

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medical Necessity of Physical and Occupational
Therapy in Skilled Nursing Facilities**

**California Probe Sample Results
[Early Alert]**



**JUNE GIBBS BROWN
Inspector General**

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OEI's San Francisco regional office prepared this report under the direction of Kaye D. Kidwell, Regional Inspector General, and Paul A. Gottlober, Deputy Regional Inspector General. Principal OEI staff included:

REGION IX

Robert Gibbons
Carrie Lozano
Brad Rollin

HEADQUARTERS

Susan Burbach

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to determine, through a probe sample, whether sufficient evidence of medically unnecessary physical and occupational therapy exists to warrant conducting a national study.

BACKGROUND

Many residents of Medicare-certified skilled nursing facilities (SNFs) receive physical and occupational therapy, whether they are covered under Medicare Part A or not. In fact, SNFs submitted claims totaling almost \$7 billion for physical and occupational therapy in 1996. The amount that Medicare pays for these therapies has grown immensely since Congress passed nursing home reform legislation in 1987. These changes required SNFs to assess all residents' needs on a regular basis. The increases in physical and occupational therapy outlays have caused the Office of Inspector General (OIG), General Accounting Office, and other oversight groups to examine these increases.

Medicare guidelines delineate specific coverage criteria. All therapy services must be *reasonable and necessary* and *specific and effective* treatment for the patient's condition. Services must be dictated by a written *plan of treatment* that encompasses specific and measurable functional goals along with a reasonable estimate of when those goals will be attained. The plan of treatment should describe the specific therapeutic services that will be utilized, the frequency of visits, and the duration of services. Services must be ordered by a physician and require the skills of a qualified therapist.

Almost all therapy services are billed by SNFs to fiscal intermediaries. In general, SNFs either contract with rehabilitation agencies for services or use in-house staff. The Balanced Budget Act of 1997 significantly changes how SNFs will be reimbursed for physical and occupational therapy. For Part A beneficiaries, it requires that HCFA implement a prospective payment system for SNFs that incorporates therapy services, to be phased in over several years. The Act requires that the prospective payment rates be based on SNFs' 1995 allowable costs plus an estimate of the amounts that would have been payable under Part B for certain services, such as physical and occupational therapy. The HCFA also will implement a \$1,500 annual cap on therapy services for Part B beneficiaries, whether or not they reside in SNFs. The legislation also requires that all Part B ancillary services provided by SNFs be billed to Medicare by the SNFs under a consolidated billing program.

Probe Sample Methodology

For the probe, we selected a stratified random sample of six SNFs in California that are administered by Blue Cross of California or Mutual of Omaha. In collaboration with a medical

review contractor, we conducted on-site reviews of their medical records for a random sample of Medicare beneficiaries for whom these intermediaries processed claims during August 1997. We assessed a total of 80 records to determine the extent to which patients received physical and/or occupational therapy in accordance with Medicare guidelines.

FINDINGS

Medically unnecessary physical and occupational therapy services at sampled facilities ranged from less than 4 to more than 80 percent

More than one-quarter of therapy services were medically unnecessary at five out of the six SNFs. The remaining facility, which had less than 4 percent medically unnecessary services, had recently been under prepayment review by its fiscal intermediary. Most unnecessary therapies were the result of skilled therapy services being provided although the medical records did not document the need for the services based on Medicare guidelines. In other cases, the patient's file was missing, failed to contain a physician order, or did not include any evidence that therapy had been provided. The rates of medically unnecessary services were slightly higher for occupational therapy than for physical therapy.

Multiple factors account for the high volume of medically unnecessary services

- ▶ Skilled services are frequently provided when non-skilled services would be more appropriate.

Some beneficiaries simply require help building strength and endurance--which can be provided by nursing staff--but receive skilled physical and occupational therapy instead. In other cases, therapists fail to cease therapy or transition patients to a nursing program within an appropriate amount of time.

- ▶ Therapists sometimes ignore the beneficiary's prior level of function and set unrealistic goals.

