

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Physical And Occupational Therapy in Nursing Homes
Cost of Improper Billings to Medicare**



**JUNE GIBBS BROWN
Inspector General**

**AUGUST 1999
OEI-09-97-00122**

OFFICE OF INSPECTOR GENERAL

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

Office of Evaluation and Inspections

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

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

REGION

Deborah Harvey, *Project Leader*
Robert Gibbons, *Program Analyst*
Carrie Lozano, *Program Analyst*
Lori Stickel, *Program Analyst*

HEADQUARTERS

Susan Burbach, *Program Specialist*
Jennifer Antico, *Program Specialist*
Stuart Wright, *Program Specialist*
Barbara Tedesco, *Statistician*

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

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

EXECUTIVE SUMMARY

PURPOSE

To determine how much Medicare paid for improperly billed and undocumented physical and occupational therapy in skilled nursing facilities.

BACKGROUND

All Medicare-certified skilled nursing facilities are required to assess each patient's status and needs, including the medical necessity for physical and occupational therapy. Medicare coverage guidelines state that therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition.

The Medicare charges for physical and occupational therapy to patients in skilled nursing facilities have increased over the past few years. The 1997 Medicare charges for physical and occupational therapy were approximately \$7.9 billion, an increase of almost 18 percent over the 1996 charges of approximately \$6.7 billion.

The Health Care Financing Administration, the Federal agency that administers the Medicare program, implemented salary equivalency guidelines for physical therapy in 1975 to ensure that the agency did not reimburse excessive hourly contracted amounts. While skilled nursing facilities may pay a therapy contractor any amount for physical therapy, they are required to apply the salary equivalency guidelines to those contracted amounts when they submit their cost reports. Occupational therapy was not subjected to salary equivalency guidelines until April 1998. Before that time, skilled nursing facilities routinely marked up charges from their occupational therapy contractors, and Medicare reimbursement included the mark-up.

We conducted on-site medical review at a random sample of 24 skilled nursing facilities nationwide. Several teams of physical and occupational therapists reviewed the March 1998 medical records of a national random sample of 218 Medicare patients. The medical reviewers determined the medical necessity of the therapy provided to the sampled patients before the implementation of the prospective payment system for skilled nursing facilities which began on July 1, 1998 and the cap on Part B therapy which began on January 1, 1999. Assuming that March 1998 is a typical month, we projected Medicare reimbursement for medically unnecessary and undocumented therapy to the 12-month period ending June 30, 1998.

In a companion report entitled *Physical and Occupational Therapy in Nursing Homes: Quality of Care and Medical Necessity for Medicare Patients* (OEI-09-97-00121), we explained the reasons and extent of improperly billed therapy. In that report, we noted that

13 percent of therapy was improperly billed, and an additional 4 percent was not documented in the patients' medical records.

FINDINGS

Medicare reimbursed skilled nursing facilities almost \$1 billion for improperly billed physical and occupational therapy

Medicare reimbursed skilled nursing facilities for improperly billed therapy primarily because the therapy was not medically necessary and therapy was provided by staff who did not have the appropriate skill for the patient's medical condition.

Medicare reimbursed skilled nursing facilities almost \$331 million for undocumented physical and occupational therapy

The time documented for therapy in the therapy ledgers and therapy charts in patients' medical records often did not match the time billed to Medicare for therapy. Also, some therapy charts in patients' records did not include the actual time therapists and assistants spent with patients. In fact, some SNFs had such poor documentation that it was virtually impossible to verify the amount of therapy that patients received within a week.

Skilled nursing facility mark-up of occupational therapy exceeded \$342 million

Because salary equivalency guidelines had not been implemented for occupational therapy until April 1998, Medicare paid skilled nursing facilities as much as 86 percent more than their contractors charged them for each unit of therapy. The mark-up between contractor invoices and skilled nursing facilities' reimbursement exceeded \$342 million.

