NOV - 6 2006

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Medical Review of Touro Rehabilitation Center's Services for Medicare Outlier Claims for 2002 (A-04-04-00010)

Attached is an advance copy of our final report on Touro Rehabilitation Center's (Touro) services for Medicare outlier claims for 2002. We will issue this report to Touro within 5 business days.

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from specific conditions requiring intensive inpatient rehabilitation therapy. Touro, an IRF, operates within the Touro Infirmary, a full-service hospital located in New Orleans, Louisiana. Medicare paid Touro $5.7 million for services relating to calendar year 2002 outlier claims. Of this amount, $2.1 million represented outlier payments and $3.6 million represented prospective payments.

Our objective was to determine whether Touro submitted IRF outlier claims that met Medicare requirements.

Touro submitted numerous IRF outlier claims during calendar year 2002 that did not meet Medicare requirements. For 69 of the 100 outlier claims in our sample, the services were not medically necessary, were not reasonable, or were not adequately documented. Touro inappropriately billed for these services because its preadmission and admitting procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, who were not capable of significant practical improvement, or who were medically unstable. As a result, Touro received $1,586,305 in unallowable Medicare payments on 69 claims. Based on the sample results, we estimate that Medicare overpaid Touro $3,309,699 for IRF outlier claims for 2002.

We recommend that Touro:

- refund $3,309,699 to the Medicare program;
- work with its fiscal intermediary to identify and refund overpayments for subsequent years' IRF outlier claims that did not meet Medicare requirements; and

- ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable.

In its comments on the draft report, Touro stated that it had taken numerous steps to ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable. However, Touro disagreed with the results of the medical determinations and took issue with many aspects of the review. Touro stated that our findings were inconsistent with those of its independent consultant, and it questioned whether all medical records were properly reviewed. Touro believed that its medical records sufficiently demonstrated that the sampled patients had a reasonable and necessary need for rehabilitation in an IRF.

Touro did not provide any additional documentation with its response, nor did its comments warrant any revisions to the results of our review or to our recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750. Please refer to report number A-04-04-00010.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

NOV - 7 2006

Report Number: A-04-04-00010

Mr. Bob Ficken
Chief Financial Officer
Touro Rehabilitation Center
1401 Foucher Street
New Orleans, Louisiana 70115

Dear Mr. Ficken:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medical Review of Touro Rehabilitation Center's Services for Medicare Outlier Claims for 2002." A copy of this report will be forwarded to the HHS action official noted on the next 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-04-00010 in all correspondence.

Sincerely,

Peter J Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAL REVIEW OF TOURO REHABILITATION CENTER'S SERVICES FOR MEDICARE OUTLIER CLAIMS FOR 2002

Daniel R. Levinson
Inspector General

November 2006
A-04-04-00010

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

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

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from conditions requiring intensive inpatient rehabilitation therapy. Medicare covers inpatient rehabilitation for patients who have an expectation of practical improvement in a reasonable period of time and who require a more coordinated, intensive program of multiple services than is generally provided in a skilled nursing facility or on an outpatient basis.

Touro Rehabilitation Center (Touro), an IRF, operates within the Touro Infirmary, a full-service hospital in New Orleans, Louisiana. Medicare paid Touro about $5.7 million for services relating to outlier claims in calendar year 2002. Of this amount, $2.1 million represented outlier payments and $3.6 million represented prospective payments. Touro received outlier payments when its estimated costs for a patient exceeded a fixed amount (adjusted to account for area wage levels, low-income patients, and rural locations) specified by the Centers for Medicare & Medicaid Services.

OBJECTIVE

Our objective was to determine whether Touro submitted IRF outlier claims that met Medicare requirements.

SUMMARY OF FINDINGS

Touro submitted numerous IRF outlier claims during calendar year 2002 that did not meet Medicare requirements. For 69 of the 100 outlier claims in our sample, the services were not medically necessary, were not reasonable, or were not adequately documented.

- For 44 outlier claims, the beneficiaries received services that were not medically necessary. Most of these claims involved situations in which the beneficiaries were clinically stable and their rehabilitation potential did not require an intensive setting. These claims were denied because the beneficiaries could have received the same services in a less intensive setting.

- For 21 outlier claims, the beneficiaries received services that were not reasonable. Most of these claims involved beneficiaries whose conditions were continuing to deteriorate. The treatment was not reasonable because it would not have brought about significant practical improvement in a reasonable period.

- For four outlier claims, the beneficiaries' medical records were insufficient to determine whether services were provided at the level billed, medically necessary, or reasonable.

Touro inappropriately billed for these services because its preadmission and admitting procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, who were not capable of significant practical improvement, or who were medically unstable. As a result, Touro received $1,586,305 in unallowable Medicare payments on 69 claims. Based on the sample results, we estimate that Medicare overpaid Touro $3,309,699 for IRF outlier claims for 2002.

RECOMMENDATIONS

We recommend that Touro:

- refund $3,309,699 to the Medicare program;

- work with its fiscal intermediary to identify and refund overpayments for subsequent years' IRF outlier claims that did not meet Medicare requirements; and

- ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable.

TOURO COMMENTS

In its comments on the draft report, Touro stated that it had taken numerous steps to ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable. However, Touro disagreed with the results of the medical determinations and took issue with many aspects of the review. Touro stated that our findings were inconsistent with those of its independent consultant, and it questioned whether all medical records were properly reviewed. Touro believed that its medical records sufficiently demonstrated that the sampled patients had a reasonable and necessary need for rehabilitation in an IRF. (See Appendix F for Touro's comments in their entirety.)