We identified several cases where the therapist listed goals that included performing independent activities of daily living that the beneficiary had not performed for several years, because the beneficiary had a full-time caregiver or was a resident of a nursing home. In other cases, the therapist seemed to overestimate a patient's ability to recover from a debilitating illness.

- ▶ The frequency of therapy is sometimes excessive.

Some SNF patients in our sample received therapy comparable to patients in acute rehabilitation--up to 5 hours per day, according to medical records and ledgers. Most alarming were instances where exceptionally frail patients or people with Alzheimer's

disease or advanced senility and dementia received 4 to 5 hours of therapy per day for several weeks.

Other observations raise additional concerns about how therapy services are provided

- ▶ Time billed for therapy exceeds the actual time that services are provided.

We observed billed time being inflated by including time to transport or ambulate the patient to a therapy area and when patient fatigue required that a therapist halt a session.

- ▶ Recurring hospitalization may trigger unnecessary therapy services.

Long-term SNF residents who are hospitalized frequently receive unnecessary therapy when they return to the SNF. We found that patients who were hospitalized with medical problems other than orthopedic (e.g. hip fracture or replacement) or neurological conditions (e.g. stroke) were more likely to receive medically unnecessary services.

Summary of SNFs reviewed by the OIG

<i>Facility</i>	<i>Percentage Medically Unnecessary</i>	<i>Summary</i>
#1	80.3	Facility recently changed ownership, but the contracted rehabilitation agency remains. Facility exemplifies all of the issues described in this report.
#2	43.3	Appropriate candidates and good use of therapists time, but services continue beyond the point where skilled therapy is necessary.
#3	54.3	Therapists appear to spend much less time with patients than they bill for. Typical issues of inappropriate candidates and excessive frequency and duration.
#4	27.5	Expensive therapy management contract adds to the costs.
#5	3.7	Until recently, the fiscal intermediary was reviewing 100 percent of this facility’s claims prior to paying them, based on concerns about the medical necessity of its therapy services.
#6	62.6	Facility bills inappropriately for routine assessments and team conferences. In addition, therapist goals were inappropriate, and therapy did not cease when appropriate.

CONCLUSION

Our probe sample findings detail some significant concerns about how therapy services are provided to SNF patients. We found that, with the exception of one facility, more than a quarter

and as many as 80 percent of recent therapy services are medically unnecessary in sampled SNFs. With almost \$7 billion in therapy charges nationally in 1996 and the upward trend not abating, we believe that Medicare is paying significant amounts for medically unnecessary physical and occupational therapy.

The Balanced Budget Act, with its implementation of a prospective payment system for Part A beneficiaries and a \$1,500 cap on therapy services for Part B beneficiaries, creates an appropriate structure to control the cost of therapy services. At the same time, we believe that the cost formulas being used to develop the prospective payment rates and Part B cap could be significantly compromised by the volume of medically unnecessary services.

During 1998, we will conduct a full national study to quantify the extent of medically unnecessary services and to develop baseline data to compare therapy utilization before and after implementation of the Balanced Budget Act.

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INTRODUCTION

PURPOSE

The purpose of this inspection was to determine, through a probe sample, whether sufficient evidence of medically unnecessary physical and occupational therapy exists to warrant conducting a national study.

BACKGROUND

Medicare (Parts A and B)

Congress enacted Medicare in 1965 to provide health services to the elderly and disabled. The program consists of two distinct parts. The first part is hospital insurance or **Part A**. Part A covers services furnished by *providers*, i.e., hospitals, home health agencies, and skilled nursing facilities. The second part, supplementary medical insurance or **Part B**, covers a wide range of medical services and supplies. These include physician services, outpatient hospital services, diagnostic laboratory tests, x-rays, ambulance services, and durable medical equipment.

The Health Care Financing Administration (HCFA) administers Medicare and contracts with private insurance companies to process and pay claims. Contractors that process Part A claims are referred to as *fiscal intermediaries*. Contractors that process Part B claims are called *carriers*.¹ Some contractors have both fiscal intermediary and carrier components. The HCFA provides substantial guidance to fiscal intermediaries and carriers on applicable laws, regulations, national policies, fee schedules, and other requirements.