CONCLUSION AND RECOMMENDATION

Our findings concerning unnecessary and undocumented therapy, as well as the mark-ups on occupational therapy, were not identified prior to the implementation of the prospective payment system. This has resulted in inflated base year costs upon which both the Federal and the facility-specific rates were based. Therefore, should any consideration be given to modifying the prospective payment system, we believe that the inappropriate costs identified in this report should be considered.

In addition to implications for modifying the prospective payment system, our findings have medical necessity implications. Under the new payment system, patients may continue to receive unnecessary (and harmful) therapy and be placed in upcoded Resource Utilization Groups. An additional financial incentive may be to underutilize therapy and deprive patients of needed rehabilitation. Similarly, medical appropriateness will continue to be an issue under

Part B with possible overutilization for patients who do not need therapy and underutilization for patients whose therapy needs exceed the cap. Therefore, we recommend:

HCFA should adequately fund Medicare contractors to perform medical reviews of therapy.

AGENCY RESPONSE

We received comments on the draft report from the Health Care Financing Administration. The agency concurred with the report's conclusions. The Health Care Financing Administration believes that the recently implemented prospective payment system for skilled nursing facilities has helped to eliminate some incentives to provide inappropriate or unnecessary therapy. The agency will continue to aggressively monitor the potential impact on the access and quality of care of therapy for Medicare beneficiaries.

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

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	1
INTRODUCTION	5
FINDINGS	10
Cost of improperly billed therapy	10
Cost of undocumented therapy	11
SNF mark-up of occupational therapy	12
CONCLUSION AND RECOMMENDATION	13
AGENCY COMMENTS	13
APPENDICES	14
A: Calculation of Average Therapy Reimbursement	14
B: Confidence Intervals for Selected Calculations	15
C: Agency Response	17

INTRODUCTION

PURPOSE

To determine how much Medicare paid for improperly billed and undocumented physical and occupational therapy in skilled nursing facilities.

BACKGROUND

Medicare Coverage and Reimbursement of Physical and Occupational Therapy

Medicare coverage guidelines state that therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. All Medicare-certified skilled nursing facilities (SNF) are required to assess each patient's status and needs, including the need for physical and occupational therapy. The Health Care Financing Administration (HCFA), the Federal agency that administers the Medicare program, requires that therapy be prescribed in a written treatment plan that describes the specific therapeutic interventions, the frequency of visits, and the duration of therapy. Therapy must be ordered by a physician and require the skills of a licensed or certified therapist. While therapy generally is expected to result in the full or partial restoration of function, this outcome is not required by Medicare.

The Medicare program provides coverage of therapy services under both Parts A and B for SNF patients. Patients are eligible for Part A benefits if they are transferred to a SNF after a minimum 3-day covered stay in an acute care hospital. Part B covers services for SNF patients who have exhausted their Part A benefits or did not have a qualifying hospital stay.

In 1997, SNF Medicare charges for physical and occupational therapy were approximately \$7.9 billion, an increase of almost 18 percent over the 1996 charges of approximately \$6.7 billion. As shown in the chart below, most therapy charges were for Part A therapy rather than for Part B therapy.

Part A Charges Comprise the Majority of Medicare Therapy Claims

Medicare Coverage	1997 SNF Therapy Charges	
	Physical	Occupational
Part A	\$3.3 billion	\$2.9 billion
Part B	\$900 million	\$800 million

Source: Health Care Financing Administration, 1998

Medicare does not pay for physical and occupational therapy when:

- ▶ the therapy is performed repetitively to maintain a level of function,
- ▶ the patient's restoration potential is insignificant in relation to the therapy required to achieve such potential,
- ▶ it has been determined that the treatment goals will not materialize, and
- ▶ the therapy performed is considered to be a general exercise program.

In September 1996, HCFA clarified its payment policy that Medicare will pay only for skilled therapy that involves direct patient care. Medicare will not pay for indirect services such as medical record documentation, care planning, and telephone calls except when they are aggregated with other overhead costs and are included in the cost report that each SNF must file with its Medicare fiscal intermediary.

