DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

May 25, 2007

Report Number: A-06-06-00107

Ms. Susan Chancellor
Administrator
Avante At Leesburg
2000 Edgewood Avenue
Leesburg, Florida 34748

Dear Ms. Chancellor:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Rehabilitation Services at Skilled Nursing Facilities – Avante At Leesburg." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-06-06-00107 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, M.D.
Regional Administrator, Region VI
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF REHABILITATION SERVICES AT SKILLED NURSING FACILITIES – AVANTE AT LEESBURG

Daniel R. Levinson
Inspector General

May 2007
A-06-06-00107

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicare pays skilled nursing facilities (SNF) a daily rate to cover skilled services (e.g., rehabilitation therapy, infusion therapy, and nursing) provided to Medicare patients during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to place patients into specific payment groups, known as Resource Utilization Groups (RUG), based on the patients' care and resource needs. Each RUG corresponds to a combination, or bundle, of services; e.g., skilled nursing services, daily physical therapy, and ancillary services.

SNFs periodically assess each patient's clinical progress. If a patient's condition changes substantially, it could result in the patient being assigned a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim may have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

OBJECTIVE

Our objective was to determine whether the services on rehabilitation claims paid to Avante At Leesburg (Avante), of Leesburg, Florida, were medically necessary, properly billed, and adequately supported by medical documentation.

SUMMARY OF FINDINGS

Of the 100 claims sampled, 20 included medically unnecessary or improperly billed skilled services.

- For 19 claims, which had 32 RUGs, the medical reviewers recommended that (1) 25 RUGs be denied because the services provided were not medically necessary at the level provided at an SNF, (2) 5 RUGs be coded at a lower level (downcoded) because some of the services provided were not medically necessary, and (3) the 2 remaining RUGs be allowed.

- For one claim, which had one RUG, the medical reviewers recommended that the RUG be downcoded because Avante had improperly billed for skilled services by adjusting the wrong claim.

These errors occurred because Avante misapplied Medicare medical necessity requirements and lacked adequate controls for adjusting claims. As a result, we estimate that Medicare overpaid Avante at least $708,086 for services that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that Avante:

- refund to the Medicare program $708,086 in overpayments,
- ensure that future claims with skilled services comply with Medicare requirements on medical necessity,
- establish adequate controls to ensure that the correct claims are adjusted, and
- work with its fiscal intermediary to determine the amount of overpayments made subsequent to our audit period and refund the overpayments to the Medicare program.

AVANTE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its comments on our draft report, Avante disagreed with the medical reviewers' determination that 30 RUGs be denied or downcoded. Avante's comments are included in their entirety in Appendix C.

We forwarded Avante's comments to EDS, which, in turn, forwarded the comments to the medical reviewers. EDS stated that it and the medical reviewers stand by the original determinations for the RUGs denied or downcoded and feel that the documentation of those decisions adequately explains and supports the reviewers' decisions. We rely on the knowledge and expertise of the medical reviewers; therefore, we stand by the findings and recommendations.

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INTRODUCTION

BACKGROUND

Medicare Prospective Payment System for Skilled Nursing Facilities

The Balanced Budget Act of 1997 mandated the implementation of a prospective payment system for skilled nursing facility (SNF) services furnished to beneficiaries under Part A of the Medicare program. SNFs provide daily services that include speech, occupational, and physical therapies; intravenous feedings or medications; and transfusions. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals for a condition previously treated at a hospital.

Under the prospective payment system, Medicare pays SNFs a daily rate to cover services provided to a patient during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to place patients into specific payment groups, known as Resource Utilization Groups (RUG), based on the patients' care and resource needs. Each RUG corresponds to a combination, or bundle, of services; e.g., skilled nursing services, daily physical therapy, and ancillary services.

Federal regulations require SNFs to complete MDSs on the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of a patient's stay. If a patient's condition changes substantially, it could result in the patient being assigned a different RUG; Medicare would then increase or decrease the SNF's payment accordingly.

A single SNF claim may have multiple RUGs that cover different periods and correspond to different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

Resource Utilization Groups

Medicare groups RUGs into seven major service categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical functions. Rehabilitation services are further divided into five levels that comprise 14 RUGs; ultra high (3 RUGs), very high (3 RUGs), high (3 RUGs), medium (3 RUGs), and low (2 RUGs). Each RUG is associated with a per diem payment rate.