OFFICE OF INSPECTOR GENERAL RESPONSE

Touro did not provide any additional documentation with its response, nor did its comments warrant any revisions to the results of our review or to our recommendations.

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INTRODUCTION

BACKGROUND

Inpatient Rehabilitation Facility Services

Inpatient rehabilitation facilities (IRF) provide specialized care for patients recovering from specific conditions requiring intensive inpatient rehabilitation therapy. According to the "Medicare Benefits Policy Manual" (the Manual), Medicare covers inpatient rehabilitation for patients who are expected to show significant practical improvement within a reasonable period and who require a more coordinated, intensive program of multiple services than is generally provided in a skilled nursing facility or on an outpatient basis.

Inpatient Rehabilitation Facility Prospective Payment System and Outlier Payments

Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs effective for cost reporting periods beginning on or after January 1, 2002. Under this system, the Centers for Medicare & Medicaid Services (CMS) pays IRFs for patient discharges using a classification system that assigns beneficiaries to case-mix groups depending on their clinical characteristics. Additionally, CMS makes outlier payments if the estimated costs for a patient exceed a fixed amount (adjusted to account for area wage levels, low-income patients, and rural locations) specified by CMS. Accordingly, Medicare outlier claims include a prospective payment component and an outlier payment component.

Program Safeguard Contractors

As authorized by the Health Insurance Portability and Accountability Act of 1996, CMS contracts with program safeguard contractors (PSC) to perform Medicare program integrity activities. Under CMS's Umbrella Statement of Work, these contractors conduct medical reviews, cost report audits, data analyses, provider education, and fraud detection and prevention.

Touro Rehabilitation Center

Touro Rehabilitation Center (Touro), an IRF, operates within the Touro Infirmary, a full-service hospital located in New Orleans, Louisiana. Medicare paid Touro $5.7 million for services relating to calendar year 2002 outlier claims. Of this amount, $2.1 million represented outlier payments and $3.6 million represented prospective payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Touro submitted IRF outlier claims that met Medicare requirements.

Scope

Our review covered discharge dates in calendar year 2002. We selected a random sample of 100 outlier claims from a universe of 235 claims for which Touro received total Medicare payments of $5,702,250.

We limited our review of internal controls to obtaining an understanding of Touro's preadmission screening and admitting processes.

We performed our review from November 2004 through July 2005.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- selected a random sample of 100 outlier claims from a CMS file representing outlier payments totaling $2,315,554 (Appendix A);
- interviewed Touro personnel;
- reviewed applicable procedures for preadmission screening, patient admitting, billing, and fiscal administration;
- obtained the medical records, patient assessment instrument forms, and Medicare bills for each sampled claim;
- contracted, under CMS's Umbrella Statement of Work, with a PSC to review all medical records obtained for the 100 sampled claims and to determine whether the beneficiaries required the IRF level of care and whether the IRF services provided were medically necessary, reasonable, and supported by adequate documentation;
- provided the PSC with the medical records, the patient assessment instrument forms, the Medicare bills, and other records needed to conduct the medical review;
- used an unrestricted variable appraisal program to estimate overpayments to Touro (Appendix B); and
- discussed the results of our review with Touro officials.

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

FINDINGS AND RECOMMENDATIONS

Touro submitted numerous IRF outlier claims that did not meet Medicare requirements for medical necessity, reasonableness, and documentation. For 69 of the 100 outlier claims in our sample, the services were not medically necessary, were not reasonable, or were not adequately documented.

- For 44 outlier claims, the services were not medically necessary.
- For 21 outlier claims, the services were not reasonable.
- For four outlier claims, the medical records were insufficient to determine whether services were provided at the level billed, medically necessary, or reasonable.

Appendixes C through E summarize the medical review determinations for the 69 claims.

Touro inappropriately billed for these services because its preadmission and admitting procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement, or were medically unstable. Touro has since taken corrective actions in this area.

As a result, Touro received $1,586,305 in unallowable Medicare payments on 69 claims. Based on the sample results, we estimate that Medicare overpaid Touro $3,309,699 for IRF outlier claims for 2002.

MEDICARE REQUIREMENTS FOR INPATIENT REHABILITATION FACILITY SERVICES

Section 1862(a)(1)(A) of the Act excludes from Medicare coverage any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part. Federal regulations (42 CFR § 411.15(k)) implement this provision.

To evaluate the reasonableness and necessity of IRF admissions, medical reviewers from the PSC applied the standards detailed in chapter 1, section 110.1 of the Manual. According to the Manual, beneficiaries require a hospital level of rehabilitative care if they need a "relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function." Two basic requirements must be met for Medicare to cover inpatient hospitals' rehabilitative care:

1. The efficacy, duration, frequency, and amount of services must be reasonable and necessary for the treatment of the patient's condition.
2. Furnishing the care on an inpatient hospital basis, rather than in a less intensive facility such as a skilled nursing facility or on an outpatient basis, must be reasonable and necessary.

The Manual elaborates on the reasonableness and necessity requirements, stating that Medicare covers inpatient hospital rehabilitation for beneficiaries who are expected to show significant practical improvement within a reasonable period and who require a coordinated, intensive program of multiple services. The Manual also states that the IRF must determine whether a hospital stay for rehabilitation services is reasonable and necessary by assessing each beneficiary's individual care needs rather than by relying on fixed criteria.

Finally, the Act requires that adequate documentation be maintained to support the services rendered. Section 1833(e) states in part: ". . . no payment shall be made to any provider of services . . . unless there has been furnished such information as may be necessary in order to determine the amounts due such provider . . . ."

NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

Services Not Medically Necessary

For 44 of the 69 unallowable outlier claims, the services were not medically necessary for the beneficiary's condition. Most of these claims involved situations in which the beneficiaries were clinically stable and their rehabilitation potential did not require an intensive setting. These claims were denied because the beneficiaries could have received the same services in a less intensive setting.

Services Not Reasonable

For 21 of the 69 unallowable outlier claims, the services were not reasonable for the beneficiary's condition. Most of these claims involved beneficiaries whose conditions were continuing to deteriorate. The treatment was not reasonable because it would not have brought about significant practical improvement in a reasonable period.

Services Not Supported by Adequate Documentation

For 4 of the 69 unallowable outlier claims, the medical records were insufficient to determine whether services were provided at the case-mix group billed, medically necessary, or reasonable.

INADEQUATE ADMITTING PROCEDURES

Touro inappropriately billed for these services because its preadmission screening and admitting procedures did not consistently identify beneficiaries who could be treated in a less intensive facility, were not capable of significant practical improvement as a result of therapy, or were medically unstable. Touro informed us that it had taken corrective actions in this area.

ESTIMATED MEDICARE OVERPAYMENTS

The 100 outlier claims in our sample represented $2,315,554 in Medicare payments. Of this amount, $1,586,305 represented overpayments related to services determined to be unallowable. Based on the sample results, we estimate that Touro improperly received $3,309,699 for inpatient rehabilitation services that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that Touro:

- refund $3,309,699 to the Medicare program;
- work with its fiscal intermediary to identify and refund overpayments for subsequent years' IRF outlier claims that did not meet Medicare requirements; and
- ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable.

TOURO REHABILITATION CENTER COMMENTS

In its comments on the draft report, Touro stated that it had taken numerous steps to ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable. However, Touro disagreed with the results of the medical determinations and took issue with many aspects of the review.

Touro stated that our findings were inconsistent with the findings of its independent consultant, and it questioned whether all medical records were properly reviewed. According to Touro, the independent consultant found that the sampled patients had a medical need for admission to an IRF and showed reasonable progress toward established goals. Touro also questioned the expertise of the PSC's medical reviewer and asserted that experts in the IRF level of care should review the claims. Finally, Touro commented that the PSC's medical reviewer may not have reviewed the preadmission assessment reports for the sampled claims because those reports were not maintained in the medical record, and Touro was not certain whether they were provided to the PSC. (See Appendix F for Touro's comments in their entirety.)

OFFICE OF INSPECTOR GENERAL RESPONSE

Touro did not provide any additional documentation with its response, nor did its comments warrant any revisions to the results of our review or to our recommendations.

Regarding the medical review, the PSC medical review team was highly qualified to conduct this review and was approved by CMS to conduct program safeguard activities, including medical reviews. The team consisted of registered nurses with years of medical review experience, including one who had worked with IRF patients. Additionally, the team included a medical director, a physician who conducted a quality assurance review of the team's work.

As to the preadmission assessment reports, we gave Touro every opportunity to provide us with the complete medical records and all supporting documentation of the patients in our sample. During the medical review, the PSC considered all documentation that Touro provided to us.

The PSC reviewed Touro's written comments and noted that the PSC had considered the eight criteria (HCFA Ruling 85-2) that CMS established to assist in the determination of whether there is a "reasonable and necessary" need for rehabilitation in an IRF. Although Touro met the eight criteria for many of the claims, the PSC found that the patients could have been treated in a less intensive setting for various reasons. Moreover, as stated in the report, we applied criteria consistent with sections 1862(a)(1)(a) and 1833(e) of the Act; Chapter 1, section 110.1, of the Manual; and Federal regulations (42 CFR § 411.15(k)).

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether Touro Rehabilitation Center (Touro) submitted inpatient rehabilitation facility (IRF) outlier claims that met Medicare requirements.

POPULATION

The population consisted of 235 IRF outlier claims for Medicare beneficiaries discharged from Touro between January 1, 2002, and December 31, 2002.

SAMPLE UNIT

The sample unit was an outlier claim for a Medicare beneficiary discharged from Touro between January 1, 2002, and December 31, 2002.

SAMPLE DESIGN

We used a simple random sample of claims.

SAMPLE SIZE

The sample size was 100 claims.

ESTIMATION METHODOLOGY

Using the Office of Inspector General, Office of Audit Services RAT-STATS variable appraisal program, we projected the excessive payments to Touro resulting from claims that did not meet Medicare requirements.

APPENDIX B

SAMPLE RESULTS AND PROJECTION

SAMPLE RESULTS

Sample Size	Number of Errors	Value of Errors
100	69	$1,586,305

VARIABLE PROJECTION

	Projected Value of Overpayments for 2002
Point estimate	$3,727,817
90-percent confidence interval:	
Lower limit	3,309,699
Upper limit	4,145,935

MEDICAL REVIEW DETERMINATIONS—SERVICES NOT NECESSARY

Following are excerpts from the medical reviewers' determinations for the 44 unallowable claims for services that were not medically necessary.

