DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

MAR 21 1997

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

Mr. C. Norman Moore, Manager
Medicare Audit and Reimbursement
4507 N. Sterling Avenue, 3rd Floor
Peoria, Illinois 61615-3800

Dear Mr. Moore:

The enclosed report and recommendation for adjustment of charges provides the results of the Operation Restore Trust (ORT) audit of Integrated Health Services, Inc. (Medicare provider number 14-5211), a skilled nursing facility (SNF) located in Burbank, Illinois. The primary objective of the audit 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 1995 through March 31, 1996.

The ORT team questioned $148,955 of the $1,305,163 in Medicare charges reported for the 40 sample beneficiaries in our audit. This amount is comprised of $60,908 of charges for which the SNF could not produce adequate supporting documentation, $55,533 for services which were not reasonable or necessary, and $32,514 of services which are specifically unallowable.

We are recommending an adjustment of the above charges. In addition, we request that a focused review of all rehab therapies and the physician orders for these therapies be conducted by the Fiscal Intermediary in order to recoup overpayments made to this SNF and to implement corrective action by the facility.

To aid in your adjustments, we have enclosed the details of our basis for recommending adjustments of charges. Following your review of the report, please prepare and submit to the Health Care Financing Administration, Chicago Region V office, a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within 30 days of receipt of this letter.

If there are any questions regarding this report, please call Roy Wainscott at 404-331-2446 extension 106.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures

cc:
HCFA Region V

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

AUDIT OF INTEGRATED HEALTH SERVICES, INC. SKILLED NURSING FACILITY BURBANK, ILLINOIS

JUNE GIBBS BROWN
Inspector General

MARCH 1997
A-04-96-01148

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OPERATION RESTORE TRUST
AUDIT OF INTEGRATED HEALTH SERVICES
BURBANK, ILLINOIS

I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust (ORT) audit of Integrated Health Services (IHS) at Brentwood, a skilled nursing facility (SNF), in Burbank, Illinois. The objective of the review was to determine whether charges billed to the Medicare Fiscal Intermediary (Intermediary) were allowable.

We determined that $148,955 of charges were unallowable because IHS did not have an effective system of administrative internal controls.

For the charges to be allowable, they must be for services:

- considered a specific and effective treatment for the patient's condition;
- 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;
- reasonable in amount, frequency and duration; and
- fully supported by the patient's medical records.

The unannounced audit was conducted by a team comprised of two Office of Inspector General (OIG), Office of Audit Services auditors and two Health Care Financing Administration (HCFA) nurse-consultants.

The team determined the allowability of amounts charged for services provided to 40 beneficiaries during the period January 1995 through March 1996. Based on the audit results, we questioned $148,955 of $1,305,163 in Medicare charges reported by the SNF. The $148,955 in charges did not meet Medicare reimbursement guidelines for allowability as stated above for 38 of the 40 beneficiaries in our sample. The amount questioned consists of $60,908 of charges for which the SNF could not produce adequate supporting documentation, $55,533 for services which were not reasonable or medically necessary, and $32,514 of services which are specifically unallowable. (See Appendix A)

We are recommending that the Intermediary:

- remove $148,955 of charges from the SNF's Medicare cost report;

- o direct the SNF to implement a Corporate Compliance Policy which includes effective administrative internal controls which would ensure future compliance with pre-admission, level-of-care, billing and supporting documentation criteria.

II. BACKGROUND

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

- o home health agencies
- o nursing homes
- o durable medical equipment

Departmental records further disclosed that the States of California, Florida, Illinois, New York and Texas annually receive approximately 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, the ORT project 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.

The HCFA Bureau of Data Management and Strategies (BDMS) has identified certain SNFs in targeted ORT States 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 Calendar Year 1994. Data for all SNF claims was summarized first by SNF and then by beneficiary. Key beneficiary statistics 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. The BDMS generated a listing of the facilities with high reimbursement amounts per day and per stay. The final listing of SNF providers within each of the five targeted States was manually scanned and the SNF with the highest reimbursement and with any type of chain affiliation was selected for review. In Illinois, Integrated Health Services at Brentwood was the SNF chosen for audit.

III. SCOPE OF REVIEW

The audit was conducted by a team comprised of two nurse consultants from the regional HCFA and two auditors from the OIG Office of Audit Services. The individuals who participated in this audit are shown on Appendix B.

The SNF was selected for audit based upon its high therapy costs, average length of stay by residents, cost per stay and cost per day.

The objective of the review was to identify and quantify charges associated with unnecessary care (over-utilization) and to identify any abusive practices. We determined the allowability of SNF reported charges for the following services:

- room and board
- physical therapy
- occupational therapy
- respiratory therapy
- speech therapy
- telemetry/EKG
- radiology
- drugs
- laboratory services

We reviewed documentation relating to Medicare-funded services provided to 40 residents of the facility during the January 1995 through March 1996 audit period. Our review included an analysis of charges made to Medicare for services provided to residents of the facility. We also reviewed the financial agreements related to the Medicare reimbursement of these services.

The HCFA nurses identified services which were (i) not reasonable or necessary, (ii) not supported in the medical records or (iii) not allowable. The auditors quantified the charges associated with the questioned services.

The audit was performed in accordance with generally accepted government auditing standards. Fieldwork was performed in Burbank, Illinois and Atlanta, Georgia from October 1996 to February 1997.

IV. FINDINGS AND RECOMMENDATIONS

Our review disclosed that $148,955 of $1,305,163 in reported Medicare charges for the 40 beneficiaries in our sample did not meet Medicare reimbursement guidelines established by HCFA. Because the SNF had not established an effective system of administrative internal controls, charges were reported for services that were undocumented ($60,908),

not medically necessary (55,533), and specifically unallowable ($32,514). The specific services that comprise these amounts are illustrated in Appendix A. The details of our findings and applicable recommendations follow.