Medicare Program Safeguard Contractors

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, in part to strengthen CMS's ability to deter fraud and abuse in the Medicare program. In accordance with this legislation, CMS created program safeguard contractors to perform medical reviews, cost report audits, data analysis, provider education, and fraud detection and prevention. Under a contract with CMS, EDS performs fraud and abuse safeguard functions for the Medicare Part A workload in several States, including Florida.

Avante At Leesburg

Located in Leesburg, Florida, Avante At Leesburg (Avante) is an SNF with 116 Medicare-licensed beds.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the services on rehabilitation claims paid to Avante were medically necessary, properly billed, and adequately supported by medical documentation.

Scope

We reviewed summary data for SNF providers who received payment for Medicare claims submitted with dates of service in calendar year 2003. We isolated providers with paid claims having a ratio of ultra high rehabilitation days to total rehabilitation days exceeding 75 percent. We selected Avante for review because it had the highest percentage of ultra high rehabilitation days compared to total rehabilitation service days (93.72 percent) of the four SNFs having the highest total dollar amounts of paid claims for all SNF services. To review the most current claims available, we audited claims that included rehabilitation services submitted with calendar year 2004 service dates.

For January 1 through December 31, 2004, Avante submitted 1,222 Medicare claims totaling $6,046,959. For our audit, we selected only the paid claims that included at least 1 rehabilitation service period, a total of 1,187 claims with payments totaling $6,029,977. From these 1,187 claims, we selected an unrestricted random sample of 100 claims (containing 164 RUGs) totaling $565,013.

Our review of internal controls focused on gaining an understanding of Avante's policies and procedures for (1) assessing patient care needs and completing their MDSs, (2) billing for Medicare services, and (3) maintaining medical records.

We performed our fieldwork at Avante in Leesburg, Florida.

Methodology

To accomplish our objective, we:

- reviewed the applicable laws, regulations, and guidance concerning the Medicare payment process for SNFs;

- interviewed Avante officials and reviewed the Avante policies and procedures that focused on (1) assessing patient care needs and completing their MDSs, (2) billing for Medicare services, and (3) maintaining medical records;

- obtained Avante's medical records for the 100 sample claims;

- forwarded the medical records for the sample claims to EDS's medical reviewers to determine whether the claimed services were medically necessary, properly billed, and supported by adequate documentation;

- obtained the medical review results on the sample claims and verified the overpayment amounts calculated by EDS; and

- estimated total Medicare overpayments based on our sample results.

Appendix A shows our sampling methodology and the resulting projection of overpayments.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the 100 claims sampled, 20 included medically unnecessary or improperly billed skilled services.

- For 19 claims, which had 32 RUGs, the medical reviewers recommended that (1) 25 RUGs be denied because the services provided were not medically necessary at the level provided at an SNF, (2) 5 RUGs be coded at a lower level (downcoded) because some of the services provided were not medically necessary, and (3) the 2 remaining RUGs be allowed.

- For one claim, which had one RUG, the medical reviewers recommended that the RUG be downcoded because Avante had improperly billed skilled services by adjusting the wrong claim.

These errors occurred because Avante misapplied Medicare medical necessity requirements and lacked adequate controls for adjusting claims. As a result, we estimate that Medicare overpaid Avante at least $708,086 for services that did not meet Medicare requirements.

Appendix B contains a more detailed breakdown of the medical reviewers' findings on the 100 sample claims.

SKILLED SERVICES NOT MEDICALLY NECESSARY

Medicare Requirements

Title XVIII of the Social Security Act (the Act), section 1862(a)(1)(A), states that no payment may be made under Part A or Part B of Medicare for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or for improving the functioning of a malformed body member.

Pursuant to 42 CFR § 424.20, SNF patients must be correctly assigned to the RUG category that represents the required level of care. Further, 42 CFR § 413.343(b) requires periodic assessments (e.g., on the 5th and 14th days of posthospital SNF care) and such other assessments that are necessary to account for changes in patient care needs.

