DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
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# Memorandum

SEP 1 8 2008

**To:** Nanette Foster Reilly
Consortium Administrator
Centers for Medicare & Medicaid Services

**From:** Peter J. Barbera
Regional Inspector General
for Audit Services

**Subject:** Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Ultimate Rehabilitation Agency, Inc. (A-04-05-02009)

The attached final report provides the results of our review of the comprehensive outpatient rehabilitation facility (CORF) therapy services provided by Ultimate Rehabilitation Agency, Inc. (Ultimate).

CORF facilities provide outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons. Ultimate was a CORF located in Miami, Florida, which received $2,502,269 for 4,838 claims for physical and occupational therapy services provided during calendar year (CY) 2003.

The objective of our review was to determine whether payments to Ultimate for physical and occupational therapy services provided during CY 2003 were in accordance with Medicare reimbursement requirements. From a sample of 100 claims for 2,576 services, medical reviewers identified 98 claims for 1,400 services totaling $32,227 that did not meet Medicare reimbursement requirements, including:

- 1,189 services totaling $27,527 that did not meet requirements for reporting service units,
- 151 services totaling $3,296 that did not meet documentation requirements, and
- 60 services totaling $1,404 that were not medically necessary.

Based on our sample results, we estimated that for CY 2003, Ultimate received $1,400,062 for therapy services that did not meet Medicare reimbursement requirements.

We recommended that Ultimate refund to the Medicare program the estimated $1,400,062 in unallowable payments for CY 2003.

In response to our draft report, we learned that Ultimate closed operations. An authorized representative of the former company indicated the facility will not be contesting or responding to the report of findings, as the facility is no longer in existence. Therefore, for the record and your future use, we are sending this final report to you.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Andrew A. Funtal, Audit Manager at (404) 562 -7762 or through e-mail at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-05-02009 in all correspondence.

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY THERAPY SERVICES PROVIDED BY ULTIMATE REHABILITATION AGENCY, INC.

Daniel R. Levinson
Inspector General

September 2008
A-04-05-02009

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http://oig.hhs.gov

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## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## EXECUTIVE SUMMARY

### BACKGROUND

Comprehensive outpatient rehabilitation facilities (CORF) provide outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons. Sections 4523(d) and 4541 of the Balanced Budget Act of 1997 amended the Social Security Act to require that payment for hospital outpatient services, including CORF services, be made under a prospective payment system.

Ultimate Rehabilitation Agency, Inc. (Ultimate), was a CORF located in Miami, Florida. Ultimate received $2,502,269 for 4,838 claims for physical and occupational therapy services provided during calendar year (CY) 2003. With the assistance of a program safeguard contractor, we reviewed a random sample of 100 of these claims. Each claim included multiple therapy services.

### OBJECTIVE

Our objective was to determine whether payments to Ultimate for physical and occupational therapy services provided during CY 2003 were in accordance with Medicare reimbursement requirements.

### SUMMARY OF FINDINGS

From our sample of 100 claims for 2,576 services, medical reviewers identified 98 claims for 1,400 services totaling $32,227 that did not meet Medicare reimbursement requirements, including:

- 1,189 services totaling $27,527 that did not meet requirements for reporting service units,
- 151 services totaling $3,296 that did not meet documentation requirements, and
- 60 services totaling $1,404 that were not medically necessary.

Based on our sample results, we estimated that for CY 2003, Ultimate received $1,400,062 for therapy services that did not meet Medicare reimbursement requirements.

Ultimate's policies and procedures did not address Medicare requirements for reporting service units. In addition, Ultimate did not always follow its policies and procedures for ensuring that therapy services were adequately documented and provided in accordance with Medicare reimbursement requirements.

## RECOMMENDATIONS

We recommend that Ultimate refund to the Medicare program the estimated $1,400,062 in unallowable payments for CY 2003.

### Ultimate Rehabilitation Agency, Inc. Comments and Office of Inspector General Response

Ultimate closed operations in 2006. An authorized representative of the former company indicated that it would not be contesting or responding to the report of findings because the entity is no longer in existence. For this reason, we are making no procedural recommendations.

