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**OFFICE OF
INSPECTOR GENERAL**

**Physical And Occupational Therapy in Nursing Homes
Medical Necessity and Quality of Care**



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Inspector General**

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EXECUTIVE SUMMARY

PURPOSE

To determine the medical necessity and quality of care of physical and occupational therapy rendered to Medicare patients in skilled nursing facilities.

BACKGROUND

All skilled nursing facilities must meet the requirements of Section 1819 of the Medicare law. The facilities must, for example, (1) provide 24-hour skilled nursing service; (2) develop treatment plans for each patient from a physician's order; (3) maintain clinical records on all patients; and (4) meet a number of conditions to assure patients' health and safety. Most skilled nursing facilities also provide custodial care.

Medicare coverage guidelines state that all therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. Policies developed by the Health Care Financing Administration, the federal agency that administers the Medicare program, require that therapy be ordered by a physician, require the skills of a qualified therapist, and be dictated by a written treatment plan. The treatment plan must include specific and measurable functional goals and a reasonable estimate of when those goals will be attained. It should describe specific therapeutic services, the frequency of visits, and the duration of therapy.

We conducted on-site medical review at a random sample of 24 skilled nursing facilities nationwide. Several teams of physical and occupational therapists reviewed the March 1998 medical records of a national random sample of 218 Medicare patients. The medical reviewers determined the medical necessity of the therapy provided to the sampled patients before the implementation of the prospective payment system for skilled nursing facilities which began on July 1, 1998.

FINDINGS

Most skilled nursing facility patients were appropriate candidates for physical and occupational therapy, and they benefitted from therapy

Most patients received appropriate therapy interventions for their initial medical conditions, and at least two-thirds of patients achieved their treatment goals. Most patients would not have achieved similar levels of function without therapy.

However, almost 13 percent of therapy was billed improperly to Medicare

By facility, the percentage of therapy that was billed improperly ranged from zero to 51 percent. Smaller facilities were more likely than larger facilities to bill improperly.

Therapy was deemed as improperly billed to the Medicare program when it was not medically necessary and/or therapy was provided by staff who did not have the appropriate skill for the patient's medical condition.

In addition to the 13 percent of therapy that was billed improperly, another 4 percent was not documented in the patients' medical records

In several cases, therapists did not explain changes in the patient's progress which would justify large variations in the duration of therapy.

RECOMMENDATION

From our findings, it is clear that some problems stem from a lack of awareness and understanding of Medicare coverage and guidelines, while others may be more directly related to overutilization in order to maximize Medicare reimbursement. Our findings also reflect our general concern for the need for improved quality of care, with an emphasis on patient safety and appropriate therapy treatment.

Therefore, we recommend that the Health Care Financing Administration provide more training to SNFs and therapy staff on Medicare coverage criteria and guidelines for physical and occupational therapy, local medical review policies, and monitoring procedures. This could be accomplished by:

1. instructing Medicare fiscal intermediaries to provide regular workshops to SNFs, especially smaller facilities, and therapists and
2. working collaboratively with the national therapy and nursing home associations to assure that they provide accurate and comprehensive information to their members.

In this report, we have focused on the medical necessity of physical and occupational therapy. In a companion report entitled *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare* (OEI-09-97-00122), we analyzed how much improperly billed therapy costs the Medicare program.

AGENCY RESPONSE

We received comments on the draft report from the Health Care Financing Administration. The agency concurred with the report's conclusions. The Health Care Financing Administration already has increased medical review efforts at the Medicare contractors as part of its on-going program integrity efforts, and they will continue to focus on appropriate therapy for Medicare beneficiaries. The agency also has published new medical review guidelines for skilled nursing facilities and plans to conduct related training to strengthen provider education.

The full text of the Health Care Financing Administration's comments appears in appendix C.

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INTRODUCTION

PURPOSE

To determine the medical necessity and quality of care of physical and occupational therapy rendered to Medicare patients in skilled nursing facilities.

BACKGROUND

Medicare Coverage for Skilled Nursing Facilities

All skilled nursing facilities (SNF) must meet the requirements of Section 1819 of the Medicare law. The facilities must, for example, (1) provide 24-hour skilled nursing service under policies developed by physicians, registered nurses, or other professionals; (2) develop health plans for each patient, under the supervision of a physician; (3) maintain clinical records on all patients; and (4) meet a number of conditions to assure patients' health and safety.

The Medicare program provides SNF coverage under Part A, which does not include custodial care. The Part A benefit includes:

- ▶ nursing care;
- ▶ bed and board;
- ▶ physical, occupational, and/or speech therapy;
- ▶ medical social services; and
- ▶ drugs, biologicals, supplies, appliances, and equipment for use in the facility.