Pursuant to 42 CFR § 409.31(b), Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily; (2) the beneficiary needs care for a condition previously treated in a hospital or critical access hospital; and (3) the skilled services, as a practical matter, can be provided only in an SNF on an inpatient basis.

Pursuant to 42 CFR § 409.44(c)(2), for physical and occupational therapy and speech-language pathology to be reasonable and necessary, certain conditions must be met, including the following:

> There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program.

In addition, the "amount, frequency, and duration of the services must be reasonable."

According to Section 3159 of the "Part A Intermediary Manual," custodial care is excluded from coverage. Custodial care is essentially "personal care that does not require the continuing attention of trained medical or paramedical personnel." For example, custodial care involves assisting an individual in the activities of daily living, such as walking, getting in and out of bed, bathing, dressing, and eating. Additionally, 42 CFR § 411.15(g) also excludes custodial care from coverage, except as necessary for the palliation or management of terminal illness.

Skilled Services Not Medically Necessary

Of the 100 claims sampled, for 19 claims, which had 32 RUGs, the medical reviewers recommended that:

- 25 RUGs be denied because the services provided were not medically necessary at the level provided in an SNF,
- 5 RUGs be downcoded because some of the services provided were not medically necessary, and
- the 2 remaining RUGs be allowed.

For some of the 19 claims, the reviewers cited multiple reasons for recommending that the claims be denied or downcoded. Two examples illustrate these types of claims:

- A 79-year-old male had been residing in the long-term-care facility at Avante when he was sent to the hospital after not eating or drinking for several days. He was diagnosed with dehydration, acute renal failure, and leukocytosis. Following treatment at the hospital, he was admitted to the SNF at Avante because he required skilled nursing care. The SNF provided the patient with speech therapy for swallowing issues because he continued to refuse food and fluids. Skilled physical therapy and occupational therapy were ordered to screen the patient. The following day, a clarification order was noted for physical therapy.

  After reviewing the medical records, the medical reviewers concluded that skilled nursing services and skilled speech therapy services were reasonable and necessary for the resident's medical needs and illness. However, the medical reviewers also concluded that (1) the patient was unable to participate meaningfully in rehabilitation therapy because of debilitating conditions and/or cognitive impairments and (2) the patient's condition was not expected to improve significantly within a reasonable and generally predictable time period. Therefore, they downcoded the claim's two RUGs.

- After a qualifying hospital stay, an 83-year-old male patient was admitted to the SNF due to a syncopal episode and hypokalemeia. The resident, who had been diagnosed with end-stage Alzheimer's disease, had been at home, under his wife's care, prior to hospitalization. The resident also had a history of cerebral vascular accident and hallucinations and required assistance with daily living activities and mobility.

  The man was sent to the SNF where he was given physical and occupational therapy. While there, he was physically and verbally abusive, required restraints and frequent redirection from the staff due to his impaired cognition, and was referred to locked units in other facilities. The medical reviewers concluded that the patient (1) was unable to participate meaningfully in rehabilitation therapy because of cognitive impairments and (2) needed only custodial care. The reviewers further noted that custodial care is excluded under Medicare Part A, and that the patient was receiving rehabilitation therapy services that were medically unnecessary. Therefore, they denied the entire claim, which consisted of three RUGs.

Medical Necessity Requirements Misapplied

Avante provided skilled services that did not meet Medicare requirements for medical necessity because it misapplied Medicare medical necessity requirements. As a result, Medicare overpaid Avante for services that did not meet Medicare medical necessity requirements.

IMPROPERLY BILLED SKILLED SERVICES

Medicare Requirements

As previously noted, SNFs use a uniform clinical assessment form called an MDS to place patients into specific payment groups, known as RUGs, based on the patients' care and resource needs. Pursuant to section 515.1 of the "Skilled Nursing Facility Manual," for Medicare billing

purposes, each of the 44 RUG groups is assigned a payment code. Each payment code is associated with a per diem payment rate. Federal law requires comprehensive assessments of residents (patients), and each assessment applies to specific days of a resident's SNF stay.

Improperly Billed Skilled Services

For one claim, which had one RUG, the medical reviewers recommended that the RUG be downcoded because Avante had improperly billed skilled services by adjusting the wrong claim.

