Brickell Federal Building
909 SE 1st Avenue, Suite 732
Miami, Florida 33131
(305) 536-6540 FAX (305) 536-6787

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

101 Marietta Tower, Suite 701
Atlanta, Georgia 30323
(404) 331-2329 FAX (404) 331-0104

★ ★ ★ **OPERATION RESTORE TRUST** ★ ★ ★

February 7, 1997

Ms. Terri Ginnetti, Benefits Integrity Unit
Aetna Life Insurance, Co.
25400 US 19 N., Suite 135
Clearwater, FL 34623-2193

Dear Ms. Ginnetti:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Rosemont Health Care Center (Medicare provider number 10-5480), a skilled nursing facility located in Orlando, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from ~~November~~ JANUARY 1, 1994 through December 31, 1994.

The ORT reviewers questioned $55,306 in charges reported for the 14 sample beneficiaries in our study. This amount comprises $55,202 related to Physical, Occupational, Speech, and Respiratory therapy services that were determined to be not reasonable or medically unnecessary and in uncovered or undocumented laboratory and supply charges. Therefore, we are recommending an adjustment of the above charges.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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February 7, 1997

Mr. Marshall Kelley, Director
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Mr. Kelley;

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Rosemont Health Care Center (Medicare provider number 10-5480), a skilled nursing facility located in Orlando, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1, 1994 through December 31, 1994.

The ORT reviewers questioned $55,306 in uncovered charges reported fro the 14 sample beneficiaries in our study and we are recommending an adjustment of the above charges. In addition we request that the State Agency implement certain corrective action by this facility.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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I. EXECUTIVE SUMMARY

This report provides the results of our Operation Restore Trust (ORT) survey of Rosemont Health Care Center (Rosemont), a skilled nursing facility (SNF) in Orlando, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Part A Fiscal Intermediary (FI) and Part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. For these services to be allowable they must be:

- o considered a specific and effective treatment for the patient's condition;
- o prescribed under the assumption that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician;
- o reasonable in amount, frequency, and duration; and
- o fully supported by the patient medical records.

A team comprising a Florida State Agency for Health Care Administration (State Agency) nurse surveyor, a Regional Health Care Administration (HCFA) nurse consultant, and an Office of Inspector General (OIG) Office of Audit Services auditor conducted an unannounced focused survey at Rosemont. The members of the team evaluated the services for 14 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994. This period coincided with the SNF's Medicare Fiscal Year 1994 (FY 1994).

We found $55,306 in charges reported by the SNF that did not meet Medicare reimbursement guidelines as stated above. The disallowed costs consist of $55,202 of occupational, physical, speech, and respiratory therapy services which were not reasonable or medically necessary, and $104 of laboratory tests and medical supplies which were either not medically necessary or undocumented.

The therapy overcharges of $55,202 occurred because the SNF prescribed therapy services to all its residents upon admission and re-admission without specific medical indications for such services. We are recommending that the Intermediary make an adjustment of $55,306 from the charges reported by the SNF on its FY 1994 cost report and that the State Agency take corrective action to ensure that this facility provides therapy services based upon the medical needs of the patient.

REGION IV OPERATION RESTORE TRUST PILOT

FOCUSED REVIEW OF A SKILLED NURSING FACILITY

II. BACKGROUND

The Secretary of the Department of Health and Human Services and the President initiated Project ORT. This innovative, collaborative project was designed to address growing concerns over rising health care costs. A review of departmental records indicate that over the last 10 years, the following segments of the health care industry have experienced a surge in health care fraud:

- o home health,
- o nursing homes,
- o hospice, and
- o durable medical equipment.

Departmental records further disclosed that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds paid to the above health care segments. As a result, these States and the above health care segments were chosen as targets of the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified through investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) has identified certain SNFs in Florida as aberrant according to their billings. The method used to identify these providers was to evaluate the universe of SNF admissions in each state during CY 1994. Data for all SNF claims was summarized first by beneficiary, and then by SNF. Key statistical data included total claims per beneficiary, allowed dollars per stay, line items or services per number of beneficiaries, average dollars and claims per stay, and average dollars per day. BDMS generated a listing of SNFs with high reimbursement amounts per day and per stay. The listing of SNFs was manually scanned and 14 were judgmentally selected based on total highest reimbursement.