Skilled Nursing Facilities

This inspection focuses on patients in Medicare-certified skilled nursing facilities (SNFs). All SNFs must meet the requirements of Section 1819 of the Medicare law. The facility must, for example, (1) provide 24-hour 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.

¹ An exception to this general rule is that fiscal intermediaries process Part B claims submitted by hospitals (for inpatient and outpatient services), home health agencies, and skilled nursing facilities.

Unlike other long-term care facilities, SNFs may be reimbursed under Part A as well as for any patients who receive Part B-covered services only. The Medicare program provides coverage under Part A for skilled nursing facility services but not for custodial care.²

The Part A SNF benefit includes:

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

Medicare law stipulates that beneficiaries are eligible for Part A benefits if they are transferred to a SNF after a minimum 3-day covered stay in an acute hospital. The patient must require skilled nursing care, and a physician must order the services. Part A covers SNF services for up to 100 days per "spell of illness." The beneficiary is responsible for a copayment for the 21st through 100th day of care. After 100 days, beneficiaries 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. The SNFs are responsible for meeting the needs of long-term patients who are eligible for Part B services only during their stay.

Therapy Services for SNF Patients

What are physical and occupational therapy?

According to the American Physical Therapy Association, ***physical therapy*** primarily involves (1) examining patients with impairments or functional limitations in order to determine a diagnosis and intervention and (2) designing, implementing, and modifying a program to alleviate those impairments. Among other things, physical therapists evaluate patients' motor function, range of motion, posture, pain, gait, and balance. Common treatments include therapeutic exercise, functional training in activities of daily living, prescription and customization of prosthetic devices, and wound care. For example, physical therapy may include therapeutic exercises--such as knee extensions to restore injured joints--or walking on ramps, stairs, or curbs to improve walking ability impaired by injury or illness.

² Facilities that are certified by Medicare to provide skilled nursing services are referred to as ***skilled nursing facilities***, even if most of their patients do not receive skilled nursing services.

According to Medicare guidelines, **occupational therapy** is:

...medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury, or, where function has been permanently lost or reduced by illness or injury, to *improve the individual's ability to perform those tasks required for independent functioning* [emphasis added].

Occupational therapy primarily focuses on compensatory techniques to improve a patient's ability to complete activities of daily living. Some examples include teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand and designing, fabricating, and training a patient in the use of a device that would enable him to hold a utensil and feed himself independently.

A SNF resident may receive more than one type of therapy. While Medicare regulations define common illnesses and injuries requiring therapy services, the regulations do not specifically bar therapy for illnesses or injuries that are not mentioned.

Who provides physical and occupational therapy services?

A number of different entities provide physical and occupational therapy in SNFs. The SNFs frequently contract with rehabilitation agencies, certified outpatient rehabilitation facilities (CORFs), hospitals, or individuals to provide therapy services on-site. Rehabilitation agencies and CORFs provide most SNF therapy services by contracting with therapy professionals. In other instances, SNFs have therapy professionals on staff on-site or transport patients to outpatient therapy providers.

Medicare regulations define most therapy providers:

- ▶ **Physical therapists** must be graduates of an accredited physical therapy curriculum and be licensed by the State in which they practice.
- ▶ **Occupational therapists** must be (1) graduates of a curriculum jointly accredited by the American Medical Association's Committee on Allied Health Education and the American Occupational Therapy Association or (2) eligible for the National Registration Examination of the American Occupational Therapy Association.
- ▶ **Physical therapy assistants** must be graduates from a 2-year college-level program approved by the American Physical Therapy Association and be licensed by the State in which they practice. Physical therapy assistants provide services to patients under the direct supervision of a physical therapist. Physical therapy assistants also supervise physical therapy aides and document treatment progress.
- ▶ **Occupational therapy assistants** must be certified by the American Occupational Therapy Association.

- ▶ **Physical therapy aides** are non-licensed workers who perform designated routine tasks under the direct supervision of a physical therapist or physical therapy assistant.³ Their duties include assisting patients with robing and disrobing, positioning patients for treatments and tests, administering routine treatments such as hydrotherapy, hot packs, and paraffin baths, transporting patients to and from treatment areas, and cleaning the work area after treatment.