Avante staff did not look at the dates of service that should have been adjusted and mistakenly adjusted a claim for the same patient that was submitted for different dates within the same month. Both claims were for a period of 11 days.

Lack of Adequate Controls for Adjusting Claims

This improper claim adjustment resulted from a lack of adequate controls for adjusting claims.

As a result of this improper claim adjustment, Medicare overpaid Avante for services that did not meet Medicare billing requirements.

CONCLUSION

For the period January 1 through December 31, 2004, we estimate that Medicare overpaid Avante at least $708,086 for services that were either medically unnecessary or not provided at the level billed.

RECOMMENDATIONS

We recommend that Avante:

- refund to the Medicare program $708,086 in overpayments,
- ensure that future claims with skilled services comply with Medicare requirements on medical necessity,
- establish adequate controls to ensure that the correct claims are adjusted, and
- work with its fiscal intermediary to determine the amount of overpayments made subsequent to our audit period and refund the overpayments to the Medicare program.

AVANTE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its comments on our draft report, Avante disagreed with the medical reviewers' determination that 30 RUGs be denied or downcoded. Subsequently, we forwarded Avante's comments to EDS, which, in turn, forwarded the comments to the medical reviewers. Avante's comments are discussed below and included in their entirety as Appendix C.

Skilled Services Not Medically Necessary

In its comments, Avante misstated that our review recommended that a total of 30 RUGs be denied because of lack of medical necessity. Rather, our review reported that the medical reviewers recommended that 25 RUGs be denied because the services provided were not medically necessary at the level provided in an SNF and that 5 RUGs be downcoded because some of the services were not medically necessary.

Avante stated: "Pursuant to 42 CFR 409.31, Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily. (2) the beneficiary needs care for a condition previously treated in a hospital, and (3) the skilled services, as a practical matter, can be provided only in a SNF on an inpatient basis." Avante also stated that each claim that our "review states should not be covered all had physician orders to admit the patient to a SNF, each claim had a condition previously treated in a hospital, and each claim could only be treated in a SNF on an inpatient basis."

Avante noted that we had quoted 42 CFR § 409.44(c)(2), which states that there must be a reasonable expectation that the patient's condition will improve based on the physician's assessment of the beneficiary's restoration potential and unique medical condition. In addition, Avante noted that the report stated that the "amount, frequency, and duration of the services must be reasonable." Avante asserted that (1) each of the patients required the unique skills of physical, occupational, and speech therapists to increase their functional independence, dignified well being, and quality of life; and (2) the amount, frequency, and duration of therapy treatments were reasonable and necessary.

However, EDS stated that it and the medical reviewers stand by the original determinations for the RUGs denied or downcoded and feel that the documentation of those decisions adequately explains and supports the reviewers' decisions. In addition, a physician who reviewed all of the denials agreed with the denial decisions made by the medical reviewers. We rely on the knowledge and expertise of the medical reviewers; therefore, we stand by the findings and recommendations.

Avante may address questions regarding individual claims with CMS.

APPENDIXES

SAMPLING METHODOLOGY

Population: The population consisted of all paid Medicare claims that included at least one rehabilitation service period for Avante At Leesburg (Avante) for the period January 1 through December 31, 2004. For this period, Avante submitted 1,187 paid claims that included at least one rehabilitation service period, for a total of $6,029,977.

Sample Unit: The sample unit consisted of a paid claim that included at least one rehabilitation service.

Sample Design: We used an unrestricted random sample, selecting 100 sample units for this review.

Value of an Error: If the medical review determined that the skilled services recorded on the claim were not medically necessary, properly billed, or adequately supported by medical documentation, those services were disallowed and that portion paid on the claim was considered an overpayment.

Estimation Methodology: We used the Office of Audit Services's statistical sampling software (RAT-STATS) to estimate the overpayment amount. We reported the estimate of overpayments at the lower limit of the 90-percent, two-sided confidence interval.