In addition to these 14 SNFs, we requested the two principal fiscal intermediaries in Florida (Aetna and Blue Cross) to each identify 3 SNFs for inclusion in this project based upon their data, complaints, and experience with SNF providers.

Rosemont Health Care Center (formerly American Transitional Care) was one of the 14 SNFs judmentally selected for review. This SNF with 120 beds, 33 of which were Medicare certified, has participated in the Medicare program since November 11, 1984, It was selected for the survey based upon its high therapy costs, high average length of stay by the residents, high cost per stay, and high cost per day.

III. SCOPE OF REVIEW

The survey was conducted by a team comprising a nurse surveyor from the State Agency, a nurse consultant from HCFA , and an auditor from the OIG Office of Audit Services. This HCFA directed survey was conducted using HCFA's review protocols rather than the OIG's policies and procedures. Accordingly, the OIG's work was in compliance with generally accepted government auditing standards only in relation to the quantification of the unallowable services identified by other members of the team.

The objective of the survey was to determine whether charges other than room and board, billed to the Intermediary and Carrier, were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. Primarily, we wanted to determine whether unnecessary care was provided to the 14 beneficiaries in our sample, for whom Rosemont billed Medicare $546,701 during the period January 1, 1994 through December 31, 1994, the facility's Medicare fiscal period.

The approach used was to identify all services billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 14 beneficiaries in our sample during their stay at Rosemont between January 1994 and December 1994. This approach was adopted because many providers, other than Rosemont bill separately for services to the SNF patients, e.g., podiatrists, portable x-ray suppliers, therapy providers and DME suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely, if ever associated with each other or the SNF's bills.

Using the team concept, the State Agency and HCFA nurses identified Medicare funded services which were either not reasonable or necessary, and the OIG auditor quantified the charges associated with the services. The beneficiaries' medical records and related documentation were reviewed to determine the medical necessity of charged services; specifically, were the services: (i) recorded in the medical records, (ii) ordered by a physician, (iii) rendered by qualified personnel, and (iv) appropriate considering the physicians' diagnosis and the residents' physical/mental condition. The SNF's accounting records and supporting documentation were reviewed to determine: (i) the bases for charges reported to Medicare, and (ii) the amount of charges associated with questioned services.

Field work was performed at the SNF's offices in Orlando, Florida during the period May 6 through May 10,1996.

IV. FINDINGS AND RECOMMENDATIONS

The review of the 14 beneficiaries included in our survey consisted of a retrospective analysis of their payment history for rehabilitative services under Part A and services provided under Part B while residents of the facility. It is questionable if these beneficiaries met the criteria for rehabilitative services. Our evaluation of the medical records for the 14 beneficiaries resulted in disallowance of $55,306 in charges reported by Rosemont in its FY 1994 Medicare Cost Report. The amount disallowed includes $55,202 of therapy services which were not reasonable or medically necessary and $104 of other charges which were either not medically necessary or undocumented. We are recommending that the Intermediary adjust the questioned charges.

QUESTIONED CHARGES

THERAPIES:	
Occupational	$29,640
Physical	15,528
Speech	9,360
Respiratory	674
Subtotal	$55,202
Laboratory	42
Supplies	62
Total	$55,306

OCCUPATIONAL, PHYSICAL, SPEECH AND RESPIRATORY THERAPY SERVICES

We questioned $55,202 of occupational (OT), physical (PT), speech (ST) and respiratory therapy (RT) services provided 5 of the 14 aberrant beneficiaries included in our sample. Under paragraph 1861(h)(3) of the Social Security Act, these services are covered under Medicare Part A when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist. The Medicare Intermediary Manual at paragraph 3132 (MIM 3132) states that the ordered therapies provided in a SNF must be reasonable and necessary for the treatment of the beneficiary's illness or injury. The questioned charges did not meet the reimbursement criteria.

FINDING #1

Occupational Therapy Services

We questioned the medical necessity of $29,640 of OTprovided 4 of the 14 aberrant beneficiaries, or 12% of the $250,328 that Rosemont was reimbursed for OT during the period of our review. In order to be covered under Medicare Part A such services must be prescribed by a physician, be performed by a qualified therapist, and be reasonable and necessary for the treatment of the individual's illness or injury. OT designed to improve function is considered reasonable and necessary only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. We do not believe a basis existed for an expectation that the OT services provided would significantly improve the four residents' level of functioning. The following information provides the bases for this

conclusion.