Medicare stipulates that patients are eligible for Part A benefits if they are transferred to a SNF after a minimum 3-day covered stay in an acute care hospital. The patient must require skilled nursing care and/or rehabilitation services, and a physician must order the services. Part A covers SNF services for up to 100 days per "spell of illness." The patient is responsible for a copayment for the 21st through 100th day of care. After 100 days, patients are not covered under the SNF benefit, but they may be covered for various services under Part B, even while they are receiving only custodial care.

Most SNFs provide custodial care as well as skilled nursing services. Unlike other long-term care facilities, SNFs also may be reimbursed under Part B for any patients who receive Part B-covered services only. The SNFs are responsible for meeting the needs of long-term patients who are eligible for Part B services only during their stay.

Description of Physical and Occupational Therapy

According to the American Physical Therapy Association, *physical therapy* is “... the care and services that includes (1) examining patients with impairments, functional limitations or disabilities or other health-related conditions in order to determine a diagnosis, prognosis, and intervention; (2) alleviating impairments and functional limitations by designing, implementing and modifying therapeutic interventions; and (3) preventing injury, impairment, functional limitation and disability, including the promotion and maintenance of fitness, health, and quality of life.”¹ Common treatments include therapeutic exercise, prescription and customization of prosthetic devices and equipment, and wound management. For example, physical therapy may include gait training on ramps, stairs, or curbs to improve a patient’s walking ability impaired by injury or illness.

The American Occupational Therapy Association defines *occupational therapy* as “...the use of purposeful activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability, and which develop, improve, sustain or restore the highest possible level of independence of any individual who has an injury, illness, cognitive impairment, psycho social dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition.”² Occupational therapy primarily focuses on compensatory techniques to improve a patient’s ability to complete the activities of daily living independently. Therapy may include (1) assessing patient need; (2) designing, developing, adapting, applying, or training in the use of assistive or orthotic devices; (3) adapting environments and processes to enhance functional performance; or (4) promoting health and wellness. Two examples include teaching a patient who has lost the use of an arm how to prepare food and cook with one hand and designing, building, and training a patient in the use of an assistive device that would enable him to hold a utensil and feed himself independently.

The staff who provide physical and occupational therapy to patients include therapists, assistants, and aides. Staff are distinguished by training and experience and often are licensed, registered, or certified by the State where they practice. We have included descriptions of each staff level and some common terminology in appendix A.

Medicare Coverage of Physical and Occupational Therapy

¹American Physical Therapy Association, *Model Definition of Physical Therapy for State Practice Acts, Board of Directors Policies, Positions and Guidelines*, March 1998.

²The American Occupational Therapy Association, Inc. Definition of occupational therapy practice for State regulation. *The American Occupational Therapy Association, Inc. Policy Manual (Association Policy 5.3.1)*, July 1994.

All SNFs are required to assess each patient's status and needs shortly after admission, including the need for physical and occupational therapy. The *Nursing Home Reform Act* (P.L. 100-203), which Congress passed as part of the *Omnibus Budget Reconciliation Act of 1987*, requires that SNFs assess the needs of all patients within 14 days of admission and reassess long-term patients annually. Problems identified through the assessment must be treated to attain or maintain "the highest practicable level" of functioning based on the patient's physical, mental, and psycho social well-being.

Medicare guidelines state that all therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. While Medicare regulations define common illnesses and injuries requiring therapy, the regulations do not specifically bar therapy for illnesses or injuries that are not mentioned. Fiscal intermediaries, the insurance companies that adjudicate cost reports for inpatient hospitals and SNFs, often develop local medical review policies to supplement Medicare guidelines.

Medicare coverage requires that the therapy meet all of the following conditions:³

- ▶ the therapy must be ordered by a physician;
- ▶ the therapy level's complexity and sophistication, or the patient's condition, require the skills of a qualified therapist rather than nonskilled SNF staff;
- ▶ the medical record contains an active written treatment plan that includes specific and measurable treatment goals related to the patient's condition along with a reasonable time estimate of when those goals will be achieved;
- ▶ the treatment plan should describe the specific therapeutic interventions that will be utilized to restore the patient's level of function which has been lost or reduced by illness or injury;
- ▶ the amount, frequency, and duration of therapy should be reasonable and necessary for the patient's condition;
- ▶ therapy is provided either by or under the direct supervision of a certified therapist;⁴
- ▶ therapy must be provided with the expectation, based on the assessment made by the physician or therapist of the patient's restoration potential, that the patient's condition will improve substantially in a reasonable and generally predictable period of time, or the therapy must be necessary for the establishment of a safe and effective maintenance program. However, therapy will only be covered until the physician and/or therapist concludes that the patient is not going to improve; and
- ▶ the patient is seen by the physician at least every 30 days.

