Brickell Federal Building
909 SE 1st Avenue, Suite 732
Miami, Florida 33131
(305) 536-6540 FAX (305) 536-6787

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

101 Marietta Tower, Suite 701
Atlanta, Georgia 30323
(404) 331-2329 FAX (404) 331-0104

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February 6, 1997

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue, 11th Tower
Jacksonville, FL 32231

Dear Mr. Lord:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Lawnwood Regional Medical Center (Medicare provider number 10-5742), a skilled nursing facility located in Fort Pierce, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1, 1994 through December 31, 1994.

The ORT reviewers questioned $95,442 in charges reported for the 32 sample beneficiaries in our study. This amount comprises $74,730 related to Physical, Occupational, and Speech therapy services; $14,827 of unallowable supplies; $5,530 in unallowable laboratory charges; and $355 in inappropriate drug payments. Therefore, we are recommending an adjustment of the above charges. In addition, we request that the FI conduct a focused review of all rehab therapies since the period of our review in order to recoup overpayments made to this SNF.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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February 6, 1997

Mr. Marshall Kelley, Director
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Mr. Kelley:

The enclosed report and recommendations for adjustment of charges provides the results of the Operation Restore Trust (ORT) Skilled Nursing Facility review conducted at Lawnwood Regional Medical Center (Medicare provider number 10-5742), a skilled nursing facility located in Fort Pierce, Florida. The primary objective of the review was to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made during the period from January 1, 1994 through December 31, 1994.

The ORT reviewers questioned $95,442 in charges reported for the 32 sample beneficiaries in our study and we are recommending an adjustment of these charges. In addition, we request that the State Agency implement corrective action by the facility to ensure that all rehab services are properly ordered, documented, and provided; and are based upon the patients' medical needs.

Following your review of this report, please prepare and submit to the Miami ORT Satellite Office a plan of corrective action to implement the recommendations made in the report. This plan should be submitted within thirty days of receipt of this letter.

If there are any questions regarding this report, please call Dewey Price at 305-536-6540.

Sincerely,

Patricia L. Talley

Patricia Talley
Acting HCFA Regional Administrator

Charles Curtis
Regional Inspector General - Audit

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I. EXECUTIVE SUMMARY

This report provides the results of the Operation Restore Trust (ORT) survey of the Lawnwood Regional Medical Center, a hospital-based skilled nursing facility (SNF) located in Fort Pierce, Florida. The objective of the survey was to determine whether charges other than room and board, billed to the Medicare Part A Fiscal Intermediary (Intermediary) and Part B Carrier (Carrier), were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. For these services to be allowable they must be:

- considered a specific and effective treatment for the patient's condition;
- prescribed under the assumption that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician;
- reasonable in amount, frequency, and duration; and
- fully supported by the patient medical records.

A team comprising a Florida State Agency for Health Care Administration (State Agency) nurse surveyor, a Regional Health Care Administration (HCFA) nurse consultant, and an Office of Inspector General (OIG) Office of Audit Services auditor conducted an unannounced focused survey at the facility. The members of the team evaluated the services for 32 Medicare beneficiaries with aberrant charges made for the period January 1, 1994 through December 31, 1994. This period coincided with the SNF's Medicare Fiscal Year 1994 (FY 1994).

Our review disclosed that $95,442 in charges reported by the SNF in its FY 1994 Medicare Cost Reports did not meet Medicare reimbursement requirements. The amount questioned consisted of $74,730 of speech, physical and occupational services which were not reasonable or medically necessary; $15,182 of routine supply and drug services reported as ancillary services, and $5,530 of laboratory tests in excess of those ordered by the physician. We are recommending adjustment of the questioned costs that total $95,442; for the FI to identify and recoup overpayments for subsequent periods; and for the State Agency to require certain corrective actions..

II. BACKGROUND

The Secretary of the Department of Health and Human Services and the President initiated Project ORT. This innovative, collaborative project was designed to address growing concerns over rising health care costs. A review of Departmental records indicate that over the last 10 years, the following segments of the health care industry have experienced a surge in health care fraud:

- o home health,
- o nursing homes,
- o hospice, and
- o durable medical equipment.

Departmental records further disclosed that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds paid to the above health care segments. As a result, these States and the above health care segments were chosen as targets of the ORT 23-month pilot project.

Within the Department of Health and Human Services ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on Program vulnerabilities identified through investigations and audits.

HCFA's Bureau of Data Management Services (BDMS) identified certain SNFs in Florida as aberrant according to their billings. The method used to identify these providers was to evaluate the universe of SNF admissions in each state during FY 1994. Data for all SNF claims was summarized first by beneficiary, and then by SNF. Key statistical data included total claims per beneficiary, allowed dollars per stay, line items or services per number of beneficiaries, average dollars and claims per stay, and average dollars per day. BDMS generated a listing of SNFs with high reimbursement amounts per day and per stay. The listing of SNFs was manually scanned and 14 were judgementally selected based on total highest reimbursement.