Count	Sample Number	Excerpt	Disallowed Amount
1	1	. . . no evidence that this patient required intensive inpatient rehabilitation . . . no evidence that therapy could not be rendered in a less intensive setting.	$10,943.44
2	2	. . . on admission . . . minimal assistance for functional activities of daily living . . . no evidence that therapy could not be rendered in a less intensive setting.	11,084.99
3	6	. . . onset was two months prior to admission into the IRF . . . patient not outpatient due to transportation issues . . . no immediate need for IRF services . . . therapy could be rendered in a less intensive setting.	18,017.48
4	14	. . . absence of acute co-morbidities that required medical management in an acute setting . . . services could have been appropriately rendered in a skilled nursing facility [SNF] setting	29,096.16
5	17	. . . minimal functional deficits . . . a few co-morbidities that required straightforward medical management . . . services could have been rendered in a less intense setting such as a skilled nursing facility.	14,817.02
6	23	. . . it appeared that these services could have been rendered in a less intense setting such as the home health or outpatient settings.	17,709.83
7	27	. . . medically uncomplicated course of treatment and was at a fairly high functional level prior to her rehab stay. This patient could have received treatment in a less intense setting.	17,731.70
8	28	. . . simple transfers and bed mobility with moderate assistance . . . patient was also using a wheelchair . . . patient could have received rehabilitative services in a less intense setting (SNF).	20,721.93
9	29	. . . able to do some walking. Review of the medical record shows that the patient's rehabilitative services could have been rendered in a less intense setting (SNF).	16,535.42

Count	Sample Number	Excerpt	Disallowed Amount
10	32	. . . not fully participating therapy . . . patient was utilizing a wheelchair . . . patient could have received her rehabilitative services in a less intense setting of a SNF.	$19,055.99
11	33	. . . eventually discharged to a nursing home . . . very little progress made towards the stated goals . . . patient could have been treated and received her rehabilitative services in a less intense setting of a SNF.	25,419.06
12	38	. . . independent with bed mobility . . . . Minimal assist with transfers . . . discharged to have PT [physical therapy] as an outpatient . . . could have received rehabilitative services in a less intense setting as that of a SNF.	13,259.13
13	40	. . . sometimes utilizes wheelchair, but ambulation with assistance also occurred . . . patient could have received rehabilitative services in a less intense setting as that of a SNF.	10,285.28
14	41	. . . moderately independent . . . strength and endurance continued to need to increase . . . . patient could have received his rehabilitative services at a less intense level as that of a SNF.	18,593.63
15	45	. . . the patient could have received his rehabilitative therapies in a SNF setting . . . patient could have received rehab therapy at a lower level of care (SNF).	17,132.48
16	47	. . . rehab course medically unremarkable and was discharged to home with home health . . . could have been treated in a less intense setting.	17,628.07
17	53	. . . patient could have received rehabilitative services in a less intense setting such as a SNF	18,069.66
18	55	This patient does not meet criteria for this level of rehab. SNF would have been more appropriate. Deny services as not medically necessary.	21,082.24
19	56	Patient is ambulatory . . . could have obtained services at a lesser level of care . . . more appropriate for the patient to attend rehabilitative therapies as an outpatient.	10,881.90

Count	Sample Number	Excerpt	Disallowed Amount
20	57	. . . patient's rehabilitative therapy could have appropriately been rendered at a SNF instead of an IRF. She had started therapy prior to transferring to the IRF and was tolerating it well.	$11,475.26
21	58	. . . patient was ambulating . . . could have received rehabilitative services on an outpatient basis (less intense level).	23,105.87
22	59	Services not medically necessary for the patient's condition; i.e. diagnosis or treatment of illness or injury . . . patient ambulating without an assistive device and driving . . . could have received treatment at a lesser intense setting.	21,685.26
23	60	. . . able to ambulate with a rolling walker . . . currently at minimal assistance with gait . . . could have received rehabilitative services in a less intense setting of a SNF.	9,822.31
24	61	. . . not medically necessary due to the chronic nature of the illness and the patient could have been treated in a lesser intense setting.	12,067.60
25	62	Admitting diagnosis was other malaise and fatigue . . . dizziness and giddiness . . . patient does not feel like she can go home due to her weakness . . . could have been treated at a less intense setting.	18,351.67
26	63	. . . this intense, specialized level of rehab was not medically necessary for his illness. Less intense setting would have been more appropriate.	23,750.47
27	64	This patient did not need this intense level of rehab. Lesser intense setting would have been more appropriate.	14,812.55
28	65	Although this patient needed rehab . . . the level of intense, skilled rehab was not medically necessary. She would have benefited from a lesser level of care.	29,246.81

Count	Sample Number	Excerpt	Disallowed Amount
29	66	. . . little functional improvement during this patient's 2½ week stay. This stay is deemed not medically necessary due to the lack of need of specialized, intense inpatient rehab. Patient could have received treatment in a less intense setting.	$18,642.83
30	67	. . . pain and difficulty ambulating . . . patient confused and required restraints. This rehab stay is not medically necessary. The patient could have received treatment in a less intense setting.	21,376.66
31	68	. . . patient was non-compliant with treatment . . . the patient could have received rehabilitative services in a less intense setting as that of a SNF.	20,885.53
32	70	Intense skilled rehab was not necessary to treat illness. Less intense setting would have been appropriate.	51,393.85
33	71	. . . the patient could have received therapy in a less intense setting. Inpatient rehab was not medically necessary for his condition.	19,952.43
34	72	. . . patient requires long-term care based on his condition and severity of spinal cord injury. This level of intense rehab is not appropriate based on the patient's medical condition.	45,445.02
35	73	. . . minimal benefit from this rehab stay and was definitely not functional in any capacity . . . severely debilitated and due to various problems was not a candidate for intense inpatient rehab.	68,779.23
36	75	. . . did not require this intense level of therapy and would have been more appropriately placed in a less intense setting.	22,511.76
37	78	. . . noted to refuse therapy often . . . minimal change from admission and discharge levels of functioning . . . not a good candidate for inpatient rehab and could have received services from a SNF from the beginning.	25,189.59
38	79	. . . admitted to rehab for pain management . . . socialization therapy . . . This could have been provided on an outpatient basis . . . not medically necessary to be rendered in this setting.	11,403.85