³Health Care Financing Administration, *Skilled Nursing Facility Manual*, Sections 214, 230, 230.3(C), and 271.

⁴State regulations define whether or not direct supervision includes the onsite presence of a certified therapist.

A SNF patient may receive more than one type of therapy within the same episode of care. For example, the occupational therapist may assist the patient with the use of adaptive self-help devices while the physical therapist might address a different need, such as increasing muscle strength, sitting balance, and control of head movement.

Prior Work by the Office of Inspector General

In April 1998, the Office of Inspector General published a report describing the results from a probe sample of physical and occupational therapy provided in six randomly selected SNFs in California.⁵ The major conclusions were:

- ▶ Medically unnecessary physical and occupational therapy at sampled SNFs ranged from less than 4 to more than 80 percent, and
- ▶ Multiple factors account for the high volume of medically unnecessary therapy, such as:
 1. skilled therapy is frequently provided when nonskilled maintenance services would be more appropriate,
 2. therapists sometimes ignore the patient's prior level of function and set unrealistic goals, and
 3. the frequency of therapy is sometimes excessive.

Based on the probe sample, the Office of Inspector General decided to conduct this national inspection.

METHODOLOGY

Sampled SNF Selection

From the Medicare Common Working File, we extracted all March 1998 physical and occupational therapy claims (both Parts A and B) submitted by SNFs to fiscal intermediaries for payment. We limited the extract to SNFs in the continental United States. We reviewed therapy rendered to patients before the Health Care Financing Administration implemented the SNF prospective payment system on July 1, 1998. We purposely selected claims submitted before July 1, 1998 to maintain consistency in SNF and fiscal intermediary policies and procedures for the 12 months prior to the change in payment systems.

⁵Office of Inspector General, *Medical Necessity of Physical and Occupational Therapy in Skilled Nursing Facilities--California Probe Sample Results [Early Alert]*, OEI-09-97-00120, April 1998.

We stratified the SNFs into four strata by (1) regions of the United States and (2) the total physical and occupational therapy charges for March 1998. Within each stratum, we grouped the SNFs into clusters such that

- ▶ the SNFs were in the same geographic area and
- ▶ the sum of physical and occupational therapy charges per cluster was fairly constant.

United States Region	Stratum	Facility Charges for Physical and Occupational Therapy
East	1	less than \$60,000
	2	equal to or greater than \$60,000
West and Central	3	less than \$60,000
	4	equal to or greater than \$60,000

We then randomly selected two SNF clusters per stratum. Within each SNF cluster, we randomly selected 3 SNFs, resulting in a total sample of 24 SNFs. Within each SNF, we randomly selected 10 patients who received physical and/or occupational therapy during March 1998. If a SNF had fewer than 10 patients who received therapy in that month, we reviewed all of them.

Calculations for the confidence intervals account for all levels of clustering and stratification. The 95 percent confidence intervals for the statistics in this report are listed in appendix B.

On-Site Medical Review

We conducted on-site reviews at the 24 SNFs for the 218 sampled patients who received physical and occupational therapy in March 1998. Several teams of physical and occupational therapists reviewed the medical records. All reviewers are licensed or certified therapists in their respective States and are current members of both their national and State therapy associations. The medical reviewers used structured medical review instruments to determine if each therapy (i.e., treatment encounter) was medically necessary, unnecessary, or undocumented. We presented the draft instruments to representatives of various therapy and nursing home national associations and patient interest groups and provided them the opportunity to comment.

The reviewers used structured medical review instruments to determine whether or not:

- ▶ therapy was ordered by a physician,
- ▶ the patient was a good candidate for physical and/or occupational therapy,
- ▶ therapy was based on medical need,

- ▶ the medical condition warranting the therapy was documented in the medical records,
- ▶ the treatment plan was appropriate,
- ▶ the types of therapeutic activities and the frequency and duration of the treatment were delineated clearly,
- ▶ the therapy was rendered with appropriate frequency,
- ▶ therapy was discontinued at the appropriate time,
- ▶ appropriate therapy staff performed the interventions, and
- ▶ medical records clearly documented the patient's progress.