How SNFs Document and Bill for Therapy

Prior to July 1, 1998, skilled therapy was billed in a fixed-time increment called a "unit." One unit equaled 15 minutes of therapy. Each therapy session would be composed of various therapeutic interventions or activities that the therapist or assistant completed with a patient. For example, if a patient completed 45 minutes of therapy in one session, the SNF billed for three units of therapy. If the same patient received an hour of therapy in the morning and another hour in the afternoon, the SNF billed four units in each session for a total of eight units of therapy for the day.

Therapists document their services in various ways, including departmental ledgers, which are maintained in the therapy department, and therapy charts (often called grids), which are included in each patient's medical record. Ledgers generally are weekly or monthly summaries of therapy rendered to all patients, usually separated by the type of reimbursement that the SNF receives for each patient. Therapy grids often duplicate the ledger information with checked boxes for each intervention, the total units, and the therapist's name. If the patient received therapy twice in one day, the interventions are checked on the "morning" and "afternoon" grids with units listed at the end of the day.

Types of SNF Therapy Contracts

Most therapy for SNF patients is provided by therapists who are employees of the SNF or therapists who work for independent companies that have contracts, or are "under arrangement," with SNFs. The SNFs may provide some therapy directly and some under arrangement. The SNFs submit Medicare claims on behalf of their staff or their contractors. Fiscal intermediaries pay SNFs for therapy throughout the year based on an interim rate which is subject to revision after the annual cost report is finalized.

Medicare Salary Equivalency Guidelines

The costs for physical and occupational therapy billed by SNFs are subjected to hourly salary equivalency guidelines. Salary equivalency is the prevailing hourly salary rate¹ plus the standard fringe benefit and expense factor. This rate includes an adjustment for geographical areas and is updated periodically.² The HCFA implemented salary equivalency guidelines to ensure that it did not reimburse SNFs for excessive contracted therapy costs. While SNFs may charge any amounts that are considered to be reasonably related to therapy costs, fiscal intermediaries apply salary equivalency guidelines to therapy costs claimed on SNF cost reports. The HCFA implemented salary equivalency guidelines for physical therapy in 1975. Salary equivalency guidelines for occupational therapy were not implemented until April 1998, i.e., 23 years later.

Legislation for SNF Therapy

The *Balanced Budget Act of 1997* significantly changed how SNFs are reimbursed for all services, including physical and occupational therapy. All SNF cost reports filed after July 1, 1998 are subjected to a prospective payment system. Under this system, SNFs receive a facility-specific per diem rate, which includes therapy, for each patient who is in a Part A covered stay.³ The facility-specific per diem is based on the adjudicated cost report for fiscal year 1995, and the SNF will receive a blended rate over a 3-year transition period that blends a portion of the facility-specific per diem and the Federal per diem rate. The legislation also included a \$1,500 annual cap for Medicare Part B patients, whether or not they reside in SNFs. Occupational therapy is limited to \$1,500 annually, while physical therapy and speech language pathology share the same \$1,500 annual cap. The cap was effective January 1, 1999.

METHODOLOGY

Sampled SNF Selection

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

¹*Prevailing salary* is the hourly salary rate based on the 75th percentile of salary ranges paid by therapy companies in the same geographical area, by type of therapy, to full-time therapists.

²42 Code of Federal Regulations, Part 413, Section 413.106.

³Health Care Financing Administration, Program Memorandum for Intermediaries A-97-17, December 1997.

before July 1, 1998 to maintain consistency in SNF and fiscal intermediary policies and procedures for the 12 months prior to the change in payment systems.

We stratified the SNFs into four strata by (1) regions of the United States and (2) the total physical and occupational therapy charges for March 1998. Within each stratum, we grouped the SNFs into clusters such that the SNFs were in the same geographic area and the sum of physical and occupational therapy charges per cluster was fairly constant.