Count	Sample Number	Excerpt	Disallowed Amount
39	80	During the IRF stay . . . significant decline in medical status . . . benefiting from the SNF stay and could have stayed in that setting until medical issues warranted re-admission to the acute setting.	$23,193.41
40	81	. . . did not need this intense, skilled rehab . . . due to not an acute process . . . the patient could have been treated in a less intense setting.	21,200.47
41	83	. . . condition did not warrant inpatient rehab. Lesser level of service would have been more appropriate . . . questionable about medical status . . . on disability . . . testing does not show acute process	31,826.17
42	92	This patient's condition did not require intense skilled rehab. His admission goals were the following: increase mobility, endurance, strengthening, transfer training, and family education.	33,840.94
43	95	. . . did not require this intense level of rehab . . . would have been appropriately treated in a less intense setting.	10,695.18
44	99	. . . right total knee replacement . . . . Patient did not require this intense setting of rehab.	14,687.90
TOTAL			**$933,408.03**

MEDICAL REVIEW DETERMINATIONS—SERVICES NOT REASONABLE

Following are excerpts from the medical reviewers' determinations for the 21 unallowable outlier claims for services that were not reasonable.

Count	Sample Number	Excerpt	Disallowed Amount
1	16	. . . absence of significant improvement in response to therapy . . . poor rehabilitation potential . . . unreasonable to expect significant improvement in response to therapy at this point.	$22,571.37
2	24	. . . the evidence does not support the continuation of intense therapy after September 6, 2002 . . . there was no evidence that the patient would benefit from further therapy. Consideration was given to his impaired cognition that interfered with the ability to progress . . .	10,826.59
3	31	. . . history of Alzheimer's . . . non-compliant with therapies, transfers . . . readiness to learn was poor to fair . . . the patient should have been directly transferred to the SNF instead of going to the IRF.	18,047.16
4	43	. . . the patient could have received her rehabilitative services at a less intense level . . . her ability to do rehabilitative services was limited due to her ongoing pain.	20,319.49
5	44	. . . limitations in mobility skills . . . maximum assistance needed . . . "fair" rehab candidate due to her anxiety and deconditioning . . . anxiety prevented her from benefiting fully from the intense rehabilitative services rendered in the IRF.	23,899.89
6	46	. . . patient having trouble with confusion and memory issues . . . rehabilitative services in a less intense setting actually would have been more appropriate in regards to her confusion and memory issues.	19,276.36
7	49	. . . services not medically necessary for the patient's condition . . . rehab stay was medically unremarkable . . . minimal functional gains while in rehab . . . "too weak" for therapies	15,047.29
8	51	. . . services not reasonable for the patient's condition . . . poor wound healing and gangrene . . . repeatedly refused therapies . . . "poor endurance secondary to anxiety" . . . "exhibits minimal motivation" and "poor participation." This patient was not mentally ready for this rehab setting.	19,975.38

Count	Sample Number	Excerpt	Disallowed Amount
9	54	. . . memory was an issue . . . oxygen dependent . . . arrhythmia problems . . . some lethargy and fatigue . . . . could not fully benefit due to medical condition . . . fatigue and memory loss impacted her ability to fully participate in rehabilitative therapies.	$31,704.09
10	69	. . . patient could not participate fully in the needed therapies due to medical status . . . could have received the needed rehabilitative services at a less intense level of care . . . not appropriately placed due to medical status.	18,663.15
11	74	. . . frequently noted to be confused, frail/weak, with poor endurance and with inconsistent effort in therapy. This patient would have been more appropriately placed in the SNF from his hospital discharge.	28,401.68
12	77	. . . services not reasonable for the patient's condition . . . refused nursing home . . . "confused" and not receptive to learning new techniques and wants to do things her way.	22,376.13
13	82	This patient was not a good candidate for inpatient rehab . . . tolerance and endurance was not tolerable to intense rehab . . . often refused therapy.	41,447.46
14	84	…during the IRF stay . . . no improvement in functional status . . . "poor alertness" and not making any progress . . . admission and discharge status the same. This intense level of rehab was not appropriate for this patient's condition.	36,267.45
15	85	. . . services not reasonable and necessary for the patient's condition . . . not a good inpatient rehab candidate . . . unable to follow commands consistently. She is confused and aphasic.	36,741.04
16	87	. . . services not reasonable for the patient's condition . . . patient lived at home and after rehab he was discharged to the SNF.	30,403.55
17	89	. . . services not reasonable for the patient's condition . . . fearful of ambulation and participating in therapy . . . pathological fear of falling . . . not a good candidate for intense inpatient rehab due to his psychiatric history and cognitive level of functioning.	26,389.87

Count	Sample Number	Excerpt	Disallowed Amount
18	91	. . . services not reasonable for the patient's condition . . . noted to be confused . . . did not have any functional improvement . . . not a good rehab candidate. She showed little benefits from her two-week stay	$37,436.24
19	97	. . . services not reasonable for the patient's condition . . . felt the rehab was "too intense" and desired a transfer to a less intense setting . . . persistent nausea . . . not medically stable for this level of rehab.	11,729.51
20	98	. . . services not reasonable for the patient's condition . . . not doing well with therapies secondary to pain and weakness. This patient was not a good inpatient rehab candidate	48,600.50
21	99	. . . services not reasonable for the patient's condition . . . refusing therapy . . . irrational, hallucinating, and agitated . . . not a good candidate for this intense setting . . . needed a slower, less intense setting.	43,719.14
TOTAL			**$563,843.34**

APPENDIX E

MEDICAL REVIEW DETERMINATIONS—SERVICES NOT SUPPORTED

Following are excerpts from the medical reviewers' determinations for the four unallowable outlier claims for services that were not supported by adequate documentation.