While on-site, we reviewed therapy ledgers, requested copies of the Medicare bills for the sampled patients (i.e., Form UB-92), interviewed SNF administrators and some key therapy staff, obtained therapy contracts that were in effect in March 1998, and observed some physical and occupational therapy conducted with patients. Assuming that March 1998 is a typical month, we projected the results of the medical review to the 12-month period ending June 30, 1998. See appendix B for more details. After the onsite review, we requested local medical review policies and therapy guidelines from the fiscal intermediaries for the sampled SNFs.

This report is one in a series of reports on physical and occupational therapy for Medicare SNF patients. A companion report, *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare* (OEI-09-97-00122), details the costs for medically unnecessary and undocumented therapy described in this report.

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Most SNF patients were appropriate candidates for physical and occupational therapy, and they benefitted from therapy

Most patients received appropriate therapy given their initial medical conditions

Approximately 83 percent of physical and occupational therapy provided in 1998 to SNF patients was billed properly to Medicare. Medical reviewers determined that treatment goals and plans were appropriate to the therapy diagnoses, and most patients initially received therapy with the appropriate frequency and duration of individual sessions. In fact, reviewers found that most patients would not have achieved similar functional levels without therapy.

Medical reviewers determined that the medical conditions for most patients required the need for skilled physical and occupational therapy. The therapy interventions appeared functionally relevant and clinically appropriate. When a patient's condition or progress changed, the therapist usually revised the goals and plan in measurable ways, and the medical record usually documented the patient's prior functional level. Positive outcomes included shorter lengths of stay and returning more patients to independent living. Reviewers found that these medical records were complete, in order, and provided enough data to clearly justify all therapy provided to the patients.

At least two-thirds of patients achieved their treatment goals

Almost 67 percent of physical therapy patients and 73 percent of occupational therapy patients had good outcomes from therapy. Reviewers determined that most treatment goals were reached within a reasonable time given the patient's medical condition, tolerance level, and therapy progress. Based on the planned interventions (for example, gait training or re-learning bathing and personal grooming activities), therapists provided sessions with the proper frequency and duration of individual sessions.

ACHIEVEMENT OF TREATMENT GOALS

Achievement	Percent of Therapy	
	Physical	Occupational
Patient achieved goals fully or partially	66.8%	73.3%
Patient did not achieve goals	27.1%	16.5%
Reviewer could not determine	6.0%	10.1%

Source: Office of Evaluation and Inspections, 1999

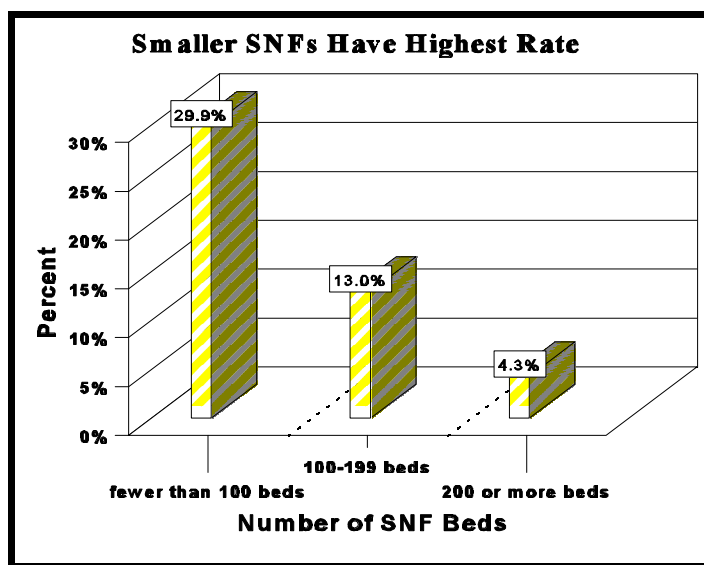
Medical reviewers noted that in a few of the SNFs, physical and occupational therapists collaborated when they developed initial treatment plans and re-evaluated the patients. By collaborating, therapists assured that they did not duplicate goals and plans, thereby helping the patients progress further within a shorter time frame. One medical reviewer remarked, “When collaboration occurs, the patient is the winner.”

Nationally, almost 13 percent of therapy was billed improperly to Medicare

Almost 13 percent of physical and occupational therapy, or 10.6 million of 82.9 million sessions, was billed improperly by SNFs to Medicare.⁶ Of these 10.6 million sessions, 51.6 percent were physical therapy, and 48.4 percent were occupational therapy.