Sample Results:

Population	Sample Size	Value of Sample	Number of Errors	Value of Errors
1,187	100	$565,013.22	20	$99,925.30

Projection:

Point Estimate	Lower Limit	Precision
$1,186,113	$708,086	$478,027

MEDICAL REVIEW DETERMINATIONS FOR THE 100 SAMPLE CLAIMS

A single claim may have multiple Resource Utilization Groups (RUG), and each RUG may cover a different period and correspond to a different payment rate. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently and make individual decisions on each one. The table below summarizes the medical review determinations for the 100 sample claims, including the total number of RUGs for each determination category and a breakdown of the number of RUGs that the reviewers recommended be denied, paid at a lower RUG level (downcoded), and allowed.

Summary of RUGs for the 100 Sample Claims

			Recommendations		
Medical Determination	**No. of Claims**	**Total No. of RUGs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
Allowed	80	131	-	-	131
Medically Unnecessary	19	32	25	5	2
Improperly Billed	1	1	-	1	-
Totals	**100**	**164**	**25**	**6**	**133**

Detail of RUGs for the 100 Sample Claims

The table below lists detailed information for the 100 sample claims reviewed and the medical reviewers' recommendation for each claim.

			Recommendations		
Sample No.	**Error Categories[2]**	**Total No. of RUGs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
1		1			1
2	M	1	1		
3		1			1
4		2			2
5		1			1
6		1			1
7		1			1
8	M	2		1	1
9		1			1
10		2			2
11	M	1		1	
12	M	1	1		
13		1			1
14		2			2
15		2			2
16	M	2	2		

			Recommendations		
Sample No.	**Error Categories[2]**	**Total No. of RUGs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
17		2			2
18		1			1
19		1			1
20		3			3
21		1			1
22		3			3
23	B	1		1	
24		1			1
25		1			1
26		3			3
27		2			2
28		1			1
29		1			1
30		3			3
31		1			1
32		2			2
33		1			1
34		2			2
35		1			1
36		2			2
37	M	1	1		
38		1			1
39	M	1	1		
40		1			1
41		1			1
42		3			3
43		2			2
44	M	2		2	
45		2			2
46		1			1
47	M	2	1		1
48		2			2
49	M	2	2		
50		1			1
51		3			3
52		1			1
53		1			1
54	M	1	1		
55		2			2
56		1			1
57		3			3
58		1			1
59	M	2	2		
60		1			1
61		2			2
62		2			2
63		2			2
64		2			2

			Recommendations		
Sample No.	**Error Categories[2]**	**Total No. of RUGs**	**No. of RUGs Denied**	**No. of RUGs Downcoded**	**No. of RUGs Allowed**
65		2			2
66	M	3	3		
67	M	1	1		
68		2			2
69		2			2
70	M	3	3		
71		1			1
72		2			2
73		2			2
74		1			1
75		3			3
76		2			2
77		1			1
78		3			3
79		2			2
80	M	1		1	
81		1			1
82		1			1
83	M	2	2		
84		2			2
85		2			2
86		1			1
87		1			1
88		2			2
89		1			1
90		2			2
91		2			2
92		2			2
93		2			2
94		1			1
95		1			1
96	M	2	2		
97		1			1
98	M	2	2		
99		2			2
100		2			2
Totals		**164**	**25**	**6**	**133**

[2]Error Categories:
M = Medically Unnecessary
B = Improperly Billed

April 13, 2007

Gordon L. Sato, Regional Inspector General for Audit Services
Lisa Lara, Cheryl Blackmon, Gaye Patrick, John Perkins
Office of the Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Dear Mr. Sato and fellow OIG associates:

Avante @ Leesburg is very grateful for this opportunity to have an initial response to the Review of Rehabilitation Services at Skilled Nursing Facilities- Avante @ Leesburg (Report Number- A-06-06-00107), which was dated March 13, 2007. This was the first time that Avante @ Leesburg had the opportunity to receive feedback from the OIG. We did not know what to expect from this review. I would like to take this time to thank your staff for being extremely helpful and very professional throughout this entire process.

Avante @ Leesburg has always been driven and committed to excellent patient care and excellent patient outcomes. Part of this commitment deals with providing the most comprehensive Physical, Occupational, and Speech Therapy for every patient who requires these services. Over the years, Avante @ Leesburg has built a very strong reputation of providing extensive, excellent Therapy services. With this reputation, came many referrals from physicians for short-term rehabilitation for their patients who needed in-depth, intensive medical and therapy rehabilitation for a short period of time (less than 60 days), to achieve a higher functional level and increased quality of life. So, Avante @ Leesburg became, and is still, a leader in Lake County, Florida and surrounding communities for providing excellent intense short-term rehabilitation for needy patients.

