



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

April 22, 2008

Report Number: A-06-07-00045

Rhonda Jones
Administrator
Heartland Health Care Center
2001 Forest Ridge Drive
Bedford, Texas 76021

Dear Ms. Jones:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Skilled Services at Heartland Health Care Center of Bedford, Texas." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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If you have any questions or comments about this report, please do not hesitate to call me, or Cheryl Blackmon, Audit Manager, at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. Please refer to report number A-06-07-00045 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato".

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Page 2 - Rhonda Jones

Direct Reply to HHS Action Official:

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF SKILLED SERVICES
AT HEARTLAND HEALTH CARE
CENTER OF BEDFORD, TEXAS**



Daniel R. Levinson
Inspector General

(April/2008)
A-06-07-00045

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Prior to 1998, Medicare paid the costs of individual services provided to skilled nursing facility (SNF) patients using a retrospective reimbursement system. This system was vulnerable to abusive billing schemes because Medicare reimbursed SNFs for their actual costs, thus giving them a strong incentive to provide unnecessary and overpriced services to increase their Medicare payments. Our prior audit work confirmed that some SNFs provided overpriced and unnecessary infusion therapy services that may have harmed patients.

Currently, Medicare pays SNFs a daily rate to cover skilled services (e.g., infusion therapy, rehabilitation therapy, nursing) provided to Medicare patients during each day of a covered SNF stay; it does not base payments on the cost of individual services. For billing purposes, SNFs complete an assessment form called a Minimum Data Set (MDS) that places a patient in a specific payment group, known as a Resource Utilization Group (RUG), based on the patient's care and resource needs. SNFs periodically assess each patient's clinical progress. If a patient's condition changes substantially, the patient could be assigned a different RUG, and Medicare would then increase or decrease the SNF's payment accordingly.

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

Although Medicare pays SNFs a daily rate based on each assigned RUG, it requires SNFs to record the charge for each service, such as infusion therapy, on each Medicare claim and to summarize the related charges in their annual cost reports. The Centers for Medicare & Medicaid Services (CMS) uses this information for various rate-setting and payment-refinement activities.

OBJECTIVE

Our objective was to determine whether Heartland Health Care Center (Heartland) of Bedford, Texas, provided patients with skilled services, particularly infusion therapy services, that were medically necessary and adequately supported by medical documentation.

SUMMARY OF FINDINGS

For the period July 2, 2002, through May 31, 2003, Heartland submitted 50 claims totaling \$259,639. For 47 of the claims, Heartland provided patients with skilled services that were not (1) medically necessary at the level provided in an SNF and/or at the RUG level claimed or (2) adequately supported by medical documentation. These errors occurred because Heartland did not fully comply with Medicare requirements. As a result, Medicare overpaid Heartland \$158,210.

Additionally, each of the 50 claims included charges for infusion therapy services, although only 15 of them were for services that were medically necessary at the intense level provided in an SNF. Of the remaining 35 claims:

- Twenty-one included infusion therapy services that could have been rendered in a nonskilled setting for part or all of the claim period.
- Five were not supported by adequate documentation.
- Nine included infusion therapy supplies or drugs that were not utilized for infusion therapy treatments.

These errors did not result in overpayments because SNFs are paid based on the RUG rates assigned to patients rather than on individual services.

RECOMMENDATIONS

We recommend that Heartland:

- refund to the Medicare program \$158,210 in overpayments and
- provide training to its staff to ensure that it fully understands and complies with SNF medical necessity and documentation requirements so that future claims comply with these requirements.

HEARTLAND COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, Heartland disagreed with our findings and took issue with many aspects of the review, including issues involving medical necessity determinations and medical documentation. Heartland disagreed with the methodologies used by the program safeguard contractor, TriCenturion, in its reviews and disagreed with TriCenturion's conclusions in nearly all the cases.