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# INTRODUCTION

## BACKGROUND

### Comprehensive Outpatient Rehabilitation Facilities

Comprehensive outpatient rehabilitation facilities (CORF) provide outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons. Pursuant to section 1861(cc)(2)(B) of the Social Security Act (the Act), Medicare-certified CORFs must provide physician services, physical therapy, and social or psychological services. Medicare also covers occupational and speech-language pathology services provided by CORFs (section 1861(cc)(1)(B) of the Act).

Sections 4523(d) and 4541 of the Balanced Budget Act (BBA) of 1997 required the Centers for Medicare & Medicaid Services (CMS) to implement a prospective payment system for hospital outpatient services, including CORF services. Accordingly, CMS implemented a prospective payment system for CORF services furnished on or after January 1, 1999. The BBA also added section 1834(k) to the Act, requiring all CORF services to be paid at 80 percent of the lesser of the actual charge for the service or the applicable fee schedule amount. Section 1834(k)(3) of the Act defines the applicable fee schedule amount as ". . . the amount determined under the fee schedule established under section 1848 [i.e., the physician fee schedule]. . . ."

### Fiscal Intermediaries

CORFs generally receive payments for covered services furnished to Medicare beneficiaries through fiscal intermediaries under contract with CMS. Federal regulations specify that the intermediaries' functions include processing claims, assisting in the application of safeguards against unnecessary utilization of services, conducting provider audits, resolving provider disputes, and reconsidering payment denial determinations (42 CFR § 421.100).

### Program Safeguard Contractors

CMS contracts with program safeguard contractors (PSC) to perform medical review functions, including analyzing data, writing local coverage determinations, reviewing claims, and educating providers.

### Ultimate Rehabilitation Agency, Inc.

Ultimate Rehabilitation Agency, Inc. (Ultimate), formerly located in Miami, Florida, became a Medicare-certified CORF in January 1999. The fiscal intermediary for Ultimate was First Coast Service Options, Inc., located in Jacksonville, Florida.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether payments to Ultimate for physical and occupational therapy services provided during calendar year (CY) 2003 were in accordance with Medicare reimbursement requirements.

### Scope

Our review covered physical and occupational therapy services provided in CY 2003, for which Ultimate received Medicare payments of $2,502,269 for 4,838 claims.

Although we did not perform detailed tests of internal controls, we reviewed Ultimate's written policies and procedures relating to the documentation and submission of claims for CORF therapy services.

We contracted with the PSC, Electronic Data Systems, to perform medical reviews. The purpose of the medical reviews was to determine whether the CORF services that Ultimate claimed were reasonable, medically necessary, supported by adequate documentation, and correctly coded and reimbursed. In addition, the PSC was to determine and explain the reason for any inappropriately paid claims.

We conducted fieldwork at Ultimate in Miami, Florida.

### Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and Medicare guidance for CORF therapy services;
- used CMS's Data Extract System user interface to retrieve all Ultimate claim information related to physical and occupational therapy services for the audit period;
- selected a random sample of 100 paid claims containing 2,576 services totaling $52,987 (Appendix A);
- contracted with the PSC to review all medical and billing records for the sampled claims to determine whether Ultimate's CORF services met Medicare reimbursement requirements;
- worked with PSC staff to develop a payment error matrix that defined all the error codes;
- obtained supporting medical and billing records from Ultimate for each sampled claim;

- reviewed Ultimate's policies and procedures manual to determine whether policies existed to prevent the errors that the medical reviewers identified;

- reviewed the PSC's medical review determinations; and

- estimated overpayments to Ultimate (Appendix B).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## FINDINGS AND RECOMMENDATIONS

From our sample of 100 claims for 2,576 services, medical reviewers identified 98 claims for 1,400 services totaling $32,227 that did not meet Medicare reimbursement requirements, including:

- 1,189 services totaling $27,527 that did not meet requirements for reporting service units,

- 151 services totaling $3,296 that did not meet documentation requirements, and

- 60 services totaling $1,404 that were not medically necessary.