In order for Avante @ Leesburg to effectively benefit patients and to return them to their Prior Level of Function (PLOF), Physical, Occupational, and Speech Therapy must be provided. We are bound by the covenants in the Omnibus Budget Reconciliation Act of 1987 which require extreme **"emphasis on a resident's quality of life as well as the quality of care"**, and **"expectations that each resident's ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons."**

For the resident's of Lake County, Florida there is no Inpatient Rehabilitation Hospital. There is no other place to receive intense Rehabilitative care other than a Skilled Nursing Facility. We at Avante @ Leesburg pride our self on being the best Skilled Nursing Provider of intensive rehabilitative services in Lake County.

From your review, you state that Avante @ Leesburg was targeted due to the fact that our Ultra High Percentage of 93.72 percent was considered outside the average of other Skilled Nursing Providers in the United States. While this may seem high to the OIG, we at Avante @ Leesburg focus on each Medicare's recipient's entitlement to have access to the best care possible. Under the former Medicare cost-based reimbursement system (prior to 1997) Physical, Occupational, and Speech Therapy were billed in 15 minute increments called "units" of "modules". **It was very common for patients to receive 6 hours of combined Therapy treatment (PT, OT, ST) 5 days per week** . With the current Prospective Payment System, Medicare will only reimburse up to 2.4 hours a day of combined Therapy treatment 5 days per week (assuming the patient is being treated at a Ultra High RUGS category). However, the most common RUGS Therapy code used in the United States (and the most profitable) is Rehab High, which is only 1.06 hours of combined Therapy treatment 5 days per week. To expect providers to provide the same amount of quality Rehabilitative care in 1-2 hours a day that was done in 6 hours a day, is extremely unrealistic.

Your review goes on to state that 25 RUGs are being recommended to be denied because they were not medically necessary at the level provided at a SNF. The review recommends a total of 30 RUGs to be denied because of a supposed lack of medical necessity. Pursuant to 42CFR 409.31, Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or skilled rehabilitation, or both, daily. (2) the beneficiary needs care for a condition previously treated in a hospital, and (3) the skilled services, as a practical matter, can be provided only in a SNF on an inpatient basis. Each claim that your review states should not be covered all had physician orders to admit the patient to a SNF, each claim had a condition previously treated in a hospital, and each claim could only be treated in a SNF on an inpatient basis. There are no other types of Medical Facilities in Lake County that can handle the medical complexity, and the rehabilitation needs of these patients.

The review goes on to quote 42CFR409.44(c) (2) regarding there must be a reasonable expectation that the patients condition will improve based on the physician's assessment of the beneficiary's restoration potential and unique medical condition. Also, it was discussed that the "amount, frequency, and duration of the services must be reasonable." I can assure you that each of these patients required the unique skills of Physical, Occupational, and Speech Therapists to assist increasing their functional independence, dignified well being, and quality of life. Also, the amount, frequency, and duration of treatment are always specific to the needs of each patient in order to increase the patients function and quality of life. Therefore, the amount, frequency, and duration of Therapy treatments are reasonable and necessary.

This report shows that Avante @ Leesburg treats some very sick patients. These patients will not return to prior level of function as quickly or easily than patients who have fewer complications. These "involved" patients require more extensive treatment and medical care than other patients. All of the patients mentioned in this report were evaluated by a Licensed Physical, Occupational, or Speech Therapist. In their professional opinion with objective findings and physician order, determined that the patients listed would benefit from skilled care.

There were functional gains noted on each and every patient that would not have been possible if skilled Therapy services were not provided. Also, given the circumstance that the residents were entitled to this benefit given the medical appropriateness and the physician order for such services, we ask that your office re-consider your initial response. We relish the opportunity to review each and every claim with you to show how the skilled services provided by Avante @ Leesburg were reasonable, necessary, and qualify for payment under the Medicare program.

Respectfully yours,

4-30-2007

Marcelino Morales Jr., PT, CEAS
Corporate Director of Utilization Management
Avante Group Inc.