Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients

Medical Necessity, Cost, and Documentation Under the $1500 Caps

AUGUST 2001
OEI-09-99-00560

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's San Francisco Regional Office prepared this report under the direction of Paul A. Gottlober, Regional Inspector General. Principal OEI staff included:

REGION IX

Deborah Harvey, *Project Leader*
Christopher Tarbell, *Lead Analyst*
Robert Gibbons, *Program Analyst*
Camille Harper, *Program Analyst*
Scott Hutchison, *Program Analyst*
Steven Zerebecki, *Program Analyst*

HEADQUARTERS

Susan Burbach, *Program Specialist*
Linda Moscoe, *Technical Support Staff*
Brian Ritchie, *Technical Support Staff*
Bambi Straw, *Program Specialist*
Stuart Wright, *Director, Medicare and Medicaid Branch*

To obtain copies of this report, please call the San Francico Regional Office at (415) 437-7900.
Reports are also available on the World Wide Web at our home page address:

http://www.dhhs.gov/progorg/oei

EXECUTIVE SUMMARY

PURPOSE

This inspection analyzed the medical necessity, cost, and medical record documentation of physical, occupational, and speech therapy provided to nursing home patients in calendar year 1999 and billed to Medicare Part B by nursing homes, rehabilitation agencies, or hospital outpatient departments.

BACKGROUND

Medicare coverage guidelines state that all therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. Therapy must be ordered by a physician or other qualified health care professional, require the skills of a qualified therapist, and be dictated by a written treatment plan. The plan must include specific and measurable goals and a reasonable estimate of when the patient will attain the goals.

In 1997, Congress changed nursing home reimbursement for therapy by setting two annual caps. Occupational therapy was limited to $1500 annually, while physical and speech therapy shared the same $1500 annual cap. In November 1999, the caps were suspended for 2 years effective January 1, 2000. The moratorium on the therapy caps has subsequently been extended through calendar year 2002. The law that suspended the caps also requires the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) to (1) recommend a process to assure the appropriate utilization of Medicare outpatient therapy and (2) establish an alternative payment policy based on diagnostic categories, functional status, and prior use of therapy. To meet the requirements of the law, Agency staff requested our assistance.

Our national random sample consisted of 320 Medicare patients. We conducted on-site medical and financial reviews at 132 nursing homes, rehabilitation agencies, and hospital outpatient departments. Several teams of physical and occupational therapists and speech-language pathologists reviewed the medical records for 318 of the sampled patients.

FINDINGS

The $1500 therapy caps did not prevent Medicare nursing home beneficiaries from receiving necessary and appropriate therapy

Less than 2 percent of Medicare beneficiaries reached either of the $1500 therapy caps. While the caps were in place, beneficiaries required no additional therapy in

approximately 82 percent of therapy episodes. Furthermore, although physical and speech therapy shared a cap, most beneficiaries received the physical and speech therapy they needed.

Despite the therapy caps, 14 percent of all therapy was not medically necessary

Although most therapy was deemed medically necessary, 14 percent was not. Medicare allowed more than $28 million during the first 6 month of 1999 for these medically unnecessary services. Therapy was medically unnecessary because (1) patients were not appropriate candidates; (2) treatment goals were met, but therapy continued; (3) therapy goals were not achieved, and a reevaluation was not conducted; or (4) skilled therapy was provided instead of routine maintenance.

Approximately 10 percent of the therapy units were not supported by adequate documentation

Medicare paid nursing homes approximately $12 million for undocumented units and an additional $8 million for inadequately documented units during the first 6 months of 1999.

Physician's orders were not included in some medical records

Medicare guidelines state that therapy must be ordered in advance by a physician or other health care professional and documented in writing in the medical record. We were unable to locate physician's orders for approximately 5.6 percent of the total therapy units billed to Medicare in the first 6 months of 1999. Medicare paid nursing homes approximately $10.6 million for these units. Since the focus of our study was to determine the medical necessity, quality of care, and utilization of therapy, some of these units may have been included in the calculations for medically unnecessary, undocumented, and inadequately documented units.

Medicare allowed in error approximately $48.5 million for Part B therapy for nursing home patients during the first 6 months of 1999. This includes $28.7 million for medically unnecessary therapy, $12.2 million for undocumented therapy units, and $7.6 million for inadequately documented therapy units. These three categories represent an overall error rate of 24.7 percent of the total allowed amount of approximately $196.5 million for Part B therapy during the first 6 months of 1999.

Our sampling methodology does not allow us to make statistically valid projections for the entire year. However, if we assume that the second half of 1999 was the same as the first 6 months of 1999, we estimate that the amount Medicare allowed for unnecessary, undocumented, and inadequately documented therapy was $97 million.

RECOMMENDATIONS

The Centers for Medicare and Medicaid Services (CMS) should:

- encourage fiscal intermediaries to continue educating nursing homes on Part B billing and Medicare requirements for record documentation and retention, with an emphasis on the proper documentation of physician's orders in patients records;

- instruct fiscal intermediaries to conduct focused medical review in order to identify and collect Part B therapy overpayments;

- continue working collaboratively with the national therapy associations to assure that they provide accurate and comprehensive information to their members on proper documentation of therapy in medical records; and

- consider options when developing a new reimbursement system for Part B therapy, such as (1) reimbursement based on an episode of therapy and (2) prior authorization for therapy that exceeds a separate monetary cap for each type of therapy.