What does Medicare cover?

All SNFs are required by law to assess each patient's status and needs, 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 (OBRA 87), requires that SNFs assess the needs of all residents within 14 days of admission and annually. This assessment is completed through the Resident Assessment Instrument which identifies a resident's unique physical and mental health problems. According to the Act, problems identified through the assessment must be treated to attain or maintain "the highest practicable level" of functioning, taking into account the resident's physical, mental, and psychosocial well-being.

Coverage guidelines state that all therapy services must be *reasonable and necessary* and *specific and effective* treatment for the condition. The HCFA requires that therapy services be dictated by a written plan of treatment. The treatment plan must include specific and measurable functional goals along with a reasonable estimate of when those goals will be attained. It should describe the specific therapeutic services (*modalities*) that will be utilized, the frequency of visits, and the duration of services. Services must be ordered by a physician and require the skills of a qualified therapist.

While therapies are generally expected to result in the full or partial restoration of function, this is not required. Coverage guidelines state:

The fact that full or partial recovery is not possible or rehabilitation potential is not present is not the deciding factor. The deciding factor is based on whether the services are reasonable effective treatment for the patient's condition and require the skills of a physical therapist, or whether they can be safely and effectively carried out by non-skilled personnel, without the physical therapist's supervision.

The guidelines state that therapists should document the reason why therapy is medically necessary and the goal of the treatment, even if the goal is not full or partial restoration of function.

³ Supervisory requirements vary by State.

How does Medicare pay for therapy services for SNF patients?

Almost all therapy services are billed by SNFs to fiscal intermediaries. In general, SNFs either contract with rehabilitation agencies for services or use in-house staff.

A majority of SNFs contract and bill “under arrangement” for therapy services. Under these arrangements, SNFs contract with therapy service providers who bill the SNF for services. The SNFs submit claims to Medicare, typically marking up the amount claimed for overhead. Fiscal intermediaries reimburse services billed under arrangement on a cost basis. The costs for physical therapy services provided by rehabilitation agencies and billed by SNFs are subjected to hourly salary equivalency guidelines. The HCFA implemented salary equivalency guidelines for physical therapy in 1975 to ensure that it did not reimburse providers for excessive contracted therapy costs. While SNFs may charge amounts that are considered to be reasonably related to costs, the guidelines are applied to SNFs’ costs when they submit their cost report.

Until recently, occupational therapy services were not subjected to salary equivalency guidelines. The HCFA recently published final salary equivalency guidelines for occupational therapy and also revised the physical therapy guideline amounts.

When SNFs use staff therapists, the salaries and fringe benefits paid to those staff become the cost of providing the services and the basis for the amount claimed. These costs are not subjected to physical therapy salary equivalency guidelines. In rare cases, SNFs transport patients to other facilities for therapy or contract with a rehabilitation agency or other therapy provider that bills Medicare directly.

Recent Increases in Outlays for Physical and Occupational Therapy

In 1996, SNF charges for physical and occupational therapy services were approximately \$6.7 billion. Most of the charges were for services provided under arrangement, and a majority of the charges were for beneficiaries covered by the SNF benefit:

Part A charges comprise the majority of therapy claims

<i>Beneficiary Coverage</i>	<i>1996 Charges</i>	<i>1996 Claims</i>
Part A	\$5.3 billion	2.2 million
Part B	\$1.4 billion	1.1 million

After Congress passed OBRA 87, therapy service utilization increased significantly. According to the General Accounting Office (GAO), charges for occupational therapy grew 1,968 percent from 1989 to 1995, and charges for physical therapy grew 646 percent during that same period. This trend does not appear to be abating. The following table illustrates the increases in charges and claims for physical and occupational therapy from 1994 to 1996:

Charges and claims for physical and occupational therapy continue to skyrocket

<i>Therapy</i>	<i>Charges (percentage increase between 1994 and 1996)</i>	<i>Claims (percentage increase between 1994 and 1996)</i>
Physical Therapy	62.8%	41.2%
Occupational Therapy	66.9%	52.8%

Recent Work on Therapy in SNFs

Two 1996 GAO reports describe other weaknesses in Medicare's oversight of therapy services. Both reports describe the need for HCFA to rapidly implement salary equivalency guidelines for occupational therapy. The first report, "Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes," also states that it was impossible to determine how much time a therapist spent with a patient by reviewing claims. As a result, it is difficult to determine whether Medicare is being overbilled. The second report, "Early Resolution of Overcharges for Therapy in Nursing Homes is Unlikely," reiterated these problems and concerns.