We rely on the knowledge and expertise of the medical reviewers; therefore, we stand by the findings and recommendations. The full text of Heartland's comments (excluding privacy information) is included as Appendix B.

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INTRODUCTION

BACKGROUND

Skilled nursing facilities (SNF) provide daily services that include infusion therapy; speech, occupational, and physical therapies; and transfusions. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals and be for a condition previously treated at a hospital.

Medicare's Prospective Payment System for Skilled Nursing Facilities

Prior to 1998, Medicare paid the cost of individual services provided to SNF patients using a retrospective reimbursement system. This system was vulnerable to abusive billing schemes because Medicare reimbursed SNFs for their actual costs, thus giving them a strong incentive to provide unnecessary and overpriced services to increase their Medicare payments. Our prior audit work confirmed that some SNFs provided overpriced and unnecessary infusion therapy services that may have harmed patients.¹

The Balanced Budget Act of 1997 mandated the implementation of a prospective payment system that pays SNFs a daily rate to cover skilled services (e.g., infusion therapy, rehabilitation therapy, nursing) provided to a patient during each day of a covered SNF stay. Therefore, Medicare no longer bases payments on the cost of individual services. For billing purposes, SNFs complete a Minimum Data Set (MDS) assessment form that assigns a patient into a specific payment group, known as a Resource Utilization Group (RUG), based on the patient's care and resource needs.

Federal regulations require SNFs to complete MDSs on the 5th, 14th, 30th, 60th, and 90th days of patients' stays, and whenever a patient's medical condition substantially changes. The 5-day MDS includes the patient's initial recommended treatment and the corresponding RUG. SNFs periodically assess patients' progress. If a patient's condition changes substantially, the patient could be assigned a different RUG, and Medicare would then increase or decrease the SNF's payment accordingly.

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

Requirement to Record Charges on Medicare Claims

Although Medicare pays SNFs a daily rate based on each assigned RUG, Medicare requires SNFs to record the charges for all services on each Medicare claim. SNFs assign these costs to revenue codes that correspond to specific services, such as infusion therapy, nursing care, or physical therapy. SNFs use the revenue code data to prepare their annual cost reports.

¹We issued "Infusion Therapy Services Provided in Skilled Nursing Facilities" (A-06-99-00058) on December 13, 1999.

Medicare Program Safeguard Contractors

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

Heartland Health Care Center

Located in Bedford, Texas, Heartland Health Care Center (Heartland) is a nursing home with a Medicare-certified skilled nursing unit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Heartland provided patients with skilled services, particularly infusion therapy services, that were medically necessary and adequately supported by medical documentation.

Scope

We selected Heartland for our review due to the large amount of claimed charges for infusion therapy services. For the period July 2, 2002, through May 31, 2003, Heartland submitted 50 claims that totaled \$259,639.

We limited our review of internal controls to gaining an understanding of Heartland's policies and procedures for assessing patient care needs and completing their MDSs and maintaining medical records. We performed our fieldwork at Heartland Health Care Center in Bedford, Texas.

Methodology

To accomplish our objective, we:

- reviewed the applicable laws, regulations, and guidance concerning the Medicare payment process for SNFs;
- interviewed Heartland officials and reviewed Heartland's policies and procedures for assessing patient care needs, completing MDSs, and maintaining medical records;
- obtained Heartland's medical records for the 50 claims;

- forwarded the medical records for the claims to TriCenturion's medical reviewers to determine whether the claimed services were medically necessary and supported by adequate documentation; and
- obtained the medical review results on the sample claims and verified the overpayment amounts.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

For the period July 2, 2002, through May 31, 2003, Heartland submitted 50 claims totaling \$259,639. For 47 of the claims, Heartland provided patients with skilled services that were not (1) medically necessary at the level provided in an SNF and/or at the RUG level claimed or (2) adequately supported by medical documentation. These errors occurred because Heartland did not fully comply with Medicare requirements. As a result, Medicare overpaid Heartland \$158,210.