AGENCY RESPONSE

We received comments on the draft report from CMS. The Agency concurred with our recommendations. They will continue to educate nursing homes on Medicare Part B billing and medical record documentation and continue to recommend that fiscal intermediaries conduct focused medical review whenever their analysis suggests egregious overutilization of services. The CMS will consider options when developing a new reimbursement system for Medicare Part B therapy. Finally, CMS will continue its ongoing collaboration with the national therapy associations to provide information on proper documentation of therapy in medical records. The full text of the Agency's comments appears in appendix B.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

This inspection analyzed the medical necessity, cost, and medical record documentation of physical, occupational, and speech[1] therapy provided to nursing home patients in calendar year 1999 and billed to Medicare Part B by nursing homes, rehabilitation agencies, or hospital outpatient departments.

BACKGROUND

Medicare Coverage for Skilled Nursing Facilities

All skilled nursing facilities (SNFs) must meet the requirements of Section 1819 of the Medicare law. The SNFs 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.

All SNFs are required to assess each patient's status and needs shortly after admission, including the need for physical, occupational, and speech 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 all patients' needs within 14 days of admission and reassess long-term patients annually.

A physician must see the patient at least every 30 days.[2] If a patient needs therapy over a period of time under the same treatment plan, the physician must recertify the continuing need for therapy every 30 days and estimate how long the patient will need therapy.[3] Fiscal intermediaries, the insurance companies that process and adjudicate Medicare claims for inpatient hospitals and SNFs, often develop local medical review policies to supplement Medicare guidelines for medical necessity and utilization.

[1]Throughout this report, we will refer to speech-language pathology as speech therapy.

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

[3]*Ibid*., Section 271.1B.

Descriptions of Physical, Occupational, and Speech Therapy

Physical therapy includes, but is not limited to, (1) examining patients with impairments, functional limitations, disabilities, or other health-related conditions 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.[4] Common treatments include therapeutic exercise, prescription and customization of prosthetic devices and equipment, and wound management.

Occupational therapy is the use of purposeful activity or interventions designed to achieve constructive outcomes which promote health and/or prevent injury or disability, and which develop, improve, maintain, 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.[5] Occupational therapy primarily focuses on compensatory techniques to improve a patient's ability to complete independently the activities of daily living. An example includes teaching a stroke patient new techniques to eat and dress himself as independently as possible.[6]

Speech therapy includes (1) services for patients with speech, hearing, and language disorders which result in communication disabilities and (2) the diagnosis and treatment of swallowing disorders, regardless of the presence of a communications disability. Communication disabilities most frequently affect patients with cerebrovascular disease (e.g., stroke), Parkinson disease, multiple sclerosis, and laryngeal carcinoma. Patient conditions may include (1) hearing sounds faintly, in a distorted way, or not at all; (2) substituting simple sounds; or (3) lacking the ability to use speech and language.[7] Therapy may include, but is not limited to, diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech-language pathologist or

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

[5]The 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.

[6]Health Care Financing Administration, *Skilled Nursing Facility Manual*, Section 253.3.

[7]American Speech-Language-Hearing Association, *Recognizing Communication Disorders*, organization website, www.asha.org/consumers/brochures/comm_disorders.htm.

audiologist.[8] An example of speech therapy is teaching a patient with swallowing disorders various ways to talk and chew without choking.

Medicare Coverage and Cost of Physical, Occupational, and Speech Therapy

Coverage guidelines for Part B therapy. Medicare guidelines state that all therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. The Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration or HCFA), the federal agency that administers the Medicare program, requires that therapy (1) is ordered by a physician or other qualified health care professional, (2) requires the skills of a qualified therapist rather than nonskilled SNF staff, (3) is provided either by or under the direct supervision of a certified therapist (as defined in State law), and (4) is dictated by a written treatment plan.

Nursing home charges for Part B therapy. Part B therapy increased from 1999 to 2000. In the first 6 months of 1999, nursing homes charged the Medicare program $271 million for Part B therapy for 328,000 beneficiaries. In the first 6 months of 2000, the charges increased to $316 million for 348,000 beneficiaries.

CHANGES IN THERAPY CHARGES[9]

Therapy Type	January-June 1999 Medicare Charges	January-June 2000 Medicare Charges	Percent Change[10]
Physical	$138 million	$186 million	34.8 percent
Occupational	$86 million	$89 million	3.6 percent
Speech	$47 million	$41 million	-12.9 percent
Total	**$271 million**	**$316 million**	**16.6 percent**

Source: Office of Evaluation and Inspections, 2001

[8] 42CFR 440.110 (c).

[9] Statistics in this table were calculated from 100 percent of beneficiaries for 1999 and a 5 percent sample of beneficiaries for 2000.

[10] The totals may not add up due to rounding.

