DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
61 Forsyth Street, Room 3T41
Atlanta, GA 30303-8909

DEC 30 1999

Memorandum

Date:

From: Regional Inspector General
for Audit Services, Region IV

Subject: Review of GEM Physical Therapy, Inc., Outpatient Rehabilitation Facility (CIN: A-04-99-01200)

To: Rose Crum-Johnson, Regional Administrator
Health Care Financing Administration

This final report provides you with the results of the Review of Outpatient Rehabilitation Facility (ORF) services provided by GEM Physical Therapy, Inc. (the Provider), during Fiscal Year (FY) ended December 31, 1997.

EXECUTIVE SUMMARY

The objectives of this review were to determine: (1) whether Medicare payments to the Provider were for services which met the Medicare eligibility and reimbursement requirements, and (2) whether the costs claimed were in accordance with Medicare guidelines.

SUMMARY OF FINDINGS

Our review showed that the Provider was reimbursed for $475,996 in unallowable services and non reimbursable costs.

The Provider was reimbursed $258,185 for services that did not meet the Medicare eligibility and reimbursement requirements. The Fiscal Intermediary (FI) medical reviewers concluded that all 20 selected beneficiaries had been provided services which were not authorized by physicians, not documented, and/or not reasonable or medically necessary.

The Provider also claimed $217,811 in costs that were not reimbursable according to Medicare guidelines.

We believe the Provider claimed unallowable services because it did not ensure that the services were billed in accordance with Medicare reimbursement guidelines. We also believe unallowable and non reimbursable costs were claimed because the Provider did not ensure that Medicare guidelines relating to cost reimbursement were applied correctly.

We also found $14,604 in interim payments made to the Provider by the FI and not reflected in the Medicare Cost Report FY 1997. This was due to a 4 month lag between the filing of the actual Cost Report and the processing and the issuance of the Provider Statistical and Reimbursement Report.

We are recommending the Health Care Financing Administration (HCFA) direct the FI to:

- recover the $475,996 in overpayments for 1997;
- conduct additional claim reviews to identify other unallowable services; and
- adjust the 1997 Medicare cost report to reflect the $14,604 and any other updated interim payment information.

We issued a draft report to GEM Physical Therapy, Inc on October 22, 1999. The GEM Physical Therapy verbally requested an extension to our standard 30 day response deadline. We granted a 21 day extension to our initial deadline (until December 13, 1999). The GEM Physical Therapy called us again on December 15, 1999. We advised GEM Physical Therapy that an additional extension would not be granted. We further advised GEM Physical Therapy that any further comments should be submitted to the Department of Health and Human Services Action Official named on the last page of this report.

BACKGROUND

In 1999, HCFA, the Office of Inspector General, the FI, and the Florida Agency for Healthcare Administration, began a joint initiative involving on-site reviews of ORFs in Florida. The ORFs are free-standing facilities that render physical, speech, and occupational therapy on an outpatient basis. A review of Medicare expenditure data revealed that over the past several years reimbursements to Florida ORFs have grown substantially.

During the period of our review, GEM was paid via the bill by bill method. Under the bill by bill method, a Provider is paid an amount which represents an estimate of the actual cost (not charges) of each claim. Under this method, GEM received $1,150,321 in payments from Medicare during the year under review. The GEM submitted a cost report for this same year, totaling $1,010,675 in Medicare costs.

The GEM Physical Therapy, Inc. is a for-profit corporation with its principal place of business in Miami, Florida. Its effective date of participation in the Medicare program was September 24, 1993.

SCOPE

The objectives of this review were to determine: (1) whether Medicare payments to the Provider were for services which met the Medicare eligibility and reimbursement requirements, and (2) whether the costs claimed were in accordance with Medicare guidelines.

This review was conducted in accordance with generally accepted government auditing standards and the Office of Audit Services audit policies and procedures.

Our review of services provided and costs claimed covered the Cost Report period for Calendar Year 1997.

The field work was conducted at the Provider's home office in Miami, Florida from February 1999 to September 1999.