The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 significantly changes how SNFs will be reimbursed for physical and occupational therapy. For Part A beneficiaries, it requires that HCFA implement a prospective payment system for SNFs that incorporates therapy services, to be phased in over several years. The Act requires that the prospective payment rates be based on SNFs' 1995 allowable costs plus an estimate of the amounts that would have been payable under Part B for certain services, such as physical and occupational therapy.

The HCFA also will implement a \$1,500 annual cap on therapy services for Part B beneficiaries, whether or not they reside in SNFs. In addition, the legislation requires that all Part B ancillary services provided to SNF residents be billed to Medicare by the SNF under a consolidated billing program.

Probe Sample Methodology

For the probe, we selected a stratified random sample of six SNFs that (1) billed Medicare for more than \$291,500 in therapy charges in 1996, (2) are in 11 selected counties in northern and southern California, and (3) are administered by either Blue Cross of California or Mutual of Omaha. In order to increase statistical precision, we divided large SNFs into multiple sampling units. We eliminated SNFs from our sample if we could not determine how they provided physical and occupational therapy from HCFA's Online Survey Certification and Reporting system.

Blue Cross of California and Mutual of Omaha provided us with claims that they had received or processed during August 1997 for these six facilities. We randomly selected 15 claims to review

at each site. We contracted with Inaba-Foto Associates to conduct the on-site medical review. Inaba-Foto Associates contracts with several fiscal intermediaries nationally to conduct medical review on therapy service claims.

We evaluated medical records and therapy ledgers to assess compliance with the medical necessity criteria set forth in Medicare's SNF manual. The review included determining whether:

- ▶ the patient was a good candidate for physical and/or occupational therapy, i.e., he or she could benefit from the services;
- ▶ the services were ordered by a physician;
- ▶ the condition warranting the therapy was documented in the records;
- ▶ the plan of treatment and therapist's goals were appropriate;
- ▶ the modalities and frequency and duration of treatment were clearly delineated and followed;
- ▶ appropriate therapy staff performed the services; and
- ▶ the records clearly documented the patient's progress.

We analyzed a total of 80 records--14 or 15 records at each site except one SNF that had only 8 claims processed during August 1997. We also observed therapy services being performed, interviewed SNF and therapy staff, and obtained copies of therapy service contracts.

We determined the percentage of medically unnecessary therapy services in two ways. Four SNFs provided us with itemized ledgers which allowed us to determine how much the SNFs *charged* for medically unnecessary services. Two SNFs were unable to provide us with ledgers. For these SNFs, the percentage of medically unnecessary services is based on the percentage of *visits* documented in the medical record that were medically unnecessary. The table on page 8 notes how we determined the percentage of medically unnecessary services for each SNF.

We believe that evaluating charges is the most accurate way to assess medical necessity because it enables us to allow or disallow parts of services and to account for the difference in the length of a particular therapy service. It also enables us to make distinctions between therapy evaluations and regular therapy sessions. SNFs typically bill more for evaluations.

In order to assess the effect of using different methods to determine the percentage of medically unnecessary services, we determined the percentage of medically unnecessary services using visits for the four SNFs that provided us with itemized ledgers. In all cases, we found that the percentages corresponded within a few percentage points of the percentages we found using the itemized charges.