Medicare Guidelines for Documentation and Retention of Medical Records

Medical records should include documentation that describes all treatments and the patient's progress throughout the episode of therapy. Documentation should include, but is not limited to:

- *written or telephone physician's order* for the therapy (telephone orders should be documented in the medical record by a nurse and then confirmed in writing by the physician or other health care professional as soon as possible);
- *initial examination and evaluation* by the therapist describing the patient's history, admitting and treatment diagnoses, initial functions, diagnosis, short and long-term treatment goals, and the treatment plan;
- *information for each therapy session*, also called treatment logs or daily notes, describing the types and length of the types of therapy that the patient received and who provided the therapy (therapist, assistant, or aide);
- *progress notes* explaining the patient's progress or lack of progress on the treatment plan;
- *reexaminations and re-evaluations* (at least monthly for the same episode of therapy) confirming the continued need for therapy; and
- *discharge summary* which is required at the end of the episode of therapy.[11]

The Centers for Medicare and Medicaid Services (CMS) requires that nursing homes retain medical records for 5 years after the patient is discharged.[12] If the nursing home contracted with independent providers (such as a therapy provider) to render services, Medicare guidelines require that nursing homes retain all records for 3 years after final payment under the contract.[13]

The Therapy Caps

Section 4541(c) of the *Balanced Budget Act of 1997* changed SNF reimbursement for physical, occupational, and speech therapy by setting two annual caps for Medicare Part B patients. Effective January 1, 1999, occupational therapy was limited to $1500 annually, while physical and speech therapy shared the same $1500 annual cap.

[11]American Physical Therapy Association, *Guide to Physical Therapist Practice*, appendix 7, 1998.

[12]Health Care Financing Administration, *Skilled Nursing Facility Manual,* Chapter V–Billing Procedures, Section 545.4.

[13]*Peer Review Organization Manual*, Part 13--Management, Section 13140.

Section 221 of the *Medicare, Medicaid, and SCHIP*[14] *Balanced Budget Refinement Act of 1999*, passed in November 1999, suspended the cap for 2 years effective January 1, 2000. Section 221(c)(2) of the Law requires CMS to (1) recommend a mechanism to assure the appropriate utilization of Medicare outpatient therapy and (2) establish an alternative payment policy based on diagnostic categories, functional status, and prior use of therapy.[15]

Focused Medical Review

The 1999 law also mandated that the Secretary conduct focused medical reviews of Part B therapy claims, with an emphasis on SNF claims in calendar years 2000 and 2001. In October 2000, CMS launched a Program Safeguard Contract for therapy to (1) analyze current national and local medical review policies; (2) conduct extensive literature review, analysis, and abstraction; (3) interview fiscal intermediaries and therapy providers; and (4) develop medical review protocol for the fiscal intermediaries.

Section 421 of the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*, passed in November 2000, extended the moratorium on the therapy caps for another year, through calendar year 2002. The law also extended the requirement for focused review of SNF therapy claims until year 2003.

Previous Office of Inspector General Work

The Office of Inspector General released two reports in August 1999 concerning physical and occupational therapy rendered to Medicare patients in nursing homes. We found that most Medicare patients received appropriate therapy for their initial medical conditions and benefitted from therapy. However, almost 13 percent of physical and occupational therapy was billed improperly because it was not medically necessary and/or the therapy was provided by staff who did not have the appropriate skill. During the 12-month period before implementing the SNF prospective payment system, Medicare paid SNFs almost $1.3 billion for the unnecessary and improperly documented therapy.[16]

In our report entitled *Monitoring Part B Therapy for SNF Patients*, we noted that there was a dramatic decrease in Part B therapy charges during 1999. The decrease may be explained by the requirement that, as of January 1999, reimbursement changed from "cost-based" to the Medicare Part B fee schedule. However, preliminary reports indicate that a rebound in SNF Part B therapy charges may occur because of the moratorium on

[14]State Children's Health Insurance Program.

[15]*The Social Security Act*, Section 1833(g) as amended.

[16]Office of Inspector General, *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), August 1999.

the caps and the lack of adequate contractor oversight of billing practices and medical necessity. We recommended that CMS ensure that adequate medical reviews of Part B therapy in SNFs are conducted. We also recommended that CMS continue working with therapy providers to improve their understanding of Medicare billing procedures and the medical necessity guidelines for Part B therapy.

METHODOLOGY

Selection of Sampled SNF Part B Therapy Patients

From the Medicare Common Working File, we extracted all Part B physical, occupational, and speech therapy claims for services provided to SNF patients.[17] These claims were submitted to intermediaries by SNFs, rehabilitation agencies, and hospital outpatient departments for therapy initiated between January 1 and June 30, 1999. We limited the extract to the continental United States.

We used a multi-stage stratified clustered sample. We clustered the Medicare Part B therapy patients into groups of similar size in the same geographical area. We then stratified the clusters into four quadrants of the United States. We randomly selected 4 clusters per quadrant for a total of 16 clusters.

We used the 75th percentile of each cluster's estimated therapy reimbursement to group patients into two groups. Group 1 contained the 25 percent of patients with the highest therapy reimbursement. Group 2 contained the remaining 75 percent. For each cluster, we stratified patients within both groups and then selected 20 patients as follows:

Stratum I--patients with the highest reimbursement in Group 1	8
Stratum II--random selection of additional patients from Group 1	8
Stratum III--random selection of patients from Group 2	4
Total patients per cluster	20

Our sample for all clusters totaled 320 patients.

On-Site Medical and Financial Review

Several teams of certified and/or licensed physical and occupational therapists and speech-language pathologists conducted on-site review of the medical records for the national random sample. Reviewers used medical review instruments to assess the medical necessity, underutilization, overutilization, and quality of care provided in

[17]We identified beneficiaries as "SNF patients" if (1) the SNF submitted the claims, or (2) the beneficiaries were identified as SNF residents in CMS' minimum dataset (MDS).

calendar year 1999. The reviewers also determined if the record documentation and the information on the Medicare claims accurately reflected the types of therapy and the appropriate length of treatment that the patients received.