- o Therapy goal was to increase endurance and strengthen muscles. The resident's disease and medication prevented the attainment of this goal.

- o Therapy not medically necessary due to cognitive deficits and non-compliance of the resident.

- o Therapy duplicated administered PT and it could have been accomplished by the facility's nursing staff.

- o Therapy was not medically necessary due to decline in resident's medical conditions and cognitive status.

The therapeutic services provided the above residents should have been accomplished by the facility's nursing staff.

RECOMMENDATIONS

We recommend that the Intermediary adjust the $29,640 from OT charges reported by the SNF on its FY 1994 cost report.

We recommend that the State Agency should ensure that OT services provided by this facility are appropriately provided based upon the medical needs of the patient.

FINDING # 2

Physical Therapy Services

We questioned the medical necessity of $15,528 of PT provided 5 of the 14 aberrant beneficiaries, or 17% of the $92,424 that Rosemont was reimbursed for PT during the period of our review. In order to be covered under Medicare Part A, PT services must relate directly and specifically to an active written treatment regimen established by the physician or by the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (MIM 3101.8). To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition.

- o There must be an expectation that the patient's condition will improve significantly in a

reasonable period of time based on the assessment made by the physician.

- The amount, frequency, and duration of the services must be reasonable.

The following information provides the bases for our questioning the PT services.

- Therapy was continued after resident was discharged to restorative nursing care.
- Therapy was continued after resident's cognitive status became very limited. The medical records show she became non-verbal and non-self initiating in daily living skills.
- The side effect of medication being taken by one resident included muscle weakness, loss of muscle mass and osteoporosis. The PT evaluation did not indicate that the therapists were aware of the resident's bone cancer, his use of steroid drugs, and the side effects of the drugs.
- Therapy primarily consisted of bandage wraps and measurements.
- Therapy was continued after resident attained established goals.

The routine therapeutic services provided the above residents should have been accomplished by the facility's nursing staff.

RECOMMENDATIONS

We recommend that the Intermediary adjust the $15,528 from PT charges reported by the SNF on its FY 1994 cost report.

We recommend that the State Agency ensure that the PT services at this facility are appropriately provided and based upon the medical needs of the patient.

FINDING #3

Speech Therapy Services

We questioned the medical necessity of $9,360 of ST provided 2 of the 14 aberrant beneficiaries, or 12% of the $80,184 that Rosemont was reimbursed for ST during the period our review. Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must be related directly and specifically to a written treatment regimen established by the physician (or speech pathologist providing the services). The services must be reasonable and necessary to the treatment of the

individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition.
- o The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist.
- o There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.
- o The amount, frequency, and duration of the services must be reasonable.

Our review of the residents' records showed the ST services were not medically necessary. Additionally, the provision of services to one of the two residents was not documented in the records.

RECOMMENDATION

We recommend that the Intermediary adjust the $9,360 from ST charges reported by the SNF on its FY 1994 cost report.

FINDING #4

Respiratory Therapy Services

We questioned $674 of RT services provided 3 of the 14 aberrant beneficiaries, or 2% of the $30,798 that Rosemont was reimbursed for RT during the period of our review. These services are reimbursable under Medicare Part A if furnished by a transfer hospital or by a nurse on the staff of the skilled nursing facility. The services are considered medically necessary and reasonable if they meet the following criteria.

- o Consistent with the nature and severity of the individuals's complaints and diagnosis,
- o Reasonable in terms of modality, amount, frequency, and duration of the treatments, and
- o Generally accepted by the professional community as being safe and effective treatment for the purpose used.

Our review of the residents' records showed the documented RT services could have been provided by the facility's nursing staff. Additionally, the provision of services to one of the three residents was not documented in the records.

RECOMMENDATION

We recommend that the Intermediary adjust the $674 from RT charges reported by the SNF on its FY 1994 cost report.

FINDING #5

Laboratory Services & Supply Services

We questioned $104 of laboratory and supply charges, or 75% of the $674 that Rosemont was reimbursed for laboratory and supply services during the period of our review.

RECOMMENDATIONS

We recommend that the Intermediary should:

- Adjust the $104 from laboratory and supply charges reported to the SNF on its FY 1994 cost report.

- Conduct a focused review of all laboratory and supply services provided at Rosemont Health Care Center during the period of our review.