Count	Sample Number	Excerpt	Disallowed Amount
1	25	In the absence of a complete inpatient chart to substantiate that all of the services were . . . medically reasonable and necessary, no payment will be allowed.	$36,036.13
2	35	Insufficient information to determine medical necessity of stay.	22,339.89
3	39	Insufficient documentation submitted to determine medical necessity of stay.	16,369.61
4	42	. . . medical record did not contain any PT or [occupational therapy] progress notes . . . difficult to completely determine the medical necessity of the IRF stay . . . the stay is denied as incomplete medical records were submitted	14,307.92
TOTAL			**$89,053.55**

GRAND TOTAL App. C – E	**$1,586,304.92**

TOURO
REHABILITATION CENTER

July 24, 2006

VIA DHL

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Re: Medical Review of Touro Rehabilitation Center's Services
for Medicare Outlier Claims for 2002
Report Number: A-04-04-00010

Dear Ms. Pilcher:

Thank you for the opportunity to submit written comments regarding your office's draft report entitled, "Medical Review of Touro Rehabilitation Center's Services for Medicare Outlier Claims for 2002 (the "Draft Report"). Touro Rehabilitation Center ("TRC") takes its compliance responsibilities seriously and has worked closely with its fiscal intermediary ("Mutual of Omaha") to achieve and maintain compliance in its submission of claims for inpatient rehabilitation facility services. In addition, TRC has been continuously accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") since 1988. It has received high marks in its CARF accreditation survey reports and in particular its May 2003 CARF Survey Report found no areas of noncompliance and specifically found that TRC's programs were well run with effective medical direction and well qualified nursing and therapy staff members and utilized a well-developed program evaluation system to help measure program gains and outcomes.

TRC disagrees with many aspects of this audit review and the Draft Report. A summary of TRC's objections to the audit review and the Draft Report is as follows:

1. TRC's first and foremost concern is that the audit review appears to bypass the "Progressive Corrective Action" procedures and appeal rights provided in the Medicare Claims Processing Manual and Section 3.11 of Medicare Manual 100-8.

2. TRC asks for confirmation that TRC will be able to appeal the findings in the audit review and Draft Report with its Fiscal Intermediary, Mutual of Omaha.

3. TRC intends to work with Mutual of Omaha and upon receiving an initial determination with respect to these claims will appeal all 69 claims in the audit review sample for which the Draft Report concluded that the services were not medically necessary, were not reasonable or were not adequately documented and believes that it will be successful in overturning the claims denials.

4. TriCenturion, the Program Safeguard Contractor (the "PSC") which conducted the medical review of the 100 sampled claims, may not have used a reviewer with the expertise required to review medical records for inpatient rehabilitation facility ("IRF") services. There exists a serious difference of medical and professional opinion with respect to the findings of the PSC reviewer and the findings of both the Medical Director of TRC's IRF program and an independent consultant reviewer engaged by TRC to review the claims of the audit sample. As stated above, TRC intends to appeal all 69 claims.

5. An independent consultant with expertise in reviewing documentation, billing and claims submissions for IRF services, engaged by TRC to conduct a chart audit for each claim in the audit review sample, disagrees with the findings of the PSC reviewer and has recommended that TRC appeal all 69 claims.

6. The findings in the audit review and Draft Report are inconsistent with subsequent findings by Mutual of Omaha which reversed its denial of claims made in a Probe Audit for claims submitted in May of 2005.

7. TRC is uncertain as to whether the PSC which conducted the medical review of the 100 sampled claims reviewed the preadmission assessment reports for the sampled claims, as these reports were not maintained in the medical record produced to the PSC. The preadmission assessment reports supplement the medical record for each claim and provide additional support for a finding that the IRF services provided were medically necessary and reasonable. TRC reserves the right to provide the preadmission assessment reports for the claims in the audit sample to Mutual of Omaha prior to or upon its initial determination with respect to the claims in the audit sample.

8. TRC believes that the medical records of the claims in the audit sample contain and reflect satisfaction of the 8 criteria established by CMS in HCFA Ruling 85-2 to demonstrate the "reasonable and necessary" need for rehabilitation in an inpatient hospital.

9. TRC believes that upon appeal many of the 69 claims in the audit sample will be found medically necessary, reasonable and with adequate documentation.

Accordingly, TRC believes the error rate which was used in the Draft Report to extrapolate or estimate the amount of overpayments for IRF services will be found to be too high, resulting in an overstatement by the Draft Report of the estimated overpayments.

As noted above, the findings of the PSC incorporated in the Draft Report are inconsistent with TRC's independent consultant's findings upon review of the claims in the audit review and with TRC's successful appeals of claims chosen by Mutual of Omaha for a Probe Audit. In addition, there are significant items in the medical records of the claims in the audit review sample which support a finding of medical necessity and reasonableness of the IRF services provided. Accordingly, there are substantial questions regarding the reliability and accuracy of the PSC's review and the Draft Report's findings.

TRC's concerns are described in more detail below:

A. RIGHT TO APPEAL DETERMINATIONS ON CLAIMS

The Draft Report recommends that TRC refund monies to the Medicare program without giving TRC an opportunity to appeal. The Draft Report appears to bypass the "Progressive Corrective Action" procedures and does not offer TRC the appeal rights provided in the Medicare Claims Processing Manual and Section 3.11 of Medicare Manual 100-8. Eric Bowen of your office has indicated to TRC that the Draft Report will be presented to its Fiscal Intermediary, Mutual of Omaha, for action and that Mutual of Omaha will then make initial determinations with respect to the 69 claims at question in the audit review and Draft Report. Mr. Bowen has indicated that after Mutual of Omaha makes its initial determinations then TRC will have full appeal rights with respect to these claims. We ask for your confirmation of this process as TRC desires to preserve all rights to appeal afforded it with respect to the findings in the Draft Report.