Improper billings by SNFs ranged from zero to almost 51 percent

While 6 SNFs did not submit any improper therapy bills, 18 of the 24 sampled SNFs improperly billed for physical and/or occupational therapy. As shown in the graph below, smaller SNFs, those with fewer than 100 beds, exhibited a statistically higher rate of improper billings than the larger SNFs. The total number of licensed beds at the sampled SNFs ranged from 9 to 338 beds. We also analyzed other factors such as status (for-profit or not-for-profit), SNF affiliation (hospital-based or free-standing), type of therapy company (independent or national corporation), and type of ownership (part of multi-facility chain or independently owned). The differences among these variables were not statistically significant.



Source: Office of Evaluation and Inspections, 1999

⁶Assuming that March 1998 is a typical month, we projected the results of the medical review to the 12-month period ending June 30, 1998.

Almost 75 percent of all improperly billed therapy was not medically necessary

Of the 13 percent of improperly billed therapy, almost three-fourths was billed improperly because the therapy was not medically necessary. Medical reviewers found that therapy was not medically necessary because, among other reasons, (1) patients were not appropriate candidates for therapy, (2) treatment goals were too ambitious, (3) therapy was too frequent and/or the session was too long, or (4) therapists billed routine maintenance services as skilled therapy.

In some instances, medical reviewers suggested that physical and occupational therapy should have been postponed for some patients until their medical conditions became more stable. For example, one patient had received both physical and occupational therapy six times a week in spite of her declining medical condition. Towards the end of the month, the patient was receiving physical therapy twice each day along with one to two sessions of occupational therapy. Each session lasted 45 to 75 minutes. The patient was hospitalized for several days in the same month for dehydration and diarrhea. The treatment goals for physical therapy were to increase the patient's strength, balance, bed mobility, and sitting tolerance. The reviewer determined that the patient did not receive any significant benefit from skilled physical therapy and expressed concern that the physical stress from the excessive and unnecessary therapy may have contributed to the patient's need to be hospitalized repeatedly.

Approximately 27 percent of physical therapy patients and almost 17 percent of occupational therapy patients could not achieve their goals and complete their treatment plans because the plans were too ambitious. Medical reviewers cited plans as unrealistic because they did not sufficiently consider the patient's initial functional levels when developing goals. Several facilities used a "cookie-cutter" treatment plan for all patients within the same SNF regardless of the diagnosis. The reviewers questioned why treatment plans were not revised immediately, or at all, to reflect the patient's documented lack of progress. Reviewers also noted that some initial evaluations, especially for occupational therapy, were very lengthy-- 1½ to 2 hours. A pattern of lengthy evaluations appeared to be a standard practice at several facilities.

Excessive frequency and duration of therapy was a standard practice at some SNFs. For example, every sampled patient in three SNFs received therapy "B.I.D." or twice a day except on Sundays (when they received therapy only once). Each session was 45 to 60 minutes long. Reviewers questioned the higher frequency and duration because patients at other SNFs with similar diagnoses, goals, and plans achieved similar or better outcomes in shorter times with less frequency and duration.

Patients' medical conditions and tolerance levels often were not considered when they received therapy very frequently. For example, one patient was admitted with a diagnosis of chronic obstructive pulmonary disease and cardiac failure. The patient received 5 weeks of physical therapy with sessions twice a day. The lengthy and intense therapy was not justified in the

medical record. The medical reviewer commented, “Although the episode of care could be considered reasonable, 60 to 75 minutes of care on a daily basis raises questions of intensity of care provided, particularly given [the patient’s imminent] discharge to a rehabilitation nursing program rather than home.”

Many patients received therapy from staff with inappropriate skill or experience

Approximately 26 percent of the improperly billed physical and occupational therapy was provided by staff who did not have the appropriate skill for the patient’s medical condition. Of this 26 percent, the table below explains the major reasons.

Reason	Percent ⁷
Physical therapist assistants and occupational therapy assistants provided therapy beyond their skills	46%
Rehabilitation aides provided care that was billed as skilled therapy	50%
Therapy should have been provided by assistants rather than by therapists	5%

Source: Office of Evaluation and Inspections, 1999

Other reasons included occupational therapists who provided physical therapy and physical therapist assistants who provided nonskilled maintenance services. For example, situations where (1) occupational therapy assistants who completed patient re-evaluations and discharge summaries instead of the occupational therapists; (2) physical therapist assistants who provided the entire episode of care, from evaluation through discharge summary, for several patients in the same facility; and (3) rehabilitation aides who provided therapy without evidence of direct supervision by a therapist or an assistant.

Reviewers especially were concerned that physical therapist assistants and occupational therapy assistants were working beyond the scope of their State license and contrary to guidelines and practices followed by both national therapy associations. For example, a graduate occupational therapy student at one SNF provided services to patients, but the notes were not co-signed by the occupational therapist to indicate monitoring as required by State law. Reviewers also questioned the possible link between the length of therapy (both frequency of therapy and duration of individual sessions) and the skill level of the individual who rendered the treatments, i.e., the lesser the staff skill level, the higher the frequency and the longer the duration of therapy.