PROBE SAMPLE FINDINGS

Medically unnecessary physical and occupational therapy services at sampled facilities ranged from less than 4 to more than 80 percent

As the table below illustrates, more than one-quarter of physical and occupational therapy services were medically unnecessary at five of the six SNFs we reviewed. The SNF with less than 4 percent medically unnecessary services recently had been under prepayment review by its fiscal intermediary:

Rates of medically unnecessary services vary widely in sampled SNFs

<i>Facility</i>	<i>Percentage medically unnecessary</i>	<i>Percent that failed to meet Medicare medical necessity criteria</i>	<i>Percentage with no physician order or documentation missing</i>
#1	80.3**	65.1	15.1
#2	43.3*	41.6	1.7
#3	54.3*	54.0	0.3
#4	27.5*	27.1	0.4
#5	3.7**	3.1	0.5
#6	62.6*	55.4	7.3

* Percent medically unnecessary based on itemized charges in SNF ledgers

** Percent medically unnecessary based on visits documented in medical records (ledgers not available)

Some totals do not equal the overall percentage of medically unnecessary services due to rounding.

The percentage of medically unnecessary services is based on instances where (1) we determined that the services failed to meet Medicare coverage criteria and (2) the patient's file lacked the physician order or documentation that the services had been provided at all.

While denial rates for both types of therapy were high, occupational therapy was more likely to be medically unnecessary than physical therapy at five of the six sites. The following chart illustrates this variation:

**Rates of medically unnecessary services were slightly higher
for occupational therapy than physical therapy**

<i>Facility</i>	<i>Percentage of Physical Therapy Medically Unnecessary</i>	<i>Percentage of Occupational Therapy Medically Unnecessary</i>
#1	79.8**	80.9**
#2	41.7*	46.4*
#3	55.4*	52.7*
#4	19.1*	35.6*
#5	2.7**	6.5**
#6	57.7*	73.3*

* Percent medically unnecessary based on itemized charges

** Percent medically unnecessary based on visits

Multiple factors account for the high volume of medically unnecessary services

While many factors account for the volume of unnecessary therapy, three major reasons emerged in our analysis of these services: (1) skilled services are frequently provided when non-skilled services would be more appropriate, (2) therapists sometimes ignore the beneficiary's prior level of function and set unrealistic goals, and (3) the frequency of therapy is sometimes excessive.

Skilled services are frequently provided when non-skilled services would be more appropriate

Some beneficiaries simply require help in building strength and endurance but receive skilled physical and occupational therapy instead. Assistance in building strength and endurance should be performed by nursing staff. Of the 80 beneficiaries we assessed, 14 did not require skilled services *at all*. These patients received thousands of dollars of physical and occupational therapy nonetheless. In these cases, the therapist's role should have been only to design a program of routine therapy to be administered by nursing staff.

Therapists fail to cease therapy or transition patients to a nursing program within an appropriate amount of time. Many of the beneficiaries who received medically unnecessary services received appropriate evaluations and some medically necessary services. However, patient records often did not support the need for on-going skilled therapy services. We estimate that 26 of the 80 beneficiaries we reviewed should have been transitioned to routine nursing services after some skilled services had been provided. The therapist's role should have changed from providing services to designing a nursing routine that would continue the patient's improvement and help maintain the gains.

Therapists sometimes ignore the beneficiary's prior level of function and set unrealistic goals

Therapists are required to design realistic short- and long-term therapeutic goals for patients. These are used to guide the course and ultimately judge the success of the treatment. If a therapist sets unrealistic goals, the patient will receive lengthy and unsuccessful treatments. In 14 of our 80 cases, the therapist's goals were unrealistic. These included goals of performing independent activities of daily living that the beneficiary had not performed for several years, because the beneficiary had a full-time caregiver or was a resident of a nursing home. In other cases, the therapist seemed to overestimate a patient's ability to recover from a debilitating illness.

The frequency of therapy is sometimes excessive

Some SNF patients in our sample received therapy comparable to patients in acute rehabilitation--up to 5 hours per day, according to medical records and ledgers. In 7 out of the 80 cases, we deemed the frequency excessive. Most alarming were instances where exceptionally frail patients or people with Alzheimer's disease or advanced senility and dementia received 4 to 5 hours of therapy per day for several weeks. It is unlikely that many of these patients could tolerate such intensive therapy. In general, we found that physical therapists were prone to routinely provide 2 or more hours of therapy per day when the beneficiary would have received the maximum benefit from 1 hour of physical therapy per day.