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

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

On-Site Medical Review

We conducted on-site medical review at 24 SNFs for 218 sampled patients who received physical and occupational therapy in March 1998. The review period was before HCFA implemented the SNF prospective payment system and salary equivalency guidelines for occupational therapy. While on-site, we:

- ▶ reviewed the medical records to determine if each therapy session was medically necessary, unnecessary, or undocumented;
- ▶ reviewed therapy ledgers that documented therapeutic interventions and time spent with patients;
- ▶ requested copies of the Medicare bills for sampled patients;
- ▶ obtained copies of contracts between SNFs and therapy contractors that were in effect in March 1998; and
- ▶ obtained the Medicare cost-to-charge ratios that fiscal intermediaries apply to physical and occupational therapy charges.

The medical review was conducted by several teams of licensed or certified physical and occupational therapists. The cost estimates in this report are based on the non-statistical projections from March 1998 which we extrapolated to a 12-month period ending June 30, 1998, based on the assumption that March 1998 is a typical month and represents 31/365 of a year. See appendix B for more details.

This report is one in a series of reports on physical and occupational therapy for Medicare SNF patients. A companion report, *Physical and Occupational Therapy in Medicare Nursing Facilities: Quality of Care and Medical Necessity for Medicare Patients* (OEI-09-97-00121), details the extent and reasons for improperly billed and undocumented therapy. In that report,

we noted that 13 percent of therapy was billed improperly, and an additional 4 percent was not documented in the patients' medical records.

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

FINDINGS

Medicare reimbursed SNFs almost \$1 billion for improperly billed physical and occupational therapy

Assuming that March 1998 is a representative month of the 12-month period ending June 30, 1998, Medicare reimbursed SNFs approximately \$955 million for 49 million units of improperly billed physical and occupational therapy.⁴ Of the \$955 million for improperly billed therapy, approximately \$882 million was for Part A therapy and \$74 million for Part B therapy.⁵ Medicare SNF patients received a total of 292 million units of therapy. The following table describes the cost to Medicare and the major reasons why the therapy was billed improperly:

Major Reasons	Cost of Unnecessary Units by Therapy	
	Physical	Occupational
Patients received medically unnecessary therapy	\$360 million	\$451 million
Patients received therapy from staff with inappropriate skill	\$100 million	\$ 45 million

Source: Office of Evaluation and Inspections, 1999

SNFs received approximately \$811 million for medically unnecessary therapy

Of the \$955 million of improperly billed therapy, approximately 85 percent was billed for therapy that was not medically necessary. Therapy was not necessary because, among other reasons, therapy was not based on the patient’s medical condition and some SNFs billed medical record documentation as skilled therapy time.

The SNFs routinely received payment for therapy that was not tailored to their patients’ medical needs. This included situations where the patients already had achieved the treatment goals, the treatment goals were unattainable, therapy was not discontinued at the appropriate time, and therapists billed routine maintenance services as skilled therapy. Several patients received therapy “B.I.D.,” or twice a day, regardless of medical necessity. The B.I.D. pattern was a standard practice at several SNFs, especially if the therapy contractor was part of a large

⁴This reimbursement was the amount SNFs charged on the cost reports multiplied by the facility-specific cost-to-charge ratio for physical or occupational therapy.

⁵The totals do not total \$955 million due to rounding.

national therapy company rather than a local therapy contractor or rather than therapists employed by the SNF.

A few SNFs billed the documentation of medical records as if it were a reimbursable skilled service. The therapy records at one sampled SNF routinely included checked boxes on patients' therapy grids for documentation completed during therapy sessions. In another facility, an assistant charged Medicare one unit (15 minutes) as skilled therapy to document that the patient had refused therapy one afternoon. In fact, the patient continued to refuse therapy for 21 additional sessions, and the SNF continued to charge Medicare one unit for documentation each time the patient refused therapy.

SNFs received approximately \$145 million for therapy provided by staff with inappropriate skill

Medicare reimbursed SNFs for improperly billed physical and occupational therapy provided by staff who did not have the appropriate skill for the patient's medical condition. Examples include (1) occupational therapists providing therapy that physical therapists should have provided, (2) therapists providing therapy that assistants should have provided, and (3) both physical therapist assistants and occupational therapy assistants working beyond the scope of their State licenses.