While on-site, in addition to the medical review, we:

- reviewed therapy ledgers to determine how SNFs track each patient's charges that were billed to Part B of Medicare;
- gathered data to identify payment sources for patients' in addition to Medicare reimbursement;
- interviewed SNF administrators and key therapy staff about how they tracked the cap and their interactions with their fiscal intermediaries; and
- observed physical, occupational, and speech therapy conducted with patients.

We conducted interviews at 132 facilities--97 SNFs, 28 hospital outpatient departments, and 7 rehabilitation agencies located in 18 States. We obtained the medical records for 318 of the 320 sampled patients. We were unable to review two patient records because the facility had closed before our review, and the corporate owner could not retrieve the records from storage.

Claims Analysis

We analyzed the Part B physical, occupational, and speech therapy claims submitted for the sampled patients. For each patient, we extracted only claims that were submitted for therapy initiated between January 1 and June 30, 1999.

We analyzed the claims by individual therapy units and clusters of therapy units. An individual "unit" of physical, occupational, or speech therapy constitutes one 15-minute session of therapy. Clusters of units were grouped into an "episode of care." An episode of care consists of a series of continuous therapy units tied to a specific diagnosis, treatment plan, and set of patient goals. An episode of care may last a few days or a few months.

The *Balanced Budget Act of 1997* mandated that nursing homes use the CMS Common Procedural Coding System to describe each type of therapy that patients receive. Medicare Part B therapy claims must include both the code and the number of 15-minute sessions, or "units," for each type of therapy. To illustrate, an occupational therapist works with a patient on the activities of daily living, such as bathing and dressing, for 45 minutes. The Medicare claim would include the appropriate code with three units for the length of the treatment.

Cost projections were based on an analysis of the extracted Part B physical, occupational, and speech therapy claims. Information found on each claim was used to calculate the estimated amount that Medicare allowed for each therapy claim. Cost projections then

were calculated using the lower of the calculated Medicare allowed amount or the fiscal year 1999 Medicare fee schedule amount.

This report is one of two reports on physical, occupational, and speech therapy for Medicare SNF patients. The other report, *Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients: Medical Necessity and Quality of Care based on Treatment Diagnosis* (OEI-09-99-00563), focuses on the medical necessity and quality of care for different therapy diagnoses.

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

FINDINGS

The $1500 therapy caps did not prevent Medicare SNF beneficiaries from receiving necessary and appropriate therapy

Less than 2 percent of Medicare beneficiaries reached either of the $1500 therapy caps

Nationally, 0.5 percent of Medicare Part B patients who began therapy between January and June 1999 reached or exceeded the $1500 occupational therapy cap within 6 months, and only 1.7 percent of patients reached or exceeded the shared $1500 physical and speech therapy cap. The average Medicare allowance for patients who received occupational therapy was $516, and the average Medicare allowance for physical and speech therapy patients was $503.

In approximately 82 percent of therapy episodes, beneficiaries required no additional therapy

In most of the episodes of care,[18] patients needed no additional therapy by the time their treatment ended. To determine if additional therapy was needed, medical reviewers examined medical records, treatment logs, and physician orders for each episode of care. Reviewers discovered patients rarely needed additional therapy to reach their treatment goals or patients would not have benefitted from additional therapy. For example, one occupational therapy patient received treatment once a day for approximately 3 weeks. After reviewing his record, one medical reviewer suggested, "This is a well documented case showing appropriate improvement in a reasonable time. There was good rationale for discharging...."

With regard to the remaining 18 percent, we found that in approximately 12 percent of the episodes patients actually needed additional therapy. For the rest, reviewers were unable to make a determination.

Patients received therapy beyond the caps because SNFs ignored the caps or were unaware of them

According to administrators, SNFs rarely discontinued therapy when patients reached the therapy caps. When they reached the $1500 cap, beneficiaries and their families were

[18] An "episode of care" consisted of a series of continuous therapy units tied to a specific diagnosis, treatment plan, and patient goals.

presented with the option of switching to another type of insurance or paying for therapy costs out of their own pocket. Administrators indicated that, in some cases, they continued to provide therapy to patients and absorbed the extra costs themselves.

A lack of education on Part B therapy also caused some SNFs to provide therapy to patients after they had reached or exceeded the $1500 caps. Staff in more than half of the facilities we interviewed reported not receiving training from fiscal intermediaries on Part B therapy. According to administrators, this often left them unclear on new billing requirements, including the therapy caps. Administrators in these facilities indicated that they were unaware of how to monitor the therapy caps, and, subsequently, costs were not tracked.

Despite the therapy caps, 14 percent of all therapy was not medically necessary

Although most therapy was medically necessary, some was not. Medical reviewers deemed that 88 percent of physical therapy was medically necessary, 86 percent of occupational therapy was medically necessary, and 67 percent of speech therapy was medically necessary. This included therapy that was undocumented or inadequately documented, since reviewers were instructed to deem therapy medically necessary when documentation was absent or inadequate.