Other observations raise additional concerns about how therapy is provided

During our on-site visits, we also had some concerns with issues not directly related to our medical review. While observing therapy being performed, we found that the time billed for therapy frequently exceeds the actual time that services are provided. In addition, while reviewing the history of sampled patients, we observed that recurring hospitalization may trigger unnecessary therapy services.

Time billed for therapy exceeds the actual time that services are provided

Medicare guidelines state that time billed for therapy services must be for time spent providing skilled services. This does not include time spent on documentation, team conferences, or unskilled therapy such as simple ambulation.

Most therapy ledgers that we reviewed showed four units (1 hour) of therapy being performed and billed per session. We did not observe any therapy that lasted anywhere close to an hour. The GAO report, "Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes," noted that it was impossible to determine how much time a therapist spent with a patient by reviewing claims.

We did, however, observe that therapists inflated "billed time" by including time to transport or ambulate the patient to a therapy area. Time billed as skilled therapy included transferring the

patient to a wheelchair or walker as skilled therapy. Technically, this is skilled “bed transfer” therapy, but it might take another 5 to 10 minutes to ambulate or transport the patient to a therapy area, plus an additional 5 to 10 minutes to return the patient to his room. While the therapist might give some safety and gait instruction during transport or ambulation, these are not considered skilled services, according to Medicare guidelines.

In addition, patient fatigue frequently requires that a therapist halt a session. Some patients are frail and cannot tolerate an hour of skilled therapy. Other patients become combative or uncooperative as a therapy session progresses. These instances may force a therapist to stop therapy before the allotted hour is up. While the therapist may attempt to complete the daily session later in the day, this is not always possible.

Recurring hospitalization may trigger unnecessary therapy services

Long-term SNF residents who are hospitalized frequently receive unnecessary therapy when they return to the SNF. We found that patients who were hospitalized with medical problems other than orthopedic (e.g., hip fracture or replacement) or neurological (e.g., stroke) conditions were more likely to receive medically unnecessary services. These patients typically were hospitalized for conditions such as dehydration, bowel obstruction, or the onset of congestive heart failure. We determined that these patients might (1) require a longer recovery time prior to initiating therapy, (2) require only unskilled services to build strength and endurance, or (3) not ever attain the level of physical health they possessed before hospitalization, due to the chronic nature of their illness.

SUMMARY TABLE

The table below summarizes our primary findings at the six sampled facilities:

<i>Facility</i>	<i>Percentage Medically Unnecessary</i>	<i>Summary</i>
#1	80.3	Facility recently changed ownership, but the contracted rehabilitation agency remains. Facility exemplifies all of the issues described in this report.
#2	43.3	Appropriate candidates and good use of therapists time, but services continue beyond the point where skilled therapy is necessary.
#3	54.3	Therapists appear to spend much less time with patients than they bill for. Typical issues of inappropriate candidates and excessive frequency and duration.
#4	27.5	Expensive therapy management contract adds to the costs.
#5	3.7	Until recently, the fiscal intermediary was reviewing 100 percent of this facility's claims prior to paying them, based on concerns about the medical necessity of its therapy services.
#6	62.6	Facility bills inappropriately for routine assessments and team conferences. In addition, therapist goals were inappropriate, and therapy did not cease when appropriate.

CONCLUSION

Our probe sample findings detail some significant concerns about how therapy services are provided to SNF patients. We found that, with the exception of one facility, more than a quarter and as many as 80 percent of recent therapy services are medically unnecessary in sampled SNFs. With almost \$7 billion in therapy charges nationally in 1996 and the upward trend not abating, we believe that Medicare is paying significant amounts for medically unnecessary physical and occupational therapy.

The Balanced Budget Act, with its implementation of a prospective payment system for Part A beneficiaries and a \$1,500 cap on therapy services for Part B beneficiaries, creates an appropriate structure to control the cost of therapy services. At the same time, we believe that the cost formulas being used to develop the prospective payment rates and Part B cap could be significantly compromised by the volume of medically unnecessary services.

During 1998, we will conduct a full national study to quantify the extent of medically unnecessary services and to develop baseline data to compare therapy utilization before and after implementation of the Balanced Budget Act.