Services Provided

To accomplish our objective of determining whether Medicare payments to the Provider were for services which met the Medicare eligibility and reimbursement requirements, we:

- selected the 20 beneficiaries who represented the highest reimbursement to the Provider during the Calendar Year 1997, by using the Provider Statistical and Reimbursement Report data generated by the FI; and

- relied on the expertise of a team of medical experts from HCFA and the FI to conduct a review of the medical record documentation for the 20 beneficiaries. The reviewers used applicable laws, regulations, and Medicare guidelines, to determine whether the services rendered to these individuals were medically necessary for their conditions, were properly documented in the medical records, and were billed in accordance with Medicare reimbursement principles.

Costs Claimed

To accomplish our objective of determining whether the costs claimed were in accordance with Medicare guidelines, we:

- analyzed and reconciled the accounting books and records, including payroll, to the cost report;

- traced large, unusual, and questionable items to the cost report, and asked the Provider to furnish supporting documentation for these items; and

- interviewed the owner, the staff, and unrelated third parties (i.e., former landlord and site manager) regarding all significant matters relating to the 1997 Medicare Cost Report.

We issued a draft report to GEM Physical Therapy, Inc on October 22, 1999. The GEM Physical Therapy verbally requested an extension to our standard 30 day response deadline. We granted a 21 day extension to our initial deadline (until December 13, 1999). The GEM Physical Therapy called us again on December 15, 1999. We advised GEM Physical Therapy that an additional extension would not be granted. We further advised GEM Physical Therapy that any further comments should be submitted to the HHS Action Official named on the last page of this report.

DETAILED RESULTS OF REVIEW

Our review showed that the Provider was reimbursed for $475,996 in unallowable services and non reimbursable costs.

The Provider was reimbursed $258,185 for services that did not meet the Medicare eligibility and reimbursement requirements. The FI medical reviewers concluded that all 20 selected beneficiaries had been provided services which were not authorized by physicians, not documented, and not reasonable or medically necessary.

The Provider also claimed $250,187 in costs that were not reimbursable according to Medicare guidelines.

We believe the Provider claimed unallowable services because it did not ensure that the services were billed in accordance with Medicare reimbursement guidelines. We also believe unallowable and non reimbursable costs were claimed because the Provider did not ensure that Medicare guidelines relating to cost reimbursement were applied correctly.

Services Provided

Our review found that the Provider was paid $258,185 for the 20 selected beneficiaries that did not meet the Medicare eligibility and reimbursement requirements. For all of the 20 selected beneficiaries, the Provider billed for services that were not properly authorized, adequately documented or reasonable or medically necessary for the patients' conditions. Specifically, the medical review revealed that:

- for 12 of the 20 selected beneficiaries, the Provider billed for services that were not reasonable or medically necessary for the patients's condition;
- for 5 of the 20 selected beneficiaries, the Provider billed services that were not properly authorized by a physician; and
- for 3 of the 20 selected beneficiaries, the Provider billed for services for which documentation was not adequate to meet the Medicare reimbursement requirements.

Necessity of Services

The FI medical reviewers found that for 12 of the 20 selected beneficiaries, the Provider billed for services that were not reasonable and necessary for the patients' conditions.

Examples of services that were questioned included:

- The patient fell on 12/30/96 and started physical therapy on 1/23/97. As of 2/28/97, the patient was ambulating 150 feet using the rolling walker. Because maintenance level therapy is not reimbursable, claims for services rendered after 2/28/97 were disallowed.

- A patient had a total hip replacement and was subsequently admitted to a skilled nursing facility. On 4/28/97, he was discharged from the skilled nursing facility and returned to his home. Progress notes related that on 5/12/97, the patient was walking 80 feet and was continuing to use his wheelchair for long distances. At least in one occasion in June of 1997, the patient asked to be left alone. The Provider continued to provide and bill for the services through July 31, 1997. Because the therapy was maintenance level and was refused by the patient, the services were questioned.

- A patient's occupational therapy medical record documentation indicated services were a duplication of physical therapy treatment. Since the physical therapy had been claimed, the occupational therapy was questioned.

