from RHS;
- used the FI's medical review personnel to review medical records supporting the sampled claims; and
- used a variable appraisal program to estimate the dollar impact of improper charges in the total population.

We selected a statistical sample of 100 paid claims from a universe of 7,097 claims paid for outpatient physical therapy, occupational therapy, and speech pathology services provided in Texas during FY 1998. The RHS charged Medicare \$8.8 million and received \$5.5 million in reimbursement from the Medicare program for services included in the 7,097 paid claims.

The 100 paid claims contained 1,238 units of service that were provided to 99 Medicare beneficiaries during FY 1998 and RHS submitted charges totaling \$116,865 and received reimbursement of \$72,887 from the Medicare program. For details on our sampling methodology and the results of our sample, see APPENDIX A.

The OIG collected medical records at RHS' administrative home office in Brentwood, Tennessee; commercial storage facilities in Pflugerville, Texas; and at HealthSouth clinic locations in Bonham, Nacogdoches, Houston, Wharton, Austin, Round Rock, Corpus Christi, Kingsville, and Alice, Texas.

The RHS was no longer in operation when our field work was performed, and accounting policy and procedure manuals were not made available to us. The audit objective did not require an understanding or assessment of the internal control structure. Consequently, no evaluation of the internal control structure or internal controls was performed. Our audit was performed in accordance with generally accepted government auditing standards.

---

## FINDINGS AND RECOMMENDATIONS

---

Of the 100 claims sampled, 79 claims and supporting medical records were examined by medical reviewers. These 79 claims included 1,022 units of service, totaling \$62,949 in reimbursed charges. Medical reviewers determined that 54 of the 79 claims included 724 units of service, totaling \$45,383 in reimbursed charges, which did not meet Medicare eligibility and reimbursement requirements. The services on these 54 claims were denied because they were not:

- reasonable and necessary for the patient's condition (48 claims);
- authorized by a physician (2 claims); and/or
- supported by the medical record documentation provided (4 claims).

The remaining 21 of 100 claims sampled consisted of 216 units of service (totaling \$9,938 in reimbursed charges) for which RHS did not provide medical records. In accordance with our sampling plan, all sample items not supported by a medical record were disallowed.

The error categories relating to these claims are discussed in the following sections.

### **Services Not Reasonable and Necessary**

Forty-eight claims, totaling \$48,088 in reimbursed charges, included 682 units of service (totaling \$43,138 in reimbursed charges) which were denied because the services were not reasonable and

necessary for the patient's condition. The FI medical review personnel determined that the services were not reasonable and necessary for the following reasons.

- The patient's medical condition did not require the skills of a therapist (654 units).

For example, RHS billed \$1,792 and received Medicare reimbursement of \$1,093 on 1 claim for 64 units of outpatient physical therapy services rendered during the period from August 3, 1998 to August 31, 1998. The FI medical reviewer noted that the records showed wound care was ordered for the patient 5 days a week while nursing staff performed the treatments on weekends. The skills of a physical therapist were not required as the wound care was in the scope of nursing and could have been provided by the nursing staff 7 days a week. The FI medical reviewer noted that if nursing staff could perform the treatments on Saturday and Sunday they could also do it on Monday through Friday, and that wound care, measuring, and treatments are in the scope of nursing.

In a second example, RHS billed \$232 and received Medicare reimbursement of \$142 on one claim for six units of occupational therapy services rendered from July 6, 1998 to July 8, 1998. The patient, who had been experiencing pain in the thumb, wrist, and forearm since March 1998, wanted to return to a pain-free level of functioning using both hands in lifting and playing golf 10 hours a week. The FI medical reviewer stated that the record showed the patient had been provided with cortizone, therapy exercise, and a splint since March 1998. The FI medical reviewer noted that the patient had received treatment to a point where he/she could lift 20 pounds pain free as of June 1998, and was at a level where the services of a skilled therapist were not needed for the patient to get better.

- The patients had no potential for improvement (21 units).

For example, RHS billed \$1,975 and received Medicare reimbursement of \$1,284 on one claim for eight units of occupational therapy services rendered during the period from November 18, 1997 to November 28, 1997. The FI medical reviewer noted that the patient was "demented" with Alzheimer's disease and would not retain education.

- The patients did not have a loss of functioning or functional limitation (seven units).

For example, RHS billed \$552 and received Medicare reimbursement of \$337 for five units of outpatient physical therapy services rendered from June 22, 1998 to June 30, 1998. The FI medical reviewer noted that the patient had a chronic back problem but had not lost any function due to pain,

continued performing daily living activities, and had written exercises from a previous treatment period for the same condition. The FI medical reviewer noted that there was “No loss of function to warrant the skills of a therapist....”

### **Services Not Authorized by a Physician**

Two claims, totaling \$612 in reimbursed charges, included five units of service (totaling \$177 in reimbursed charges) which were denied because the services were not authorized by a physician. The FI medical review personnel determined that the:

- services claimed were not included in the plan of care (three units); or
- the physician’s order was not followed (two units).