Additionally, each of the 50 claims included charges for infusion therapy services, although only 15 of them were for services that were medically necessary at the intense level provided in an SNF. Of the remaining 35 claims:

- Twenty-one included charges for infusion therapy services that could have been rendered in a nonskilled setting for part or all of the claim period.
- Five were not supported by adequate documentation.
- Nine included charges for infusion therapy supplies or drugs that were not utilized for infusion therapy treatments.

These errors did not result in overpayments because SNFs are paid based on the RUG rates assigned to patients rather than on individual services.

The Appendix contains a more detailed breakdown of the medical reviewers' findings on the 50 claims.

MEDICAL REVIEW OF ALL SKILLED SERVICES

Services Were Not Medically Necessary

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

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

Pursuant to 42 CFR § 424.20, SNFs should assign patients to the RUG category that represents the required level of care.

The medical reviewers recommended that RUGS on 42 of the 50 claims reviewed be denied or downcoded. For these 42 claims, which included 74 RUGs, the medical reviewers determined that 1 RUG was medically necessary and supported by adequate documentation. For the remaining 73 RUGs, the reviewers recommended that:

- 40 RUGs be denied because all of the services were not medically necessary at the intense level provided in an SNF and
- 33 RUGs be downcoded because some of the services were not medically necessary at the RUG levels claimed.

The reviewers often cited multiple reasons for recommending either to deny or downcode the claims. The following two examples illustrate these reasons.

- A 74-year-old patient was admitted to a hospital with intractable back pain (due to a compression fracture) and altered mental status. The patient received IV steroids and a special brace while hospitalized. The patient was transferred to Heartland for a physical therapy evaluation and was also evaluated by a speech therapist because of possible aspiration problems. The patient was found to be aspirating, his diet was modified, and he was placed on maintenance IV fluids because he was not taking thin liquids. According to a therapy summary, the patient required supervision for bed mobility, minimum assistance for transfers, and was able to walk 200 feet with a rolling walker and minimal assistance. In addition, the patient required varying levels of assistance for different activities of daily living.

According to medical review results, the patient's condition did not warrant continued therapy in an SNF setting. Although he still required assistance for his chronic and debilitating condition, continued therapy was repetitive and could have been performed

by nonskilled staff. The patient could have been admitted to a long-term care facility until he was able to return to an assisted living facility environment. The IV fluids were for maintenance purposes (to prevent dehydration) rather than for an acute condition. The medical reviewer recommended that one RUG be downcoded because some services were not necessary at the RUG level claimed and that the remaining rehabilitation RUG be denied because the skilled services were not medically necessary at the level provided.

- An 82-year-old female patient was transferred to Heartland after being treated with IV antibiotics at a hospital. The SNF admission orders indicated that the patient was to receive IV antibiotics for two weeks and physical and occupational therapy consultations. According to an inpatient social worker note, the patient was alert, oriented, and very independent in all daily activities. The inpatient physical therapy evaluation reflected that the patient required minimal assistance and was able to walk 80 feet with a rolling walker. Moreover, the SNF occupational and physical therapy evaluations did not reflect significant functional deficits requiring the skills of a therapist. The patient's condition did not warrant rehabilitation.

It appears that the patient was admitted for SNF care only because she was receiving IV antibiotics. The patient could have received appropriate skilled care from home health because IV antibiotics needed to be provided only "once a day." The medical reviewer recommended that the rehabilitation RUG be denied because the skilled services were not medically necessary at the level provided at the SNF.

Heartland did not agree with any of the reviewers' recommendations to deny or partially deny a claim. However, based on the medical reviewers' determinations and written responses from nursing home officials, we have concluded that Heartland did not have a full understanding of the SNF medical necessity requirements.

Claims Were Not Supported by Adequate Documentation

Pursuant to Title XVIII of the Social Security Act, section 1819(b)(6)(C), SNFs must maintain clinical records that adequately support the need for services provided to all SNF patients.