MOST THERAPY WAS MEDICALLY NECESSARY

Therapy	All Therapy	Therapy Type		
		Physical	Occupational	Speech
Medically Necessary Therapy	85.7 percent	87.7 percent	86.3 percent	66.7 percent
Therapy Units Billed (approximate)	9,000,000	6,000,000	2,000,000	700,000

Source: Office of Evaluations and Inspections, 2001

Most SNF patients were diagnosed properly, and a necessary treatment plan was developed for each diagnosis. Therapists usually updated treatment plans when a patient's progress or condition changed, and therapy usually was administered with the proper frequency and duration. Reviewers also found that most Medicare patients benefitted from these services, and medically necessary therapy helped them reach their treatment goals.

Medical reviewers also found that some Medicare SNF patients received medically unnecessary therapy. Reviewers identified several reasons why 14 percent of therapy was medically unnecessary including, but not limited to:

- patients were not appropriate candidates based on their condition;
- treatment goals were being met, but therapy continued;
- therapy goals were not being achieved, and a reevaluation was not conducted; or
- skilled therapy was provided instead of the routine maintenance that was more appropriate for the patients's condition.

Medical reviewers found that the medical condition of some SNF patients did not indicate the need for skilled therapy. The diagnosis of some patients indicated that therapy would not have benefitted the patient, or the therapist should have postponed therapy until the patient's medical condition stabilized. For example, one occupational therapy patient with a questionable cognitive condition received unnecessary therapy three times a week for 3 weeks, without improvement. The patient's lack of motivation to participate in a previous therapy episode should have alerted the provider that this patient was not an appropriate candidate for therapy.[19]

Some therapy episodes continued 1 to 2 weeks beyond what was medically necessary. Medical reviewers noted that therapy continued because, among other reasons, a patient's medical condition had plateaued or SNFs did not properly monitor patient progress. In one rural facility, four out of the five patients in our sample received physical therapy from 1 to 4 weeks longer than was medically necessary. Reviewers also questioned why therapists continued to provide care that was not supported by documentation.

The SNFs continued to provide therapy, in some cases, to patients who were not meeting their treatment goals. Medical reviewers indicated that when a patient does not reach their treatment goals, therapy should be reevaluated and possibly discontinued. However, several facilities used a "cookie-cutter" treatment plan for all Medicare SNF patients. Therapy continued regardless of a patient's medical status. For example, one beneficiary received occupational therapy for 3 months without reaching her treatment goals. As the medical reviewer suggested, "...this case did not meet the Medicare guidelines of significant practical improvement over a reasonable time period, and treatment should have been discontinued."

Medical reviewers found that some patients did not need skilled speech therapy. Nursing home staff should have provided maintenance instead of skilled speech-language pathologists providing maintenance. For example, it was standard practice in many SNFs

[19] The effects of medical condition, or diagnosis, on medical necessity and quality of care is discussed in our companion report, *Physical, Occupational, and Speech Therapy for Medicare Part B Nursing Home Patients: An Analysis of Medical Necessity and Quality of Care based on Treatment Diagnosis*, OEI-09-99-00563, July 2001.

to bill an evaluation and several units of treatment for "changing a patient's diet" as skilled speech therapy. This therapy should have been delivered by the nursing home staff after the speech-language pathologist evaluated the patient and recommended the appropriate changes.

Medicare allowed approximately $28 million for unnecessary therapy in the first 6 months of 1999

The Medicare program allowed almost $15 million for unnecessary physical therapy, $6.4 million for unnecessary occupational therapy, and $7.5 million for unnecessary speech therapy during the first 6 months of 1999, while the therapy caps were in effect.

MEDICARE PAYS FOR UNNECESSARY THERAPY

Reimbursement Type	All Therapy (Millions)	Therapy Type (Millions)		
		Physical	Occupational	Speech
Allowed amount for unnecessary units	$28.7	$14.7	$6.4	$7.5
Total allowed amount	$196.5	$121.4	$49.0	$26.0

Source: Office of Evaluations and Inspections, 2001

The mean Medicare allowance for physical, occupational, and speech patients was higher with medically unnecessary therapy than without medically unnecessary therapy. We discovered that the mean allowance for physical therapy patients was at least $57 higher than it should have been, at least $54 higher for occupational therapy patients, and more than $76 higher for speech therapy patients. These higher payments were all a result of Medicare paying for medically unnecessary services.

Our sampling methodology does not allow us to make statistically valid projections for the entire year. Nevertheless, if we assume that the rate of medically unnecessary therapy for the second half of the year was the same as it was for the first 6 months, Medicare allowed approximately $56 million dollars for unnecessary therapy during 1999.

Patients who reached or exceeded the caps received medically unnecessary therapy

Eighty percent of the 2 percent of Medicare beneficiaries who reached either of the therapy caps received some unnecessary therapy. Medicare allowed between $1500 and $2800 for patients who reached the occupational therapy cap, with unnecessary therapy totaling anywhere from zero to $1500. Similarly, the amount allowed for Medicare SNF patients who reached or exceeded the shared physical and speech therapy cap was

between $1500 and $2700, with unnecessary therapy totaling anywhere from zero to $1900.

Sixty-three percent of the 1.7 percent of patients who reached the shared therapy cap would not have done so if they had received medically necessary therapy only. Similarly, approximately 76 percent of the 0.5 percent of beneficiaries who reached or exceeded the occupational therapy cap would not have done so had they received medically necessary therapy only. For example, more than 50 percent of the units billed to Medicare for one patient who exceeded the occupational therapy cap were medically unnecessary.