In addition to these 14 SNFs, we requested the two principal fiscal intermediaries in Florida (Aetna and Blue Cross) to each identify 3 SNFs for inclusion in this project based upon their data, complaints, and experience with SNF providers.

The Lawnwood Regional Medical Center was one of the 14 SNFs judgementally selected for review. This SNF has participated in the Medicare program since August 14, 1991. Of the hospital's 353 certified beds, 33 participated in SNF activities.

III. SCOPE OF REVIEW

The survey was conducted by a team comprising a nurse surveyor from the State Agency, a nurse consultant from HCFA , and an auditor from the OIG Office of Audit Services. This HCFA directed survey was conducted using HCFA's review protocols rather than the OIG's policies and procedures. Accordingly, the OIG's work was in compliance with generally accepted government auditing standards only in relation to the quantification of the unallowable services identified by other members of the team.

The objective of the survey was to determine whether charges other than room and board, billed to the Intermediary and Carrier, were allowable based on applicable Federal regulations and implementing instructions under the Medicare guidelines. Primarily we wanted to determine whether unnecessary care was provided to the 32 beneficiaries in our sample, for whom the Lawnwood Regional Medical Center billed Medicare $1,160,204.37 during FY 1994.

The approach used was to identify all services billed to Medicare Part A, Medicare Part B, and Medicaid cross-over claims for each of the 32 beneficiaries in our sample during their stay at the SNF between January 1994 and December 1994. This approach was adopted because many providers, other than the SNF bill separately for services to the SNF patients, e.g., podiatrists, portable x-ray suppliers, therapy providers and DME suppliers. These claims go to various Medicare contractors and to Medicaid, and are rarely, if ever associated with each other or the SNF's bills.

Using the team concept, the State Agency and HCFA nurses identified Medicare funded services which were either not reasonable or necessary, and the OIG auditor quantified the charges associated with the services. The beneficiaries' medical records and related documentation were reviewed to determine the medical necessity of charged services; specifically, were the services: (i) recorded in the medical records, (ii) ordered by a physician, (iii) rendered by qualified personnel, and (iv) appropriate considering the physicians' diagnosis and the residents' physical/mental condition. The SNF's accounting records and supporting documentation were reviewed to determine: (i) the bases for charges reported to Medicare, and (ii) the amount of charges associated with questioned services.

Field work was performed at the SNF's offices in Fort Pierce, Florida during the period June 17 through June 21, 1996.

IV. FINDINGS AND RECOMMENDATIONS

Based on the survey results, we questioned $95,442 in charges reported by the Lawnwood Regional Medical Center in its FY 1994 Medicare Cost Report. The amount questioned includes therapy services which were not reasonable or medically necessary, routine services reported as ancillary services and laboratory services in excess of those ordered by the physicians. We are recommending adjustment of the questioned charges.

QUESTIONED CHARGES

THERAPIES:		
Occupational	$ 9,235	
Physical	21,725	
Speech	43,770	
Subtotal		$74,730
SUPPLIES		14,827
DRUG		355
LABORATORY		5,530
Total		$95,442

OCCUPATIONAL, PHYSICAL AND SPEECH THERAPY SERVICES

We questioned $74,730 of occupational (OT), physical (PT) and speech (ST) therapy services provided 24 of the 32 beneficiaries included in our sample. Under paragraph 1861(h)(3) of the Social Security Act, these services are covered under Medicare Part A when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist. The Medicare Intermediary Manual at paragraph 3132 (MIM 3132) states that the ordered therapies provided in a SNF must be reasonable and necessary for the treatment of the beneficiary's illness or injury. The questioned charges did not meet the reimbursement criteria.

FINDING #1

Occupational Therapy Services

We questioned $9,235 of OT charged to 13 of the 32 beneficiaries, or 32% of the $29,115 that Lawnwood was reimbursed for OT during the period of our review. In order to be covered under Medicare Part A; OT services must be prescribed by a physician, be performed by a qualified therapist, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time.

The questioned OT services provided the 17 beneficiaries did not meet one or more of the above criteria. Specific reasons for questioning the charges follow:

- No evidence in medical records that charged therapy was provided.

- o Physician's signed order for therapy was not in residents' medical records.

- o Charges related to services provided a comatose, non-responsive resident.

- o Therapy provided was not medically necessary due to residents' cognitive state, lack of cooperation, refusal of treatment, or poor rehabilitation potential.

RECOMMENDATIONS

We recommend that the Intermediary should:

- o Adjust the $9,235 from OT charges reported by the SNF on its FY 1994 cost report.

- o Conduct a focused review of all OT services provided at Lawnwood Regional Medical Center since the period of our review.

We recommend that the State Agency should:

- ● Ensure via a Corrective Action Plan (CAP) that OT services at this facility are properly ordered, documented, and provided to appropriate patients.