The medical reviewers recommended denying 5 of the 50 claims reviewed because the services were not supported with background information necessary to determine the need for skilled care. For these five claims, which included nine RUGs, the medical reviewers recommended that all of the RUGs be denied.

According to TriCenturion's medical reviewers, background information, which may include a patient's prior level of functioning, is required to make medical necessity determinations. However, Heartland did not believe such information was required to justify SNF services. In Heartland's preliminary written comments regarding the medical review, an official stated that "the need for skilled care is primarily based on the patient's condition at the time of admission to the SNF and the attending physician's assessment and certification for the need for skilled care, not on the background information."

MEDICAL REVIEW OF INFUSION THERAPY SERVICES

A review of infusion therapy services on the 50 claims showed that:

- Thirty-six claims included charges for infusion therapy services that were medically necessary and adequately documented. However, 21 of the 36 claims included infusion therapy services that could have been rendered in a nonskilled setting for part or all of the claim period. These errors occurred because Heartland did not have a full understanding of SNF medical necessity requirements.
- Five claims were not supported by adequate documentation. For four claims, errors occurred because Heartland did not believe background information on its Medicare beneficiaries was required to justify SNF services. For the remaining claim, the physician's order to substantiate infusion therapy services could not be located.
- Nine claims included charges for infusion therapy supplies or drugs that were not utilized for infusion therapy treatments. For seven of the nine claims, infusion therapy supplies were used for wound care treatments or dressings for IV access sites. For one claim, the charges were for infusion therapy drugs that were ordered in the month preceding the claim but posted during the reviewed claim period. For the remaining claim, infusion therapy medication was ordered and received by the facility but could not be administered due to complications. According to CMS, charges for infusion therapy on all nine claims were classified correctly.

We were unable to identify overpayments associated with the charges for infusion therapy services because SNFs are paid based on the RUG rates assigned to patients rather than on individual services.

CONCLUSION

For the period July 2, 2002, through May 31, 2003, Heartland received \$158,210 for Medicare claims that were either medically unnecessary or inadequately documented.

RECOMMENDATIONS

We recommend that Heartland:

- refund to the Medicare program \$158,210 in overpayments and
- provide training to its staff to ensure that it fully understands and complies with SNF medical necessity and documentation requirements.

HEARTLAND COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, Heartland disagreed with our findings and took issue with many aspects of the review, including issues involving medical necessity determinations and medical documentation. Heartland disagreed with the methodologies used by the program safeguard contractor, Tricenturion, in its reviews and disagreed with Tricenturion's conclusions in nearly all cases.

Before we issued the draft report, we provided Heartland with the results of the medical review. Heartland then explained why it disagreed with every claim the reviewers recommended for denial or partial denial and submitted additional information. We compared the additional information to the original information and determined that there was only one claim that had new information that was not in the medical records we obtained. We sent the additional information for that one claim to TriCenturion to be rereviewed. TriCenturion did not change its original determination for that claim.

We rely on the knowledge and expertise of the medical reviewers; therefore, we stand by the findings and recommendations. The full text of Heartland's comments (excluding privacy information) is included as Appendix B.

APPENDIXES

**MEDICAL REVIEW DETERMINATIONS
FOR THE 50 CLAIMS**

A single claim can have multiple Resource Utilization Groups (RUG) that cover different periods and pay different payment rates. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently and decide whether it is valid. The table below summarizes the medical review determinations for the 50 claims Tricenturion reviewed, including the total number of RUGs for each determination category and a breakdown of the number of RUGs denied, downcoded, and allowed.

**Table 1: Summary of Medical Determinations for the
Resource Utilization Groups for 50 Claims**

Medical Determination	No. of Claims	Total No. of Rugs	Recommendations		
			No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
Claims allowed	3	8	-	-	8
Medically unnecessary	42	74	40	33	1
Lack of supporting documentation	5	9	9	0	0
Total	50	91	49	33	9

The table below lists detailed information for the 50 claims reviewed and the medical reviewers' recommendations for each claim.