Although physical and speech therapy shared a cap, most beneficiaries received the physical and speech therapy they needed

Less than 10 percent of SNF patients needed speech and/or physical therapy and did not receive them

Medical reviewers confirmed that when most patients did not receive physical or speech therapy it was because therapy would not have benefitted their medical condition. For example, after confirming that one patient needed no speech therapy, a medical reviewer noted, "Patient previously received speech therapy from October 1998 to January 1999, was discharged due to a lack of progress."

Approximately 2 percent of beneficiaries reached the shared cap at any time during calendar year 1999

Very few patients were prevented from receiving physical or speech therapy because they reached the $1500 shared cap. An analysis of the complete 1999 claims history showed that no more than 2 percent would have reached the shared cap. Approximately 1 percent of sampled beneficiaries would have reached the shared cap if Medicare had paid for medically necessary therapy only.[20]

As mentioned earlier, possible explanations for why patients reached the cap include lack of training by fiscal intermediaries on Part B therapy, unnecessary therapy, or disregard for the therapy caps by providers.

[20]We excluded all unnecessary services received by each patient during 1999.

Approximately 10 percent of the therapy units were not supported by adequate documentation

We used the decisions of medical reviewers to determine how we would quantify documentation errors within our sample. Some episodes of therapy lacked any supporting documentation. For these episodes, reviewers were unable to determine if therapy was medically necessary. We counted all the billed therapy units associated with these episodes as undocumented. In other instances, reviewers determined that the episode of therapy was medically necessary, although some individual units were undocumented or inadequately documented. We counted these units accordingly. Overall, Medicare paid almost $20 million for therapy units that were undocumented or not documented adequately in the first 6 months of 1999

Medicare paid approximately $12 million for undocumented therapy units during the first 6 months of 1999

Undocumented therapy	Type of Therapy			Total for All Undocumented Units
	Physical	Occupational	Speech	
Percent of units	8.0%	5.9%	3.3%	7.1%
Medicare payment	$8.7 million	$ 2.8 million	$730,000	$12.2 million

Source: Office of Evaluation and Inspections, 2001

Although reviewers found some documentation in medical records to support almost 93 percent of therapy units, documentation was missing for approximately 7 percent of the units. The progress notes for some billed units did not describe all types of therapy provided in the session. For example, one patient's Medicare claim included 45 minutes of therapy each day for 21 consecutive days. The reviewer noted that the medical record contained documentation for 30 minutes of therapy each day rather than 45 minutes. In other instances, Medicare claims included units for some therapy that patients did not receive. For example, one claim included one unit for 15 minutes of gait training on 2 consecutive days. However, the therapist stated in the progress notes that the patient refused treatment on both days.

Medicare paid approximately $8 million for inadequately documented therapy units during the first 6 months of 1999

Inadequately Documented Therapy	Type of Therapy			Total for All Inadequately Documented Units
	Physical	Occupational	Speech	
Percent of units	3.4%	0.7%	6.8%	2.9%
Medicare payment	$4.3 million	$333,000	$2.9 million	$7.6 million

Source: Office of Evaluation and Inspections, 2001

Because almost 3 percent of therapy units were not documented adequately, reviewers were unable to determine the full range of therapy that patients received. Progress notes, which are intended to document how patients were progressing for each type of therapy, were incomplete in some medical records. For example, one patient received three types of therapy in each session--exercises to build strength and endurance, neuromuscular reeducation, and direct therapeutic activity with the therapist. The same types of therapy continued for 12 days between January and March 1999. However, the medical reviewer found that the documentation was adequate for only two of the three types of treatment in each session, but was consistently inadequate for the third type.

Physician's orders were not included in some medical records

Medicare guidelines state that therapy must be ordered in advance by a physician or other health care professional and documented in writing in the medical record. We were unable to locate a telephone or written order for some of the therapy episodes in our sample. The lack of orders corresponds to approximately 5.6 percent of the total therapy units billed to Medicare in the first 6 months of 1999. However, medical reviewers still determined the medical necessity, quality of care, and utilization of therapy for these units.

Several reasons for missing orders may include:

- a separate log of all physician's orders was missing from a patient's medical record,
- the medical record included a signed order for the first therapy episode but not for subsequent episodes, or
- physicians did not countersign telephone orders as required by Medicare guidelines.

For example, one patient received physical therapy in two episodes. We found a physician's order for the first episode in February 1999. Therapy lasted 1 month. The patient began another episode of therapy in May and received therapy for 3 months. However, we did not locate a physician's order for the second episode of therapy.

Medicare paid nursing homes approximately $10.6 million for these therapy units. Since the focus of our study was to determine the medical necessity, quality of care, and utilization of therapy, some of these units may have been included in the calculations for medically unnecessary, undocumented, and inadequately documented units.

Some SNFs did not retain medical records according to Medicare guidelines

Medicare guidelines require that SNFs retain medical records for 5 years after the patient is discharged. We reviewed medical records for therapy provided 12 to 20 months before our review. Some SNFs were unaware that records were missing until our review. In some cases, records were missing because (1) therapy notes were purged from the records for long-term patients, sent to storage, and subsequently misplaced or (2) the SNF changed therapy providers during 1999, and the previous provider removed the therapy records from the facility.