FINDING #2

Physical Therapy Services

We questioned $21,725 of physical therapy PT charged to 17 of the 32 beneficiaries, or 23% of the $95,630 that Lawnwood was reimbursed for PT during the period of our review. In order to be covered under Medicare Part A, PT services must relate directly and specifically to an active written treatment regimen established by the physician or by the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury (MIM 3101.8). To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition. There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.

- o The amount, frequency, and duration of the services must be reasonable.

The questioned PT services provided the 17 beneficiaries did not meet one or more of the above criteria. Specific reasons for questioning the charges follow:

- o Reported therapies were not supported in the patients' medical records.
- o Physician's order for therapy were not in the patients' records.
- o Charges related to services provided a comatose, non-responsive resident.
- o Skilled unit assessment indicated that the patient receiving PT had strong motor function.

RECOMMENDATIONS

We recommend that the Intermediary should:

- o Adjust the $21,725 from PT services reported by the SNF on its FY 1994 cost report.
- o Conduct a focused review of all PT services provided at Lawnwood Regional Medical Center for the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan (CAP) that PT services at this facility are properly ordered, documented, and provided to appropriate patients.

FINDING #3

Speech Therapy Services

We questioned $43,770 of ST services provided 19 of the 32 beneficiaries, or 84% of the $52,060 that Lawnwood was reimbursed for ST during the period of our review. Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must be related directly and specifically to written treatment regimen established by the physician (or speech pathologist providing the services). The services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:

- o The services must be considered a specific and effective treatment for the patient's condition.
- o The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist.

- o There must be an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician.

- o The amount, frequency, and duration of the services must be reasonable.

The questioned ST services provided the 19 beneficiaries did not meet one or more of the above criteria. The most egregious charges questioned involved the following:

- o $4,880 charged for ST services provided a comatose, non-responsive patient.

- o $3,050 charged for ST services provided a comatose, non-responsive patient.

- o $1,430 charged for ST services provided a patient admitted to the SNF as a result of a fractured thighbone.

- o $2,420 charged for ST services provided a terminally ill patient who had no recorded communication problems.

RECOMMENDATIONS

We recommend that the Intermediary should:

- o Adjust the $43,770 from ST charges reported by the SNF on its FY 1994 cost report.

- o Conduct a focused review of all ST services provided at Lawnwood Regional Medical Center for the period of our review.

We recommend that the State Agency should:

- Ensure via a Corrective Action Plan that ST services at this facility are properly ordered, documented, and provided to appropriate patients.

FINDING #4

SUPPLY SERVICES

We questioned $14,827 of supplies charged to the 32 beneficiaries, or 12% of the $125,789.25 that Lawnwood was reimbursed for supplies during the period of our review. Federal regulations at 42 CFR 409.25 state that supplies, appliances, and equipment are covered as extended care services only if they are ordinarily furnished by the skilled nursing facility for the care and treatment of inpatients. Examples of items covered as ancillary supplies are oxygen, surgical dressings, splints,

casts, and other devices used for the reduction of fractures and dislocations. The questioned charges were for items such as underpads, diapers, slippers, and restraints. We considered these items routine supplies in the skilled nursing setting rather than ancillary supplies.

RECOMMENDATION

We recommend that the Intermediary adjust the $14,827 from ancillary supply services reported by the SNF on its FY 1994 cost report.

FINDING #5

DRUGS

We questioned $355 of drugs charged to 3 of the 32 beneficiaries, or 0% of the $439,389.35 that Lawnwood was reimbursed for drug services during the period of our review. The questioned charges included $308 for a non-prescription pharmaceutical item which we believed was a routine supply item for a skill nursing facility. The remaining $47 pertains to drug charges for which there was no doctor's order or record that the drug had been administered.

RECOMMENDATION

We recommend that the Intermediary adjust the $355 from drug services reported by the SNF on its FY 1994 cost report.

FINDING #6

Laboratory Services

We questioned $5,530 of laboratory services charged to 17 of the 32 beneficiaries, or 6% of the $89,654.23 that Lawnwood was reimbursed for laboratory services during the period of our review. The questioned charges related to laboratory profiles that tested 22 separate chemical elements. This profile is commonly referred to as a "CHEM 22." When a physician ordered a CHEM 22, the SNF billed Procedure Code 80019 for 19 of the 22 elements tested and then separately billed Procedure Codes 82150, 83540, and 83735 for the 3 remaining elements (amylase, iron and magnesium). Since the Physicians' Current Procedural Terminology (CPT) applicable during FY 1994 stated that Procedure Code 80019 would be used to charge for 19 or more chemistry test, the separate billings constituted duplicate charges.

RECOMMENDATION

We recommend that the Intermediary adjust the $5,530 from laboratory services reported by the SNF on its FY 1994 cost report.