B. MEDICAL REVIEW ISSUES

There exists a serious difference of medical and professional opinion with respect to the findings of the PSC reviewer and the opinions of the Medical Director of the IRF program, the attending physicians and the interdisciplinary team of professionals providing the IRF services. In addition, TRC engaged an independent consultant with expertise in reviewing documentation, billing and claims submissions for IRF services to conduct a chart audit for each claim in the audit review sample who discovered inconsistencies between the PSC reviewer's findings and the content of the medical records. The independent consultant has recommended that TRC appeal all 69 claims. Finally, the experience of TRC in overturning claims denials on appeals of a Probe Audit of May 2005 claims further evidences a divergence of medical and professional opinions with respect to medical review issues.

Additionally, the PSC reviewer which conducted the medical review of the 100 sampled claims may not have had the expertise required in order to review medical records for IRF services. TRC understands that the PSC reviewer was a nurse with five years of orthopedic

experience, but with no experience in IRF services. Due to the unique requirements for medical necessity in the IRF setting, TRC asserts that these claims should be reviewed by experts in the IRF level of care.

The physical medicine and rehabilitation credentials of the physicians and multidisciplinary team of professionals rendering the IRF services and the independent consultant who reviewed the medical records of the claims in the audit sample for TRC show significant expertise in the IRF level of care. All of the physicians credentialed by TRC to attend patients in the IRF program are Board Certified in Physical Medicine and Rehabilitation, except for one physician who has been practicing physical medicine and rehabilitation for more than twenty (20) years and who has demonstrated expertise in physical medicine and rehabilitation. The nurse members of the multidisciplinary team of professionals rendering IRF services are highly trained and experienced in physical medicine and rehabilitation. In fact, the CARF 2003 Survey Report commended TRC for the outstanding group of nurses which staff the IRF program, noting that their long tenure, experience, and expertise reflect the quality of care offered to the persons served.

After the PSC audit review was completed, TRC engaged an independent consultant with expertise in reviewing documentation, billing and claims submissions for IRF services which conducted a chart audit for each claim in the audit review sample. The independent consultant is a licensed physical therapist who has worked in the IRF setting for the last twelve (12) years. He has extensive experience in reviewing medical records, has worked as a consultant providing documentation and medical necessity education and training to multidisciplinary rehabilitation teams, and has assisted many inpatient rehabilitation facilities in appeal of denied claims. TRC's independent consultant disagrees with the findings of the PSC reviewer and found that in many cases the documentation in the medical record supported the need for the IRF services and that the care provided was reasonable and necessary for these patients. TRC's independent consultant has recommended that TRC appeal all 69 claims in the audit review sample for which the Draft Report concluded that the services were not medically necessary, were not reasonable or were not adequately documented.

Mutual of Omaha conducted a post-payment Probe Audit of claims for IRF services provided in May of 2005. Of the 20 records requested for review, seven (7) were denied. The error rate on the original denial was 35% which is one half (1/2) of the error rate reflected in the Draft Report. In addition, all seven (7) claims denials in the Probe Audit were appealed by TRC and to date six (6) of the seven (7) denials have been overturned. This represents an error rate of only five (5%).

In addition, the CARF 2003 Survey Report notes that TRC has an intensive and efficient system of gathering information to help measure the outcomes of its programs and has done an admirable job linking the results to its performance improvement efforts. Such measurement efforts, which incorporate functional independence measurements ("FIM Scores") and will be discussed in more detail below, provide evidence in the medical record of the multidisciplinary team approach to IRF services and also provide documentation in the medical record of each

patient's status upon admission and improvement upon discharge. The Report also notes that the interdisciplinary concept (which is one of CMS's 8 criteria demonstrating the need for inpatient rehabilitation) is well established and demonstrated in all aspects of patient care. As discussed below, TRC intends upon appeal of the 69 claims of the audit sample to show how all eight (8) criteria recognized by CMS as demonstrating the "reasonable and necessary" need for inpatient rehabilitation are reflected in the medical record.

The PSC which conducted the medical review of the 100 sampled claims, may not have reviewed the preadmission screening reports for the sampled claims, as these reports were not maintained in the medical record and TRC is uncertain as to whether these reports were provided to the PSC. TRC believes that the preadmission screening reports supplement the medical record for each claim and provide additional support for a finding that the IRF services provided were medically necessary and reasonable. TRC reserves the right to provide the preadmission assessment reports for the claims in the audit sample to Mutual of Omaha prior to or upon its initial determination with respect to the claims in the audit sample.

The section on Medicare Requirements for IRF Services in the Draft Report discussed the application of the PSC reviewer of the standards in Chapter 1, Section 110.1 of the Manual in order to evaluate the reasonableness and necessity of IRF admissions. The Draft Report does not indicate whether the PSC reviewer considered CMS's interpretation of the two ways in which an IRF stay can satisfy the "reasonable and necessary" requirements. In 1985, CMS established in HCFA Ruling 85-2 eight (8) criteria which it considers that if present in the medical record demonstrate the patient's need for rehabilitation in an inpatient hospital.