By removing records, therapy providers may have violated their contracts. Several contracts that we reviewed contained language such as, "All case records, case histories, personal and regular files concerning patients of the facility or facility patients consulted, interviewed, or treated and cared for by the provider shall belong to and remain the property of the facility." In fact, contracts between SNFs and independent therapy providers often stated that therapy records should be retained in patients' records and available for a minimum of 4 years after the contract expired.

Medicare allowed in error approximately $48.5 million for Part B therapy during the first 6 months of 1999. This includes $28.7 million for medically unnecessary therapy, $12.2 million for undocumented therapy units, and $7.6 million for inadequately documented therapy units. These three categories represent an overall error rate of 24.7 percent of the total allowed amount of approximately $196.5 million for Part B therapy during the first 6 months of 1999.

Our sampling methodology does not allow us to make statistically valid projections for the entire year. However, if we assume that the second half of 1999 was the same as the first 6 months of 1999, we estimate that the amount Medicare allowed for unnecessary, undocumented, and inadequately documented therapy was $97 million.

RECOMMENDATIONS

The CMS should:

Encourage fiscal intermediaries to continue educating SNFs on Part B billing and medical record documentation

More than half of all administrators told us that SNFs did not receive any training from the fiscal intermediary on billing for Part B therapy. Nursing home administrators and billing staff often remarked that they did not know how their facility billed therapy (charges or the fee schedule), and they were not aware that therapy reimbursement was based on the Part B fee schedule.

Fiscal intermediaries should also educate SNFs and their staff on Medicare requirements for medical record documentation and retention, with an emphasis on the proper documentation of physician's orders in patient records.

Instruct fiscal intermediaries to conduct focused medical review in order to identify and collect Part B therapy overpayments

Using focused medical review we identified approximately $28 million in overpayments for medically unnecessary Part B therapy services in the first 6 months of 1999. Instructing fiscal intermediaries to conduct similar focused medical review could result in significant cost savings for the Medicare program.

Consider options when developing a new reimbursement system for Part B therapy

As mentioned in the background, Section 221 of the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999* requires that CMS establish an alternative payment policy for SNFs. Based on our inspection, we suggest that CMS consider:

< basing reimbursement on an episode of therapy rather than an annual cap, and/or
< requiring prior authorization for therapy that exceeds a separate monetary cap for each type of therapy.

Continue working collaboratively with the national therapy associations

We believe that poor documentation is a result of a lack of awareness and understanding of Medicare guidelines and requirements on the part of SNFs and therapists. By working with the national associations, CMS can assure that they provide accurate and

comprehensive information to their members on proper documentation of therapy in medical records.

AGENCY RESPONSE

We received comments on the draft report from CMS. The Agency concurred with our recommendations. They will continue to educate nursing homes on Medicare Part B billing and medical record documentation and continue to recommend that fiscal intermediaries conduct focused medical review whenever their analysis suggests egregious overutilization of services. The CMS will consider options when developing a new reimbursement system for Medicare Part B therapy. Finally, CMS will continue its ongoing collaboration with the national therapy associations to provide information on proper documentation of therapy in medical records. The full text of the Agency's comments appears in appendix B.

APPENDIX A

Confidence Intervals for Selected Statistics

The following table shows 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 Medicare SNF beneficiaries, percent who reached either of the $1500 therapy caps	1.7%	0.4% - 3.1%
Of Medicare SNF beneficiaries, percent who reached the $1500 occupational therapy cap	0.5%	0% - 1.1%
Of Medicare SNF beneficiaries, percent who reached the $1500 shared cap for physical and speech therapy	1.7%	0.3% - 3.0%
Average allowed amount that Medicare reimbursed SNFs for occupational therapy beneficiaries	$516	$309 - $723
Average allowed amount that Medicare reimbursed SNFs for physical and speech therapy beneficiaries	$503	$425 - $581
Of Medicare nursing home beneficiaries, percent who did not need additional therapy	82.1%	75.1% - 89.1%
Of January - June 1999 therapy units, percent that were medically necessary for all therapies	85.7%	79.7% - 91.7%
Of January - June 1999 therapy units, percent that were medically necessary for physical therapy	87.7%	79.2% - 96.1%
Of January - June 1999 therapy units, percent that were medically necessary for occupational therapy	86.3%	79.3% - 93.9%
Of January - June 1999 therapy units, percent that were medically necessary for speech therapy	66.7%	48.6% - 84.9%
Of January - June 1999 therapy units, percent that were medically unnecessary for all therapies	14.3%	8.3% - 20.3%
Amount Medicare reimbursed SNFs for all therapy that was medically unnecessary	$28.7 million	$16.9 million - $40.5 million