Table 2: Detail of RUGs for the 50 Claims

Claim No.	Error Category	Total No. of RUGs	Recommendations		
			No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
1	M	2		2	
2	M	1	1		
3	M	2	2		
4	M	2		2	
5	M	1		1	
6	M	3		3	
7	M	1		1	
8	M	2	1	1	
9	M	2	2		
10	M	1		1	
11	A	3			3
12	M	1		1	
13	M	2	2		

14	M	2	2		
15	M	1		1	
16	M	1		1	
17	M	2	2		
18	A	2			2
19	M	2	1	1	
20	M	2	2		
21	M	1		1	
22	D	1	1		
23	M	1		1	
24	M	3	3		
25	M	2	1	1	
26	M	2		2	
27	M	2		2	
28	M	2		2	
29	M	1	1		
30	M	2	2		
31	M	2	2		
32	M	2	2		
33	M	2		2	
34	M	2	1		1
35	M	1		1	
36	D	3	3		
37	M	1	1		
38	M	1		1	
39	M	2	2		
40	M	2	1	1	
41	M	2	2		
42	M	2	2		
43	M	2	2		
44	M	3		3	
45	M	2	2		
46	M	2	1	1	
47	D	2	2		
48	D	2	2		
49	D	1	1		
50	A	3			3
Total		91	49	33	9

Error Categories
M = Medically unnecessary
D = Lack of supporting documentation
A = Allowed

January 30, 2008

Mr. Gordon L. Sato
Regional Inspector General for the Audit Services
Department of Health and Human Services
Office of Inspector General, Office of Audit Services
1100 Commerce St. Room 632
Dallas, Texas 75242

Re: Report No. A-06-07-00045

Mr. Sato:

This letter is a written response on behalf of Heartland Healthcare and Rehabilitation Center of Bedford, Texas (Heartland), a skilled nursing facility, in response to the draft report from the Department of Health and Human Services, Office of Inspector General (hereafter referred to as "OIG") dated December 10, 2007. While we gratefully acknowledge the efforts of this audit we strongly but respectfully disagree with the findings and welcome this opportunity to submit our comments. We disagree with the methodologies used by the contracting review organization, Tricenturion, in their review and their conclusions in nearly all of those cases.

As background, I note that the author of this response was a main independent contributing consultant to HCFA (now CMS) in the development and drafting of Revision #262 to Section 214 of the Skilled Nursing Facility Manual (now CMS Medicare Benefit Policy Manual, Part 100-2, Chapter 8, Section 30 of the CMS online manuals); that revision redefined what constitutes skilled care and continues to be the current standard criteria for defining skilled care. The author's knowledge base is well grounded having worked closely with Tom Hoyer at CMS and his staff to publish a tool that would provide greater understanding of what constitutes skilled services. Prior to that this author worked in Medicare/Medicaid Medical Review at Blue Cross and Blue Shield in Indiana. In all of the cases reviewed by TriCenturion it appears they looked only for reasons and excuses to deny coverage rather than evaluate each patient's medical and physical needs and how those needs could be addressed with the tenets of "medical safety" as outlined in Revision 262; including available viable alternatives to inpatient care. Therefore we urge the OIG to reconsider the conclusions reached by TriCenturion's reviewers.