Nationally, Medicare reimbursed SNFs almost \$331 million for undocumented physical and occupational therapy

Approximately 13 million units of therapy were deemed undocumented when (1) the number of units on the therapy ledgers did not match the units billed to Medicare, (2) necessity of therapy was not documented in the patients' medical records, and (3) medical reviewers could not determine who provided therapy to the patients.

Some SNFs had such poor documentation that it was virtually impossible to verify the total units of therapy that patients received within a week. Therapy ledgers and grids often did not include the number of units spent with patients in individual sessions. The grids had lists of interventions with checked boxes only. Because of this, medical reviewers could not determine the medical necessity of the sessions that (1) had identical interventions and checked boxes, (2) had wide variations in the total units for therapy on the Medicare bill, and (3) lacked narrative explanations of changes in the patient's treatment to justify the variation in units. Also, some ledgers were missing or were not available due to changes in SNF ownership.

Medical reviewers could not use some ledgers or therapy grids to determine who provided therapy because the names, initials, and/or certification levels were missing. These data are critical in determining if patients had received treatment from staff with skills appropriate to their medical needs.

SNF mark-up for occupational therapy exceeded \$342 million

Because salary equivalency guidelines had not been implemented for occupational therapy until April 1998, Medicare paid SNFs as much as 86 percent more than their contractors charged them for each unit of therapy. The average reimbursement for one unit (15 minutes) of occupational therapy was \$22.33 (as shown in appendix A) with a range of slightly less than \$3 to almost \$39. The practice of marking-up contractor costs is routine, but the percentage of mark-up varies from as little as 4 percent to as much as 86 percent. This, at least in part, explains the extreme variations in reimbursement per unit.

Under the new prospective payment system, SNFs are reimbursed based on per diem rates for all costs related to SNF services under Part A. The HCFA calculated the per diem rates from aggregated national data including allowable costs from SNF cost reports in fiscal year 1995, patient case mix, and geographic variation in wages. Under the SNF prospective payment system, SNFs are paid based on the patient's assessment upon admission and classification into one of the Resource Utilization Groups. Since salary equivalency guidelines for occupational therapy did not apply to costs included on the fiscal year 1995 cost reports, SNF mark-up for occupational therapy is included in the Federal per diem rates. The mark-up between occupational therapy contractor invoices and SNFs' reimbursement for therapy claimed on the Medicare cost reports exceeded \$342 million for cost report periods ending prior to April 1, 1998 (assuming March 1998 is a representative month of the 12-month period ending March 31, 1998).⁶

⁶We excluded the therapy units that were unnecessary and undocumented, prior to calculating the amount Medicare reimbursed SNFs for the mark-up.

CONCLUSION AND RECOMMENDATION

As noted in our methodology, the period we reviewed was prior to the implementation of the SNF prospective payment system, the salary equivalency guidelines for occupational therapy, and the cap for Part B therapy. Our findings concerning the cost of unnecessary and undocumented therapy, as well as the mark-ups on occupational therapy, were not identified prior to the implementation of the prospective payment system. This has resulted in inflated base year costs upon which both the Federal and the facility-specific rates were based. Therefore, should any consideration be given to modifying Federal Rates or re-basing the prospective payment system, we believe that the inappropriate costs identified in this report should be considered.

In addition to the implications for modifying rates under the prospective payment system, our findings have implications for the need to assure that therapy services are medically appropriate. Under the new payment system, patients may continue to receive unnecessary (and potentially harmful) therapy and be placed in upcoded Resource Utilization Groups. An additional financial incentive may be for facilities to underutilize therapy services which would deprive patients of needed rehabilitation services. Similarly, medical appropriateness will continue to be an issue under Part B with possible overutilization for patients who do not need therapy and underutilization for patients whose therapy needs exceed the cap. Therefore, we recommend:

HCFA should adequately fund Medicare contractors to perform medical reviews of therapy.