⁷The percents do not total 100.0 percent due to rounding.

Almost 4 percent of therapy was not documented in the patients' medical records

Approximately 3.8 percent of therapy sessions either was not documented at all in the medical records or was not documented adequately to determine medical necessity. Documentation should include signed physician orders; individual treatment goals and plans; narrative summaries of care provided and/or therapy charts (also called grids) with all therapeutic interventions, the time spent on the interventions, which staff provided the therapy, and narratives of patient progress or changes in progress.⁸ Narrative summaries did not always provide necessary information, especially explanations for large variations in treatment times, such as a change from 30 minutes to 1 hour 45 minutes for the same interventions. Medical records that did not support the need for skilled therapy also had substandard documentation, including a lack of clinical data. Reasons for undocumented therapy may include the lack of staff training and/or the lack of time to document medical records properly. When asked how therapists receive information on Medicare coverage, medical necessity, and documentation guidelines, SNF administrators stated that they rely on the therapy companies to provide information to their staff. Few SNFs sponsor or actively participate in on-site Medicare therapy training.

Reviewers commented that some forms and documentation methods were not comprehensive enough to capture clinical data to meet Medicare guidelines and professional therapy standards.⁹ Reasons may include the sharing of “cookbook forms” among staff from national therapy companies and a lack of knowledge by individual therapists of Medicare guidelines and criteria. Reviewers could not determine the skill level of the provider at one SNF due to poor documentation.

⁸The medical reviewers requested additional documentation from the on-site therapists if patient records were in storage, misplaced, or appeared incomplete.

⁹American Physical Therapy Association, “Guidelines for Physical Therapy Documentation,” *Guide to Physical Therapist Practice*, 1998, appendix 7.

RECOMMENDATION

From our findings, it is clear that some problems stem from a lack of awareness and understanding of Medicare coverage and guidelines, while others may be more directly related to overutilization in order to maximize Medicare reimbursement. Our findings also reflect our general concern for the need for improved quality of care, with an emphasis on patient safety and appropriate therapy treatment.

Therefore, we recommend that the Health Care Financing Administration provide more training to SNFs and therapy staff on Medicare coverage criteria and guidelines for physical and occupational therapy, local medical review policies, and monitoring procedures. This could be accomplished by:

1. instructing Medicare fiscal intermediaries to provide regular workshops to SNFs, especially smaller facilities, and therapists and
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AGENCY RESPONSE

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The full text of the Health Care Financing Administration's comments appears in appendix C.

Glossary of Terms

Primary Therapy Providers

- ▶ *Physical therapist*--professionally educated at the college or university level and is required to be licensed or registered in all States.¹⁰ A primary role is to provide therapy to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes.¹¹ The physical therapist is responsible for any evaluation and assessment of a patient's therapy status.
- ▶ *Physical therapist assistant*--a graduate of an accredited physical therapist assistant associate degree program accredited by an agency recognized by the Commission on Accreditation in Physical Therapy Education. Assistants are licensed, certified, registered, or approved in almost all States and Puerto Rico, except in Hawaii, Minnesota, Michigan, Washington, Wisconsin, the District of Columbia, and the U.S. Virgin Islands. The assistant works with the physical therapist in the provision of physical therapy. The assistant may perform procedures and related tasks that have been selected and delegated by the supervising physical therapist. Where permitted by law, the physical therapist assistant may complete routine operational functions, including supervision of physical therapy aides and documentation of patient progress. The assistant may modify a specific therapeutic activity in accordance with changes in patient status and within the scope of the established treatment plan.¹²
- ▶ *Physical therapy aide/technician*--a nonlicensed worker, trained under the direction of a physical therapist. The aide performs designated routine therapy tasks that are delegated by the physical therapists or, in accordance with the State law, by a physical therapist assistant. The aide performs only with the continuous on-site supervision of the physical therapist or, where allowable by State law or regulation, the physical therapist assistant.¹³

¹⁰American Physical Therapy Association, *Definition of Physical Therapist for State Practice Acts, Board of Directors Policies, Positions and Guidelines*, March 1999.

¹¹American Physical Therapy Association, *Guide to Physical Therapist Practice* (1998), page 1-1.

¹²*Ibid.*, page 1-10.

¹³*Ibid.*, page 1-10.