Conditions for Medicare coverage of ORF services are outlined in Sections 270 through 273 of the HCFA Outpatient Manual. These guidelines state that the services must be reasonable and necessary to treat an individual's illness or injury. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, and the services must relate directly to the treatment goals. In addition, the services must be at a level of complexity and sophistication that they can be safely and effectively rendered *only* by (or under the supervision of) a skilled therapist.

The HCFA Outpatient Manual, Chapter 253 further requires that a patient be discharged once the treatment goals have been met. It also states that maintenance therapy is not appropriate or allowable in an ORF setting. In addition, Medicare does not reimburse for services related to the overall good and welfare of patients, such as general fitness exercises or diversionary activities.

Physician Authorization

In the opinion of the FI medical reviewers, services claimed for 5 of the 20 selected beneficiaries, were not properly authorized by a physician.

These claims were deficient in four areas: the medical review staff found that the treatment plan certification dates appeared to have been altered, physician authorization did not occur within the prescribed time period, the services continued for 4 months after the period prescribed by the physician, or the plan of care was not authorized by a physician.

Federal regulation 42 Code of Federal Regulation (CFR) 405.1717 requires ORFs to demonstrate that the services were: (1) needed by the patient; (2) furnished under a plan of care that has been reviewed by a physician; and (3) furnished while the patient was under the care of a physician.

Additionally, it requires that a patient receiving ORF services must be seen by a physician every 30 days, and that documentation of that visit be maintained in the medical record.

Documentation of Services

In the opinion of the FI medical reviewers, for services claimed for 3 of the 20 selected beneficiaries, the medical record documentation did not support the services billed.

Medical reviewers determined that the records were missing key items to substantiate the provision of the services. Medicare eligibility and reimbursement requirements for ORF services require the Provider to maintain sufficient medical record documentation to support the services billed.

Sections 1815 and 1833(e) of the Social Security Act stipulate that when a provider does not maintain records which are sufficiently complete to determine the reasonable cost of the services, no payments can be made for these services. Also, Federal regulation 42 CFR 413.20(2)(ii) requires that providers maintain medical records.

We believe unallowable services were claimed by the Provider because it did not ensure that the services were billed in accordance with Medicare reimbursement requirements.

Effect

Based on our judgmental sample of 20 beneficiaries, the Provider was overpaid $258,185 for 1,506 unallowable units of service that did not meet Medicare's eligibility and reimbursement requirements.

COSTS CLAIMED

Our review found that the Provider claimed $217,811 in costs that were not reimbursable according to Medicare guidelines. These unallowable costs included:

- Owner's Compensation - $17,666
- Contracted Services - $79,585
- Rent - $30,775
- Utilities - $4,490
- Transportation - $48,906
- Credit Card Payments - $5,249
- Office Expense - $2,440
- Leasehold Improvements - $28,700

During our audit period, ORFs were required to follow Medicare guidelines that required: reimbursement be made on the basis of reasonable cost, costs be related to patient care, and purchases of goods and services be performed under the prudent buyer concept. The ORFs are also required to retain financial records which maintain adequate support of the costs reimbursed.

Adequate financial records are defined as cost data based on financial and statistical records that are verifiable by auditors.

Federal regulations regarding Medicare cost reimbursement limit reimbursement to those items that would be incurred by a reasonable, prudent, and cost conscious management. Federal regulation 42 CFR, Section 413.9, defines reasonable cost as including all necessary and proper costs incurred in the delivery of services to Medicare beneficiaries. This means that costs must be related to patient care or the operation of patient care facilities, and should be common and accepted practices in the field of the Provider's activities.

Additionally, Federal regulation 42 CFR, Section 413.20, states that providers receiving payment on the basis of reasonable cost must maintain adequate financial records supporting the costs reimbursed. Also, the HCFA Provider Reimbursement Manual I, Section 2300 further explains that the cost data must be based on financial and statistical records that are verifiable by auditors.