Background

The original audit was an inquiry into the utilization of Infusion therapy and supplies. The OIG selected 50 claims filed between July 2, 2002, and May 31, 2003, totaling \$259,639. The OIG auditors from the Dallas office who visited Heartland were self-admittedly accountants with no clinical knowledge or expertise. It seems illogical that personnel with no medical credentials or expertise could possibly know what records to request, review and/or photocopy. Many of the remarks by the OIG contracted reviewers stated that medical record documents were not available or missing – yet, this author easily located those very documents in the medical records in question. In the OIG Background summary they stated that, *"Prior to 1998 Medicare paid the cost of individual services provided to skilled nursing facility (SNF) patients using a retrospective reimbursement system. This system was vulnerable to abusive billing schemes because Medicare reimbursed SNF's for their actual costs, thus giving them a strong incentive to provide unnecessary and overpriced services to increase their Medicare payments.... Currently, Medicare pays*

SNF's a daily rate to cover skilled services (e.g. infusion therapy, rehabilitation therapy, nursing) provided to Medicare patients during each day of a covered SNF stay; it does not base payments on the cost of individual services". These two statements strike a significant blow to the integrity of physicians and insinuate that SNF's are capable of ordering infusion and other high cost treatments willy-nilly at their own discretion. It gives no credence to the laws and professional ethics that mandate physician assessment and involvement with the ordering and the delivery of such services. At no time are medications and /or treatments legally provided to patients without the advice and directives of licensed physicians. To say we, "frequently order overpriced and unwarranted services" extends far beyond the scope of medical review outlined in the Skilled Nursing Facility regulations. The SNF staff does not order services. Independent physicians order medical services. Texas law specifically proscribes the corporate practice of medicine and attending physicians are not employees of Heartland. We note, too, that 42 U.S.C. §1395 states that "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . ." There is a very narrow line between denying necessity and effectively supervising medicine by substituting a different philosophy of medical practice and patient quality of life. Section 1395 combined with the requirement found at 42 U.S.C. §1395i-3(b)(4)(A)(i), that further directs the SNF (i.e. *must not* may) to provide nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, creates a view of patient care apparently not shared by the OIG contractor's auditors.

Intravenous portals are only used when it is the necessary delivery system of medications and/or nutrition adjuncts; e.g., major infections, conditions that require hydration, nutrition and or medications that cannot be delivered orally or by any other method. It is a best practices policy of all health care workers and institutions to continue infusion therapy only as long as necessary as infusion therapy equipment offers a route for infection to be introduced to patients; therefore the systems are discontinued when the physician's assessment determines that the conditions have stabilized. As for today's current reimbursement structure the RUG payments for a majority of patients receiving infusion therapy do not cover the cost of the supplies, the medications and the highly skilled care involved. Heartland is one a few SNF's in their geographic area that will admit patients with IV's as most other facilities refuse to admit them because it has a negative financial impact to their business. To state that the facility inappropriately "orders" infusion therapy services to increase their cost base is directly opposite of the real circumstances of treating patients requiring such treatment. Once again demonstrating TriCenturion's lack of knowledge of SNF operations and care criteria.

Summary of Heartland's Responses

The OIG reviewer's stated that, "for 47 [of the 50 claims], Heartland provided patients with skilled services that were not (1) medically necessary at the level provided in an SNF and/or at the RUG level claimed or (2) adequately supported by medical documentation. These errors occurred because Heartland did not fully comply with Medicare requirements. Additionally, each of the 50 claims included charges for infusion therapy services, although only 15 of them were for services that were medically necessary at the intense level provided in an SNF ". SNF's provide skilled services that require the management of or direct involvement of licensed caregivers and therapy personnel in providing skilled services as outlined in the United States Code of Federal Regulations, 42 U.S.C. §409.30 thru §409.35; no where in the US Code does it state that skilled care must equate to an intense level of care or that patients must require an intense level of care to qualify for Medicare coverage. "Intense" is a term rightfully reserved for the

inpatient acute care arenas and, more appropriately the "Intensive" Care Units (ICU's) and Emergency Rooms (ER's) of those acute inpatient hospitals.