AGENCY RESPONSE

We received comments on the draft report from the Health Care Financing Administration. The agency concurred with the report's conclusions. The Health Care Financing Administration believes that the recently implemented prospective payment system for skilled nursing facilities has helped to eliminate some incentives to provide inappropriate or unnecessary therapy. The agency will continue to aggressively monitor the potential impact on the access and quality of care of therapy for Medicare beneficiaries.

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

Average Therapy Reimbursement

The following table shows the average (mean) reimbursement per 15-minute therapy intervention. While the average reimbursement for occupational therapy appears to be higher than for physical therapy, this difference, based on a T-test, is not statistically significant at the 95 percent (or even 90 percent) confidence level. The statistics in this table are limited to therapy activities. We excluded both therapy evaluations,⁷ which sometimes were reimbursed at a higher rate, and therapy reevaluations,⁸ which sometimes were reimbursed at a lower rate.

REIMBURSEMENT PER 15-MINUTE THERAPY INTERVENTION

Therapy Type	Average (mean) reimbursement per 15-minute therapy intervention	95 percent confidence interval	
		Lower	Upper
Physical therapy	\$16.74	\$13.95	\$19.53
Occupational therapy	\$22.33	\$14.72	\$29.93

Source: Office of Evaluation and Inspections, 1999

⁷An initial examination when the therapist gathers patient data and makes clinical judgments to establish the treatment plan. [Source: American Physical Therapy Association's *Guide to Physical Therapist Practice* (1998)]

⁸A follow-up examination when the therapist updates the patient's status because of new clinical indications, patient's failure to respond to planned therapeutic interventions, or patient's failure to progress from baseline data. [Source: American Physical Therapy Association's *Guide to Physical Therapist Practice* (1998)]

Confidence Intervals for Selected Statistics

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

Statistic	Point Estimate	95 Percent Confidence Interval
Amount Medicare reimbursed SNFs for physical and occupational therapy that was provided during March 1998	\$490 million	\$375 million - \$606 million
Amount Medicare reimbursed SNFs for physical and occupational therapy that was provided for a 12-month period ending June 30, 1998	\$5.8 billion	**
Number of physical and occupational therapy units provided Medicare SNF patients during March 1998	25 million	16 million - 34 million
Number of physical and occupational therapy units provided Medicare SNF patients for a 12-month period ending June 30, 1998	292 million	**
Amount Medicare reimbursed SNFs for improperly billed physical and occupational therapy that was provided during March 1998	\$81 million	\$44 million - \$119 million
Amount Medicare reimbursed SNFs for improperly billed physical and occupational therapy that was provided for a 12-month period ending June 30, 1998	\$955 million	**
Number of improperly billed physical and occupational therapy units provided Medicare SNF patients during March 1998	4.2 million	2.3 million - 6.0 million
Number of improperly billed physical and occupational therapy units provided Medicare SNF patients for a 12-month period ending June 30, 1998	49 million	**
Number of undocumented units provided Medicare SNF patients during March 1998	1.1 million	0.7 million - 1.5 million
Number of undocumented units provided Medicare SNF patients for a 12-month period ending June 30, 1998	13 million	**

APPENDIX B

Statistic	Point Estimate	95 Percent Confidence Interval
Amount Medicare reimbursed SNFs for undocumented physical and occupational therapy that was provided during March 1998	\$28 million	\$19 million - \$37 million
Amount Medicare reimbursed SNFs for undocumented physical and occupational therapy that was provided for a 12-month period ending June 30, 1998	\$331 million	**
Amount Medicare reimbursed SNFs for mark-up of occupational therapy that was provided during March 1998	\$29 million	\$7 million - \$51 million
Amount Medicare reimbursed SNFs for mark-up of occupational therapy that was provided for a 12-month period ending March 31, 1998	\$342 million	**

Source: Office of Evaluation and Inspections, 1999

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

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 20 1999

TO: June Gibbs Brown
Inspector General

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

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

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

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

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

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

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

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

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

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

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