For example, on one claim RHS billed \$150 and received Medicare reimbursement of \$92 for three units of occupational therapy services rendered during the period from August 25, 1998 to August 31, 1998. The therapy was provided for the development of cognitive skills to improve memory. These services were not part of the plan of care (POC) established by the physician. The FI medical reviewer noted that there were “No modalities found on POC for this service.”

### **Lack of Documentation in Medical Records**

Four claims, totaling \$2,068 in reimbursed charges, consisted of 37 units of service which were denied because the services were not supported by documentation in the medical records. The medical review disclosed that:

- medical records did not document that the billed services were provided (32 units); and
- a medical record was missing an occupational therapy evaluation that was needed to support the necessity of the services provided (5 units).

For example, on one claim RHS billed \$715 and received Medicare reimbursement of \$436 for 16 units of outpatient physical therapy for which there was no documentation in the medical record to support that the services were rendered on the billed dates of service. The billing indicated that the services were rendered from September 3, 1998 to September 23, 1998.

### **Medical Records Not Provided**

Twenty-one claims, totaling \$9,938 in reimbursed charges, consisted of 216 units of service which were disallowed because RHS did not provide medical records that related to the claimed services. Due to the quick shutdown of RHS’ operations, and haste in storing records without detailed

cataloguing, home office and MPAN officials were not certain where all of the RHS records were located.

Shortly after an agreement was reached to sell its assets to HealthSouth, RHS began moving medical records to various facilities including: (1) the home office in Brentwood, Tennessee; and (2) commercial storage facilities in Atlanta, Georgia, and Pflugerville, Texas. Some of the medical records that were filed in the clinics at the time of the sale were kept by HealthSouth. We searched these clinics and facilities with the exception of the Atlanta facility. An MPAN official searched for the records in Atlanta and made them available in Brentwood. HealthSouth employees provided information during on-site visits indicating that 4 of the 21 missing records were located in a Corpus Christi storage facility used by RHS, but MPAN officials did not make the records available after being notified of their location. In accordance with our sampling plan, all sample items not supported by a medical record were disallowed.

## **CONCLUSION**

For FY 1998, the Medicare program paid RHS \$5.5 million for charges submitted for outpatient physical therapy, occupational therapy, and speech pathology services provided in Texas. Our audit of 100 statistically selected claims, totaling \$72,887 in reimbursed charges, disclosed that \$55,321 should not have been reimbursed to RHS for 940 units of services that did not meet Medicare eligibility and reimbursement requirements. We projected the results of the statistical sample over the population using standard statistical methods described at APPENDIX A. We estimate that RHS was paid at least \$3,097,201 for outpatient physical therapy, occupational therapy, and speech pathology services that did not meet the Medicare eligibility and reimbursement requirements.

The assets of RHS, a subsidiary of MPAN, were sold exclusive of Medicare accounts receivable, provider numbers, and liabilities. In addition, because RHS operations terminated effective July 1999, MPAN is responsible for Medicare liabilities.

## **RECOMMENDATION**

We recommend that MPAN, which retained responsibility for RHS Medicare liabilities, repay the \$3,097,201 relating to outpatient physical therapy, occupational therapy, and speech pathology services provided by RHS' that did not meet Medicare eligibility and reimbursement requirements. We will provide the results of our review to the FI so that the FI can apply the appropriate adjustment during the settlement of RHS' Rehabilitation Center - Texas FY 1998 Medicare cost report and recover the overpayment of at least \$3,097,201.

Since RHS is no longer in operation, we are not making any recommendations regarding the establishment of controls to ensure that charges for outpatient physical therapy, occupational therapy, and speech pathology services are covered and properly documented in accordance with Medicare requirements.

## **MPAN COMMENTS AND OIG RESPONSE**

### **MPAN Comments**

The MPAN stated it did not have a basis to dispute calculations of the projected overpayments, but it had reviewed a number of the claim determinations and disagreed with the reviewer's conclusions. The MPAN stated it intended to pursue its appeal rights with respect to the denials of individual claims or services that were included on those claims after our report was finalized. The MPAN also believed it had located additional records, but because it did not know the claims being sought it did not know if these records included any of the missing claims.

### **OIG Response**

The OIG considers the auditee's comments to be an essential part of a report's development. As such, we provided MPAN officials with an opportunity to respond to our findings through the issuance of our draft report and provided details on the FI's medical review determinations with respect to medically reviewed claims. However, MPAN chose not to specify which of the 54 denied claims it examined, or to comment on why it disagreed with any of the FI's medical review determinations. With regard to the 21 missing claims, RHS home office and MPAN officials were provided with: (1) a listing, at the beginning of the audit, which identified the specific RHS clinic and nursing home service locations associated with the sampled FY 1998 claims; and (2) a 4-month period during the audit to locate these requested records. During the audit, OIG made every effort to assist MPAN in locating requested records. The MPAN was informed of the RHS service locations which related to the sampled claims for which medical records had not been located. The OIG emphasized that the bulk of records relating to these locations had not been made available for review. The MPAN's comments did not state that the additional records located included FY 1998 medical records and records related to the disclosed RHS service locations associated with the missing claims. Therefore, we continue to believe that our findings and recommendations are valid, and that MPAN was provided with adequate information about the requested records and with more than a reasonable amount of time to locate such records.