Based on our sample results, we estimated that for CY 2003, Ultimate received $1,400,062 for therapy services that did not meet Medicare reimbursement requirements.

Ultimate's policies and procedures did not address Medicare requirements for reporting service units. In addition, Ultimate did not always follow its policies and procedures for ensuring that therapy services were adequately documented and provided in accordance with Medicare reimbursement requirements.

## SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS

Medicare requirements specify that CORF services must meet requirements for reporting service units, be adequately documented, and be medically necessary. Medical reviewers determined that 98 claims for 1,400 physical and occupational therapy services totaling $32,227 did not meet Medicare requirements.

### Service Units Reported

Section 1833(e) of the Act precludes payments to any service provider unless the provider has furnished information necessary to determine the amounts due such provider. Pursuant to Federal requirements, providers must report therapy services using the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes and the

appropriate number of units of service.[1] Providers must determine the appropriate number of units based on the total treatment time and CMS-designated treatment intervals. Specifically, Medicare guidance provides that:

> For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. . . .
>
> . . . Providers should not bill for services performed for [less than] 8 minutes. . . .
>
> The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a time code, should be recorded. (The length of the treatment to the minute could be recorded instead.) ["Medicare Intermediary Manual," Pub. No. 13, part 3, section 3653(I).]

Ultimate claimed $27,527 for 1,189 therapy services that did not comply with Medicare requirements for reporting service units. For 914 of these services, Ultimate did not document the number of units billed by recording either the beginning and ending times or the length of time to the minute. For 166 services, Ultimate billed for single units that were less than 8 minutes in duration. In addition, for 109 services, Ultimate billed for more units of direct contact therapy than were documented in the records. For example, in one case, Ultimate billed for two units of service, which require a minimum of 23 minutes of direct contact. However, Ultimate's records documented only 12 minutes of direct contact.

**Documentation**

Medicare requirements pertaining to documentation of CORF services include the following:

- Pursuant to Federal regulations (42 CFR § 485.60), documentation on each patient must be consolidated into one clinical record that must contain progress notes or other documentation that reflects the patient's reaction to treatment, tests, or injury or the need to change the established plan of treatment. Medicare guidance states: "Progress notes are to be maintained in the patient's record . . . . Progress notes must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition" (Local Coverage Determination for Therapy Rehabilitation Services (L1125)).[2]

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[1]Section 1834(k)(5) of the Social Security Act, 42 U.S.C. § 1395m(k)(5) (requiring all claims for outpatient rehabilitation therapy services and CORF services to be reported using a uniform coding system specified by the Secretary); Program Memorandum, HCFA Pub. 60A, Transmittal No. A-98-8, dated March 1, 1998 (specifying HCPCS/CPT codes as the uniform coding system). See also "Medicare Intermediary Manual," Pub. No. 13, part 3, section 3653(I).

[2]We used Medicare guidance that was current during CY 2003, our audit period.

- Pursuant to 42 CFR § 410.105, services must be furnished under a written plan of treatment, and the plan must be reviewed at least once every 60 days by a facility physician.[3] Medicare guidance states: "Therapy services must relate directly and specifically to a written treatment plan. The plan [(also known as a plan of care or plan of treatment)] must be established before treatment is begun" (Local Coverage Determination for Therapy and Rehabilitation Services (L6196)).

- Medicare guidance states: "The plan of treatment must be reviewed by the CORF physician at least once every 60 days" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, Chapter II, section 252(E)).

- Pursuant to 42 CFR § 424.11, the provider must obtain the required certification and recertification statements. Medicare guidance states: "Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 60 days) is required for the review of the plan. Recertifications are signed by the physician who reviews the plan of treatment" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, Chapter II, section 252(F)(2)).

Ultimate claimed $3,296 for 151 therapy services that did not have supporting documentation. For 110 of these services, there were no progress notes, written plan of treatment, or recertification. In addition, for 41 services, there was no documentation indicating that services were provided. For example, there was no documentation in the progress notes to indicate that therapy services were performed on the dates billed.