UNDOCUMENTED SERVICES

Our review showed that $60,908 of charges were claimed for reimbursement without the required supporting documentation. The Skilled Nursing Facility Manual (SNFM) Section 545.1 (a) and (c) requires the SNF to maintain documentation necessary to support its reported charges; i.e., UB-92 billing statements and any other billing forms, supporting documents and forms, charge slips, daily patient census records and other business and accounting records applicable to specific claims.

We reviewed the medical records for 40 beneficiaries to determine whether there was supporting documentation for the services claimed. Our review showed that of the $1,305,163 in costs claimed for these beneficiaries, $60,908 were not supported as required by HCFA. Our review showed that $44,195 of physical, occupational, speech and respiratory therapies were not documented in the beneficiaries' medical records. We also determined that $16,713 of other costs were claimed without supporting documentation.

Had the SNF had an effective system of administrative internal controls, it could have prevented claims being made for services which were not documented.

We are recommending that the Intermediary:

- remove the $60,908 of questioned charges from the SNF's Medicare cost report.

- instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for services not documented.

MEDICAL NECESSITY

Our review disclosed that the SNF claimed reimbursement for $55,533 of services that were determined to not be reasonable or necessary. The SNFM (280.1) provides that items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

We reviewed the medical records for 40 beneficiaries to determine whether the services were reasonable and necessary. Our review showed that, of the $1,305,163 in costs claimed for these beneficiaries, $55,533 were either not reasonable or necessary.

Illustrative examples of medical records data upon which the nurse-consultants based their conclusions:

- o A beneficiary was being provided skilled physical therapy when the medical records showed that only routine physical services were necessary. The nurse-consultant determined the skilled level of physical therapy was not reasonable or necessary.

- o A beneficiary being given occupational therapy when that beneficiary had a primary diagnosis of colitis with pneumonia. This beneficiary was too ill to benefit from occupational therapy. The nurse consultant determined that the occupational therapy was not reasonable or necessary.

In total, we determined that $54,390 of occupational, physical and speech therapy were claimed when medical data showed it was not necessary. We also determined that $1,143 of other costs were not reasonable or necessary.

Had the SNF had an effective system of administrative internal controls it could have prevented claims being made for services which were not reasonable or necessary.

We recommend that the Intermediary:

- o remove the $55,533 of questioned charges from the SNF's Medicare cost report.

- o instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for services that are not reasonable or necessary.

UNALLOWABLE SERVICES

Our review showed that $32,514 of charges were claimed for reimbursement of costs which are specifically unallowable pursuant to the HCFA SNFM Sections 230.10 C.2 and 541. The SNFM contains specific requirements which regulate the provision of SNF services, including therapies.

We reviewed the medical records for 40 beneficiaries to determine whether any services were specifically unallowable. Our review showed that, of the $1,305,163 in costs claimed for these beneficiaries, $32,514 were not allowable.

Laboratory

Our review disclosed $30,095 in laboratory charges which did not meet reimbursement guidelines. In a July 19, 1993 memorandum, HCFA clarified Section 541 of the SNFM by stating:

> The SNF cannot bill under Part A for services obtained from an independent laboratory even if the SNF inpatient is covered under Part A.

Our review disclosed that laboratory services were provided by Smithkline Beecham; yet, the SNF billed Medicare for the services. We questioned $30,095 in laboratory charges for the 40 beneficiaries reviewed.

Respiratory Therapy Services

Our review disclosed that $1,840 of unallowable respiratory therapy charges had been made for the 40 beneficiaries. The use of oxygen concentrators for respiratory therapy is considered a routine service in the SNF under HCFA Provider Reimbursement Manual Section 2203.1. Since these charges were in addition to the routine service rate, we questioned $1,840 in charges made for the use of oxygen concentrators.

Drugs

Our review disclosed that $579 of unallowable drug charges had been made for the 40 beneficiaries. To reduce the potential impact of unusual or inconsistent charging practices, certain items and services are always considered routine in a SNF for purposes of Medicare cost apportionment. Nonlegend (nonprescription) drugs are included as an example in the listing of such routine items. (Paragraph 2203.1 of Part 1 to the HCFA Provider Reimbursement Manual) We questioned $579 in charges that were for nonlegend drugs.

Had the SNF had an effective system of administrative internal controls, it could have prevented claims being made for services which were unallowable.

We are recommending that the Intermediary:

- remove the $32,514 of questioned charges due to unallowable respiratory, drug, and laboratory charges from the SNF's Medicare cost report.

- instruct the SNF to initiate a Corporate Compliance Policy that includes administrative internal controls to preclude claiming reimbursement for unallowable services.

OPERATION RESTORE TRUST
AUDIT OF INTEGRATED HEALTH SYSTEMS
BURBANK, ILLINOIS

RECOMMENDED ADJUSTMENT OF CHARGES

SERVICE	TOTAL QUESTIONED	UNSUPPORTED SERVICES	MEDICAL NECESSITY	UNALLOWABLE SERVICES
EKG	8,350	8,000	350	0
Occupational Therapy	35,750	7,350	28,400	0
Physical Therapy	31,625	15,835	15,790	0
Speech Therapy	27,250	17,050	10,200	0
Respiratory Therapy	6,593	3,960	793	1,840
Drugs	9,292	8,713	0	579
Laboratory	30,095	0	0	30,095
TOTAL	148,955	60,908	55,533	32,514

MAJOR CONTRIBUTORS TO THIS REPORT

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