- ▶ *Occupational therapist*--professionally educated at the college or university level obtaining, at a minimum, a bachelor's degree from a program accredited by the Accreditation Council for Occupational Therapy Education. The occupational therapist completes a minimum of 6 months of clinical training under the supervision of an experienced occupational therapist. The therapist must successfully complete a national registration examination administered by the National Board of Occupational Therapy. States regulate occupational therapists by licensure, registration, certification, or trademark. The occupational therapist is responsible for (1) determining and interpreting the evaluation, (2) initiating treatment goals and plans, (3) initiating substantive changes to the goals and plans, and (4) determining when to discharge patients from occupational therapy programs.¹⁴
- ▶ *Occupational therapy assistant*--a graduate of an associate degree program accredited by the Accreditation Council for Occupational Therapy Education. The assistant completes 12 weeks of clinical training under the supervision of an occupational therapist or an experienced occupational therapy assistant. The assistant must successfully complete a national certification examination for occupational therapy assistants administered by the National Board Certification of Occupational Therapy. Many States regulate occupational therapy assistants by licensure or registration. The assistant (1) collects data for evaluation, (2) carries out treatment plans, and (3) modifies the treatment goals and plan under the supervision of an occupational therapist. Assistants also may gather data and complete portions of the re-evaluation for the occupational therapist's interpretation to change treatment goals and plans.
- ▶ *Occupational aide/technician*--may assist an occupational therapist, under the direct supervision of the therapist at the time the therapy is given. Direct supervision is the physical presence of the qualified occupational therapist.

Other Terminology¹⁵

- ▶ *Activities of Daily Living*--self-care activities that must be performed to achieve functional independence may be classified as mobility activities, bathing, grooming, personal hygiene, eating, dressing, bowel control, and bladder control. An expectation exists that the therapy will result in a significant practical improvement in the patient's level of functioning in a reasonable period of time.

¹⁴Accreditation Council for Occupational Therapy Education, *OTA Essentials*, updated July 1995.

¹⁵Most definitions were included in the American Physical Therapy Association's *Guide to Physical Therapist Practice* (1998).

APPENDIX A

- ▶ *Episode of care*--all patient management activities provided, directed, or supervised by the therapist, from initial contact through discharge.
- ▶ *Evaluation*--used to report the initial assessment before the treatment plan is established by the therapist or physician. The therapist makes clinical judgments based on data gathered during the initial examination.
- ▶ *Re-evaluation*--process by which the patient's status is updated following the initial examination because of new clinical indications, failure to respond to interventions, or failure to establish progress from baseline data. The re-evaluation usually is completed by a therapist or physician, not by an assistant or aide.
- ▶ *Therapeutic intervention*--the purposeful and skilled interaction of the therapist with the patient, and, when appropriate, with other staff involved in the patient's care, using various methods and techniques to produce changes in the patient's condition.
- ▶ *Treatment goals*--the therapist's or physician's description of what the patient is expected to achieve as a result of therapy.¹⁶
- ▶ *Treatment plan*--specifies the anticipated short-term and long-term goals and the desired outcomes, predicted level of optimal improvement, specific interventions to be used, duration and frequency of the therapy required to reach the goals and outcomes, and criteria for discharge.

¹⁶Health Care Financing Administration, *Medicare Intermediary Guidelines*, Section A3 3904C5 under Medical Review of Part B Intermediary Outpatient Bills.

Confidence Intervals for Selected Statistics

The following tables show the point estimates and 95 percent confidence intervals for selected statistics, in the order that they appear in the report. These calculations account for all levels of clustering and stratification as described in the methodology.

Statistic	Point Estimate	95 Percent Confidence Interval
Of March 1998 physical and occupational therapy for SNF patients, percent that was billed properly	83.5%	79.7% - 87.2%
Of March 1998 physical and occupational therapy for SNF patients, percent that was billed improperly	12.7%	8.6% - 16.9%
Of March 1998 physical and occupational therapy for SNF patients, percent that was undocumented	3.8%	2.6% - 5.0%
Of SNF patients who received physical therapy during March 1998, percent who achieved their treatment goals	66.8%	63.3% - 70.4%
Of SNF patients who received physical therapy during March 1998, percent who did not achieve their treatment goals	27.1%	21.2% - 33.1%
Of SNF patients who received physical therapy during March 1998, percent for whom the reviewers could not determine whether the patient achieved treatment goals	6.0%	1.5% - 10.6%
Of SNF patients who received occupational therapy during March 1998, percent who achieved their treatment goals	73.3%	63.4% - 83.3%
Of SNF patients who received occupational therapy during March 1998, percent who did not achieve their treatment goals	16.5%	10.0% - 23.1%
Of SNF patients who received occupational therapy during March 1998, percent for whom the reviewers could not determine whether the patients achieved treatment goals	10.1%	0.2% - 20.0%
Total number of physical and occupational therapy sessions provided to SNF patients during March 1998	7.0 million	3.5 million - 10.6 million