**Medical Necessity**

Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act provide that Medicare pays for services only if they are medically necessary and supported by documentation. Medicare guidance states: "When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends for that aspect of the plan of treatment" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, Chapter II, section 252(E)).

Ultimate claimed $1,404 for 60 therapy services that were not medically necessary because the services were provided after the patients had met their rehabilitation goals. For example, although a discharge summary indicating that the patient had met his or her goals was dated October 25, 2003, Ultimate continued to bill for services beyond that date. Medical reviewers determined that these additional services did not meet medical necessity requirements. In another case, Ultimate documented that a patient had met his or her goals as stated in the plan of care for home management training (i.e., meal preparation, laundry, and bed making) and activities of daily living, such as eating, grooming, personal hygiene, dressing, and bathing. However, Ultimate continued to bill for services after the patient had met home management and self-care goals.

[3]CMS amended 42 CFR § 410.105 in 2007, effective January 1, 2008 (72 Fed. Reg. 66222, 66400 (Nov. 27, 2007)) requiring the plan of treatment to be reviewed at least every 90 days. We used regulations that were in effect during CY 2003, our audit period, instead of the later version.

## POLICIES AND PROCEDURES NOT FOLLOWED

Ultimate did not always follow Medicare requirements or its own policies and procedures, and Ultimate's policies and procedures did not address Medicare requirements for reporting service units. If Ultimate had followed its policies and procedures for ensuring that therapy services were adequately documented and that Medicare coverage was terminated when patients reached their rehabilitation goals, it would have prevented some of the errors identified.

## UNALLOWABLE PAYMENTS

Ultimate received $32,227 in unallowable payments for therapy services in our sample that did not meet Medicare reimbursement requirements. Based on our sample results, we estimated that Ultimate received $1,400,062 for services provided during CY 2003 that did not meet Medicare reimbursement requirements. (See Appendix B.)

## RECOMMENDATIONS

We recommend that Ultimate refund to the Medicare program the estimated $1,400,062 in unallowable payments for CY 2003.

## ULTIMATE REHABILITATION AGENCY, INC. COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Ultimate closed operations in 2006. An authorized representative of the former company indicated that it would not be contesting or responding to the report of findings because the entity is no longer in existence. For this reason, we are making no procedural recommendations.

# APPENDIXES

# SAMPLING METHODOLOGY

## OBJECTIVE

Our objective was to determine whether payments to Ultimate Rehabilitation Agency, Inc. (Ultimate), for physical and occupational therapy services provided during calendar year (CY) 2003 were in accordance with Medicare reimbursement requirements.

## POPULATION

The population consisted of 4,838 paid claims for physical and occupational therapy services provided in CY 2003, representing $2,502,269 in Medicare payments to Ultimate.

## SAMPLING UNIT

The sampling unit was a paid claim for a Medicare beneficiary. A paid claim consisted of multiple units of therapy services claimed by Ultimate for the period covered by the claim.

## SAMPLING DESIGN

We used an unrestricted random sample.

## SAMPLE SIZE

The sample consisted of 100 claims, which contained 2,576 therapy services.

## ESTIMATION METHODOLOGY

Using the Office of Inspector General, Office of Audit Services statistical software, we estimated the unallowable payments for physical and occupational therapy services that Ultimate provided during CY 2003.

**APPENDIX B**

## SAMPLE RESULTS AND ESTIMATES

### SAMPLE RESULTS

| Sample Size | Value of Sample | No. of Unallowable Claims | Unallowable Payments |
|---|---|---|---|
| 100 | $52,987 | 98 | $32,227 |

### ESTIMATES OF UNALLOWABLE PAYMENTS

| | | |
|---|---|---|
| Point estimate: | | $1,559,148 |
| 90-percent confidence interval: | | |
| | Lower limit | $1,400,062 |
| | Upper limit | $1,718,235 |