APPENDIX A

Statistic	Point Estimate	95 Percent Confidence Interval
Amount Medicare reimbursed SNFs for physical therapy that was medically unnecessary	$14.7 million	$4.3 million - $25.2 million
Amount Medicare reimbursed SNFs for occupational therapy that was medically unnecessary	$6.4 million	$2.4 million - $10.4 million
Amount Medicare reimbursed SNFs for speech therapy that was medically unnecessary	$7.5 million	$1.5 million - $13.5 million
Of Medicare nursing home beneficiaries, percent who needed physical and/or speech therapy but did not receive them	9.3%	3.6% to 14.9%
Of January - June 1999 therapy units, percent that were undocumented	7.1%	2.4% - 11.7%
Of January - June 1999 therapy units, amount Medicare reimbursed nursing homes for units that were undocumented	$12.2 million	$5.0 million - $19.5 million
Of January - June 1999 physical therapy units, amount Medicare reimbursed nursing homes for units that were undocumented	$8.7 million	$1.5 million - $15.8 million
Of January - June 1999 occupational therapy units, amount Medicare reimbursed nursing homes for units that were undocumented	$2.8 million	$0.8 million - $4.8 million
Of January - June 1999 therapy units, percent that were not documented adequately	2.9%	0.8% - 5.1%
Of January - June 1999 therapy units, amount Medicare reimbursed nursing homes for units that were not documented adequately	$7.6 million	$2.1 million - $13.1 million
Of January - June 1999 physical therapy units, amount Medicare reimbursed nursing homes for units that were not documented adequately	$4.3 million	$0.4 million - $8.2 million
Of January - June 1999 occupational therapy units, amount Medicare reimbursed nursing homes for units that were not documented adequately	$333,000	$50,000 - $616,000

APPENDIX A

Statistic	Point Estimate	95 Percent Confidence Interval
Of January - June 1999 speech therapy units, amount Medicare reimbursed nursing homes for units that were not documented adequately	$2.9 million	0 - $6.0 million
Of January - June 1999 therapy units, percent of units for which we were unable to find a physician's order	5.6%	2.0% - 9.3%
Of January - June 1999 units, amount Medicare reimbursed nursing homes for units that were medically unnecessary, undocumented, and inadequately documented	$48.5 million	$29.6 million - $67.4 million
Of January - June 1999 therapy episodes, percent that did not have physician's order	9.2%	3.5% - 14.9 %

APPENDIX B

Agency Comments

APPENDIX B

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED
2001 JUN 20 AM 11:58
OFFICE OF INSPECTOR GENERAL

Health Care Financing Administration
Deputy Administrator
Washington, D.C. 20201

DATE: JUN 13 2001

TO: Michael F. Mangano
Acting Inspector General
Office of Inspector General

FROM: Michael McMullan
Acting Deputy Administrator
Health Care Financing Administration

SUBJECT: Office of Inspector General (OIG) Draft Reports: *Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients: Medical Necessity and Cost Under the $1,500 Therapy Caps,* (OEI-09-99-00560); *Medical Record and Documentation and Billing,* (OEI-09-99-00562); and *Medical Necessity and Quality of Care Based on Treatment Diagnosis,* (OEI-09-99-00563)

Thank you for the opportunity to review the above-referenced draft reports. The Health Care Financing Administration's (HCFA) main focus is to ensure health care security for all of our beneficiaries. These three companion reports have provided us with information that will allow us to protect and improve beneficiary health and satisfaction with outpatient rehabilitation services.

Following a thorough review, OIG found that less than 2 percent of Medicare beneficiaries reached either of the $1,500 therapy caps and that 86 percent of all Medicare Part B therapy was medically necessary. The OIG also found that the providers' medical documentation and billing techniques were not up to HCFA's standards and that efforts should be made to address these issues. We concur with OIG findings and will continue to work with the fiscal intermediaries (FIs), nursing home staff, and national therapy associations to make sure our beneficiaries receive the quality care they deserve.

The OIG has issued the following recommendations:

OIG Recommendation
HCFA should encourage FIs to continue educating nursing homes on Medicare Part B billing.

HCFA Response
We concur. The HCFA will continue to encourage FIs to educate nursing homes on Part B billing. The Therapy Review Program (TRP) mentioned in this report is tasked with providing educational materials and activities. We believe that providers of services

as well as administrators of nursing homes should be provided with information that facilitates appropriate claims billing.

OIG Recommendation
HCFA should instruct FIs to conduct focused medical review in order to identify and collect Medicare Part B therapy overpayments.

HCFA Response
We concur. The HCFA highly recommends focused medical review. The FIs were instructed to conduct focused medical review whenever their analysis suggests egregious overutilization of services. Furthermore, progressive correction action ensures both education and monitoring. The TRP will provide medical review of a statistically significant number of skilled nursing facility (SNF) Part B service claims for the years 1998, 1999, and 2000.

OIG Recommendation
HCFA should consider options when developing a new reimbursement system for Medicare Part B therapy such as: (1) reimbursement based on an episode of therapy; and (2) prior authorization for therapy that exceeds a separate monetary cap for each type of therapy.

HCFA Response
We concur. As required by statute, HCFA will be considering alternative payment systems for therapy services. Information collected by TRP from data analyses, medical review, and a variety of information-gathering activities will be analyzed by HCFA in the reports that Congress requested in the Balanced Budget Reconciliation Act of 1999.

OIG Recommendation
HCFA should continue working collaboratively with the national therapy associations to ensure that they provide accurate and comprehensive information to their members on proper documentation of therapy in medical records.

HCFA Response
We concur. The HCFA plans to continue working collaboratively with the national therapy associations to encourage provision of accurate and comprehensive information to their members on documentation of therapy services. The TRP has developed working relationships with the relevant associations resulting in a valuable exchange of information.

OIG Recommendation
HCFA should instruct FIs to provide regular workshops to nursing homes and their staff on Medicare requirements for record documentation and retention with an emphasis on the proper documentation of physician's orders in patient records.

HCFA Response
We concur. Nursing home staff will be encouraged to learn and use appropriate documentation and retention, including documentation of physician's orders.

Attachment

APPENDIX B