APPENDIX B

Statistic	Point Estimate	95 Percent Confidence Interval
Total number of physical and occupational therapy sessions provided to SNF patients for a 12-month period ending June 30, 1998	82.9 million	**
Total number of improperly billed physical and occupational therapy sessions provided to SNF patients during March 1998	0.9 million	0.3 million - 1.5 million
Total number of improperly billed physical and occupational therapy sessions provided to SNF patients for a 12-month period ending June 30, 1998	10.6 million	**
Of improperly billed physical and occupational therapy sessions provided during March 1998, percent that were physical therapy	51.6%	41.3% - 61.8%
Of improperly billed physical and occupational therapy sessions provided during March 1998, percent that were occupational therapy	48.4%	38.2% - 58.7%

**NOTE: These estimated projections from March 1998 to a 12-month period are based on the assumption that March 1998 is a typical month. We tested this assumption by examining SNF Medicare charges for physical and occupational therapy. For example, the SNFs submitted \$685 million in physical and occupational therapy charges during March 1998 and \$7.85 billion during the 12 months ending March 31, 1998. This ratio (\$685 million/\$7.85 billion) is approximately equivalent to the ratio (31/365) that we used in projecting to a 12-month period. Because our sample was limited to March 1998, we are unable to calculate 95 percent confidence intervals for these 12-month estimates.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 20 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash *Michael M. Hash*
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Physical and Occupational Therapy in Nursing Homes: Quality of Care and Medical Necessity for Medicare Patients," (OEI-09-97-00121) and "Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare," (OEI-09-97-00122)

We appreciate the Inspector General's timely efforts to evaluate the quality and medical necessity of physical and occupational therapy provided in skilled nursing facilities in early 1998. These reports analyze the situation prior to the implementation of major changes required by the Balanced Budget Act of 1997, which affect the way Medicare pays for therapy in nursing homes.

We agree generally with the report's conclusions. Specifically, we are gratified that most beneficiaries who received these therapy services in skilled nursing facilities benefited from the care, which was both medically justified and appropriate for their conditions. We also recognize that some services were provided inappropriately or unnecessarily to some beneficiaries.

The report demonstrates that problems of overutilization are common in a cost reimbursement system. In recognition of the vulnerabilities inherent in such a system, the Congress required HCFA to implement a prospective payment system for skilled nursing facilities (SNFs). HCFA began to implement the new prospective payment system on July 1, 1998, and all Medicare-participating SNFs were paid under this system before July 1, 1999.

Taken by itself, the prospective payment system may still encourage overuse of services. For this reason, we issued new medical-review guidelines to our fiscal intermediaries to assess whether services were reasonable and necessary as they determine whether a

payment was made properly. In addition, HCFA recently published new medical review guidelines regarding Medicare's new prospective payment system for skilled nursing facilities, and we plan to hold related training in the coming fiscal year. We also will look for effective ways to strengthen our provider education efforts on this subject.

However, there are also competing incentives for nursing home administrators. The Congress also enacted beneficiary therapy caps as part of the Balanced Budget Act. Inappropriate high use (or low use) of certain services (such as therapy) or the exaggeration of severity of patient conditions can invite more intense review by state survey agencies.

Because we have instituted a new payment system which departs quite significantly from the old, cost reimbursement payment system, we believe it is essential to gain a more complete understanding, as soon as possible, of the nature and distribution of any payment errors being made. Hence, we have instructed our contractors to concentrate their efforts on random review of claims, and plan to use those results to focus additional efforts. If we find problems in therapy use or other areas during these random reviews, we will move quickly to instruct contractors to focus on those problem areas. This will ensure that we devote appropriate resources to therapy use, as the report recommends.

Given these changes, we also consider it crucial to continue to aggressively monitor their potential impact on the access and quality of care for Medicare beneficiaries. In particular, we remain concerned about the anecdotal reports on the \$1,500 therapy caps, which may not be sufficient to cover necessary care for all Medicare beneficiaries. We look forward to your upcoming report on this issue, which could help us and Congress develop appropriate policy changes if necessary.

As you know, the President's Medicare plan sets aside \$7.5 billion over 10 years to smooth out any Balanced Budget Act provisions that begin to affect beneficiaries' access to quality services. We will continue to work with Congress and others to identify and appropriately address such situations to ensure quality care and services to Medicare's nearly 40 million beneficiaries.