The data supporting our recommendations will be provided to the FI which is responsible for adjudicating claims determined to be in error. The MPAN is entitled by law and regulations to specified appeals.

This final report includes our findings and recommendations as well as MPAN's comments. In accordance with OIG policy, the final report is made available to the public through our internet site. The statutory or regulatory support for publishing a report on the internet is the Electronic Freedom of Information Act Amendments of 1996 [Public Law 104-231].



## **SAMPLING METHODOLOGY AND RESULTS**

### **OBJECTIVE**

The objective of this review was to determine whether outpatient physical therapy, occupational therapy, and speech pathology services provided and billed by RHS Rehabilitation Center - Texas were in accordance with Medicare eligibility and reimbursement requirements.

### **POPULATION**

We used the population of claims paid for outpatient physical therapy, speech pathology, and occupational therapy billed for services rendered in FY 1998. The population consisted of 7,097 paid claims with a total gross reimbursement of \$7,264,860.05 for revenue codes 420 to 444. The Medicare net reimbursements totaled \$5,488,531.88.

The PS&R summary and payment reconciliation reports were provided by the FI. The summary, which showed there were 7,097 paid claims, was reconciled to the payment reconciliation report which listed the detail transactions. The detail transactions were numbered sequentially with the exception that claims and adjustments that did not result in a Medicare payment were not numbered as they were not part of the 7,097 in paid claims.

### **SAMPLE UNIT**

The sample unit was a paid claim for outpatient physical therapy, occupational therapy, and/or speech pathology services rendered to a Medicare beneficiary. A paid claim includes multiple units of therapy services claimed by RHS for the period of time covered by the claim.

### **SAMPLE DESIGN**

A simple random sample of paid claims was used.

### **SAMPLE SIZE**

The sample size was 100 paid claims.

### **ESTIMATION METHODOLOGY**

Using the OAS Statistical Software Variable Appraisal Program, we projected the amount of Medicare reimbursement for outpatient rehabilitation claims paid to RHS for services that did not meet the Medicare eligibility and reimbursement requirements.

## RESULTS OF SAMPLE

### For Overpayments by the Medicare Program:

Sample Size	Value <sup>1</sup> of Sample	Number of Errors	Value <sup>2</sup> of Errors	Units <sup>3</sup> of Service	Units of Error
100	\$72,886.66	75	\$55,321.18	1,238	940

## VARIABLE PROJECTION

### For Overpayments by the Medicare Program:

Point Estimate: \$3,926,144

At the 90 % Confidence Level:

**Lower Limit: \$3,097,201**

Upper Limit \$4,755,087

---

<sup>1</sup>The value equals the Medicare net reimbursement for the 100 sampled items.

<sup>2</sup>The value equals the Medicare net reimbursement for the 940 units in error. The RHS charges billed for these units totaled \$88,587.

<sup>3</sup>There were 1,022 units of service reviewed by medical review personnel and 216 units that were not medically reviewed because RHS did not provide the patient's records.



**Gary W. Reicherzer**  
**Vice President of Reimbursement**

November 9, 2000

**UPS PRIORITY OVERNIGHT**

Mr. Donald L Dille  
Regional Inspector General  
Office of Audit Services  
Department of Health & Human Services  
1100 Commerce - Room 6B6  
Dallas, Texas 75242

**RE: CIN A-06-99-00057**

Dear Mr. Dille:

We have reviewed the draft audit report on the Department's review of Rehability Health Services' Texas operations for its Outpatient Rehabilitation Facility program for the year ended September 30, 1998. The draft report presents the findings of the Department with respect to services that were provided to Medicare beneficiaries and that were billed to Medicare Part B.

The report concludes that a large number of claims included billing for services that either were not reasonable and necessary (48), were not authorized by a physician (2) or were not supported by the medical record documentation (4). The report also includes narrative descriptions of examples of the types of determinations as well as calculations of the projected overpayment.

In addition to the determinations on claims that were reviewed, the auditors did not locate 21 claims. We believe that we have now located additional records in storage in Atlanta; however, not knowing the claims that are being sought, we do not know if these include any of the missing claims.

At this time we do not have a basis to dispute the calculations; however, we have reviewed a number of the claim determinations and disagree with the reviewer's conclusions. After the report is finalized it is our intention to pursue our appeal rights with respect to the denials of individual claims or services that were included on those claims.

Very truly yours,

A handwritten signature in black ink that reads "Gary W. Reicherzer".

Gary W. Reicherzer  
Vice President of Reimbursement

CTNA069900057\_NOV 10 2000/vst

**CC: Sonia Feist**