TRC maintained during the period of the claims in the audit sample and has maintained thereafter a comprehensive preadmission assessment program. All patients who are referred to TRC are screened prior to admission either by a physiatrist or by a nurse with extensive rehabilitation experience. TRC does not accept all patients that are referred, but in actuality declines admission to many patients that do not meet the medical necessity criteria. As a result on an average the number of individuals rejected for admission to the program as compared to the number of individuals admitted to the program is approximately 25% annually. This further evidences TRC's commitment to identifying only those beneficiaries whose clinical state and rehabilitation potential require the intensive setting of the IRF services provided.

In addition, TRC brings to your attention the following elements of its IRF program, as reflected in its medical records, which evidence and support a finding of satisfaction of the Medicare criteria which support the "reasonable and necessary" requirements of IRF services:

a. Each IRF patient receives medical supervision by a physician who is board certified in physical medicine and rehabilitation or has significant specialized training and experience in rehabilitation.

b. TRC provides 24 hour nursing for IRF services.

c. It is the policy of TRC that upon each nurse shift change, the attending nurse is to complete and document in the medical record the functional independence measures scores ("FIM Scores") for the patient. The FIM Scores for each patient show the patient's status upon admission and discharge and consistently shows improvements in the patient. The FIM Scores should have been considered by the PSC reviewer in review of the medical record.

d. The attending physician's involvement in care, along with 24 hour nursing and each nurse's evaluation of the patient and the recording of the FIM Scores in the medical record evidences the multidisciplinary approach to care which is provided to patients receiving IRF services.

e. The FIM Scores also evidence a significant practical improvement in the patient's functional independence through the course of IRF services.

f. TRC provides a coordinated program of care for its IRF services.

g. TRC provides a relatively intense level of IRF services.

h. The multidisciplinary team, which includes close physician supervision, establishes realistic goals for improvements and monitors the length of the IRF services provided to the patient.

TRC intends to provide specific evidence of the existence of and satisfaction of CMS's 8 criteria which evidences satisfaction of the "reasonable and necessary" requirements in the appeal of each claim denial which results from the findings of the audit review and Draft Report

The Draft Report makes assertions that 44 cases were ones where services were not medically necessary, 21 cases were not reasonable, and 4 cases were not supported by adequate documentation. TRC and the independent consultant that reviewed many of theses denied claims disagree with these statements. The cases reviewed generally demonstrated a medical need for admission to an IRF, and showed reasonable progress towards established goals. Some patients progressed more quickly than others, and some did not ultimately achieve complete independence. However, they made significant progress to ultimately have a positive impact on their function and their quality of life. Due to the medical complexity of these patients their care could not have been effectively completed in a less intensive setting.

C. INACCURACY OF ERROR RATE USED IN EXTRAPOLATION AND ESTIMATION OF OVERPAYMENT

TRC believes that the error rate which was used in the Draft Report to extrapolate or estimate the amount of overpayments for IRF services will be found to be too high, resulting in

an overstatement of the estimated overpayments. This belief is supported by the opinions of its multidisciplinary IRF team and the independent consultant who reviewed the 69 claims denied by the PSC reviewer that many of the claims denials will be reversed upon appeal. It is also supported by TRC's experience with Mutual of Omaha's finding of a 35% error rate in its initial denials in its May 2005 Probe Audit and the reversal of its claim denials which resulted in an error rate of only 5% upon appeal.

D. PREADMISSION AND ADMITTING PROCEDURES

The Draft Report found deficiencies in TRC's preadmission screening and admitting procedures. TRC maintained during the period of the claims in the audit sample and has maintained thereafter a comprehensive preadmission assessment program. All patients who are referred to TRC are screened prior to admission either by a physiatrist or by a nurse with extensive rehabilitation experience. TRC believes that it's preadmission screening and admitting procedures, including the use of preadmission screening assessments and the patient assessment instrument required by CMS, enabled TRC to satisfy Medicare requirements in determining the appropriateness of admission of beneficiaries for the IRF level of care.

Although TRC takes exception and disagrees with the Draft Report finding with respect to its preadmission screening and admitting procedures, TRC has taken numerous steps since the audit interview to ensure that its preadmission screening and admitting procedures provide reasonable assurance that beneficiaries who are admitted for IRF services require treatment at the IRF level of care, are capable of significant practical improvement, are able to participate in intensive rehabilitation, and are medically stable. These steps include education of the IRF multidisciplinary team on documentation for rehab providers, including distribution of the March 2005 LCD issued by Mutual of Omaha and information on compliance with CMS' 8 criteria to evidence "reasonable and necessary" IRF services. TRC has also developed an internal audit review form for reviewing charts 72 hours after admission using the CMS 8 criteria and now routinely conducts these internal audits. TRC also has developed an IRF screening criteria form for physicians and pre-admit nurses to use on consults and a pre admission check list. The physicians, nurses and therapists who are members of the IRF team have all received numerous in-service education sessions on Medicare requirements for admission for IRF services. Finally, TRC has worked closely with and received guidance from Mutual of Omaha on medical record documentation, criteria, medical necessity and coverage issues, including the provision of a presentation by Mutual of Omaha to all staff and physicians at TRC on these issues.

E. CONCLUSION

Thank you for the opportunity to respond to and comment on the Draft Report. We ask that the OIG reconsider issuance of the Draft Report in its current form. Specifically we ask that:

a. The Final Report include the specific appeal rights of TRC; and

b. indicate that no monies would be refunded to the Medicare program until all levels of appeal have been exhausted for all individual claims.

If I can be of any further assistance, please contact me at 504-897-8247.

Sincerely,

Leslie D. Hirsch
President
Touro Rehabilitation Center

ACKNOWLEDGMENTS

This report was prepared under the direction of Pete Barbera, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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