Owners'/Officers' Compensation

We questioned **$17,666** GEM claimed for excessive, unallowable and unsupported owners' compensation. The Provider claimed **$17,666** in compensation which was deemed to be in excess of what was determined to be reasonable or necessary ($61,872) according to the Intermediary generated *Michigan Survey.*

In addition to this amount being over the above noted salary cap, we found that the Provider paid the owner a salary for administrative duties *and* a full salary under the Physical Therapy Department. Through interviews with the owner and his staff, we learned that the owner had no involvement with the administrative functions of the business.

Expenses for Contracted Services

The Provider claimed **$79,585** for undocumented subcontracted staffing service expenses. In addition to these being undocumented, the payments were made to an undisclosed related company. The Provider misrepresented this fact by stating that he had no dealings with related entities on Form HCFA-2088-92 (Treatment of Costs of Services from Related Organizations).

Other Unrelated Expenses

The Provider claimed **$89,420** for unallowable and unallocable miscellaneous items. The breakdown of these items is as follows:

- **Rent - $30,775.** The Provider did not allocate rent expense between Medicare and non Medicare patients.

- **Utilities - $4,490.** The Provider did not allocate utility expense between Medicare and non Medicare patients.

- **Transportation expenses - $48,906.** These are expenses related to the transportation of the beneficiaries to and from the facilities. The 42 CFR, Chapter IV, Subpart E, Section 409.49 specifically excludes these costs as a reimbursable expense. During inspection of the cost report and other financial records, it was noted that costs incurred for automobile and related expenses were reimbursed by Medicare. Of these expenses, $28,131.51 was charged to a corporate American Express card and paid for by the Provider, and at the end of the year reclassified as payroll. Additionally, $8,081.35 in costs were paid by check.

- **Credit cards payments - $5,249.** Payments were to American Express for personal expenses such as boating related expenses and trips to the Caribbean. These expenses were not reasonable, necessary, or related to patient care, and therefore were not reimbursable according to Medicare guidelines.

The Provider claimed **$31,140** for undocumented miscellaneous items. The breakdown of these items is as follows:

- **Office expenses - $2,440.** In undocumented decoration expenses and payments to the office administrator's personal credit card.

- **Leasehold improvements - $28,700**. In amortization of leasehold improvements in the amount of $112,074 for which the Provider could not produce documentation to show that the expenditures were actually incurred.

We believe the Provider claimed unallowable and non reimbursable costs because it did not ensure that the Medicare guidelines relating to cost reporting were applied correctly.

Effect

The Provider claimed $217,811 in its 1997 Medicare cost report for items that were not allocable or reimbursable according to Medicare guidelines.

OTHER MATTERS

As part of our cost report review, we reconciled interim payments from the Provider Summary Report to the cost report issued on July 1, 1998. We noted that $14,604 in interim payments made to the Provider, by the FI were not reflected in the Provider's cost report FY 1997. This was due to a 4 month lag between the processing and issuance of the Provider Summary Report and the actual cost report.

CONCLUSIONS AND RECOMMENDATIONS

We believe the Provider claimed unallowable services because it did not ensure that the services were billed in accordance with Medicare reimbursement guidelines. Additionally, we believe the Provider claimed unallowable and non reimbursable costs because the Provider did not ensure that Medicare guidelines relating to cost reimbursement were applied correctly.

We are recommending HCFA direct the FI to:

- recover the $475,996 in overpayments for 1997;
- conduct additional claim reviews to identify other unallowable services; and
- adjust the 1997 Medicare cost report to reflect the $14,604 and any other updated interim payment information.

We issued a draft report to GEM Physical Therapy, Inc on October 22, 1999. The GEM Physical Therapy verbally requested an extension to our standard 30 day response deadline. We granted a 21 day extension to our initial deadline (until December 13, 1999). The GEM Physical Therapy called us again on December 15, 1999. We advised GEM Physical Therapy that an additional extension would not be granted. We further advised GEM Physical Therapy that any further comments should be submitted to the Department of Health and Human Services Action Official named below.

Dale Kendrick, Associate Regional Administrator
Division of Financial Management and Program Initiatives
Health Care Financing Administration
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

for Charles J. Curtis