CMS Manual of Medicare Services, Chap. 100-2, Chapter 8, Section

30.2.1 A3-3132.1, SNF-214.1

30.2.1 - Skilled Services Defined

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- *Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and*
- *Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.*

The OIG summary further stated that, "Twenty-one included infusion therapy services that could have been rendered in a non-skilled setting for part or all of the claim period". These patients had been assessed by the hospital physicians, licensed nurses and social service discharge planning staffs and had been deemed to require inpatient skilled care. Additional assessments by the admitting SNF physicians and licensed nurses further affirmed that an inpatient skilled setting was the most appropriate arena for these patients to receive medically safe care and treatment. To conclude that these patients could have been cared for in "non-skilled settings for part or all of the claim period", strikes at the integrity and ethics of the physicians' clinical knowledge and care delivery. Many of these patients were being treated for wounds (Decubitus Ulcer, Surgical, Vascular, and other types) that would have deteriorated in non-skilled environments. Some of these residents had positive cultures for MRSA (Methicillin Resistant *Streptococcus Aureus*) the very bacterium that has been deemed to be life threatening without adequate treatment and supervision. Placing these Medicare eligible patients in non-skilled settings such as Assisted Living or nursing facilities that are not certified to provide a Medicare skilled level of care would have put them at significant medical risk for further skin breakdown, exposed them to the potential for development of secondary infections and left their care to those not trained to care for such patients until the current unstable problems have been appropriately treated and stabilized.

Many of the infusion therapy patients that were denied were patients receiving multiple antibiotics and/or multiple infusion therapy treatments, conditions that are not accepted by Home Health organizations as they cannot provide treatments that require more than one visit per day. The CMS manuals clearly states that medical safety issues are a major consideration in treating patients as inpatients in skilled facilities and additionally describes cases where the sum total of all unskilled services mandate skilled care because of the risk to medical safety if the care is not provided by properly educated and trained skilled nursing and rehabilitation staff.

CMS Manual 100-2, Chapter 8, Section 30.2.3.1 - Management and Evaluation of a Patient Care Plan (Rev. 1, 10-01-03) A3-3132.1.C.1, SNF-214.1.C.1

The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

EXAMPLE 2:

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be assured only if the total care, skilled or not, is planned and managed by skilled nursing personnel, the intermediary assumes that skilled management is being provided even though it is not readily discernible from the record. It makes this assumption only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management.

As SNF residents, the patients whose records were audited had been hospitalized for at least the three day inpatient stay (that is required for coverage in a skilled facility); they had their inpatient skilled level of care certified by their physicians; and had direct skilled services ordered to address their conditions. Thus, to place them in any other type of facility when physicians had assessed and certified these patients for inpatient skilled care would have been a direct violation of those patients' rights under the Medicare regulations and moving Medicare eligible patients to non-skilled environments would require the patient to waive their right to Medicare coverage. Direct skilled services are listed in the Medicare Coverage Manual:

CMS Manual 100-2, Chapter 8, Section 30.3
30.3 - Direct Skilled Nursing Services to Patients
(Rev. 1, 10-01-03) A3-3132.2, SNF-214.2

Some examples of direct skilled nursing services are:

- *Intravenous or intramuscular injections and intravenous feeding;*
- *Application of dressing involving prescription medications and aseptic technique*
- *Treatment of Decubitus ulcers of a severity of Stage III or worse, or a widespread skin disorder.*
- *Initial phases of a regimen involving the administration of medical gases such as bronchodilator therapy and oxygen*

The OIG reviewers stated that nine cases included infusion therapy supplies or drugs that were not utilized for infusion therapy treatments. The OIG report admits, that, “these errors did not result in overpayments because SNF’s are paid based on the RUG rates assigned to the patients rather than on individual services”. Those charges generally involved a dressing such as one called Opsite, and others, that are designed to protect skin. It is a standard dressing used with infusion therapy services as well as an adjunct to wound healing. This item is obtained through the pharmacy and therefore logically appears as a pharmacy charge on the patient ledgers.

After repeated reviews of the claims involved in this audit, it is our continued position that these residents required and received necessary and appropriate inpatient skilled care as outlined in the federal regulations and guidelines. The CMS (then HCFA) project, in which this author participated, was formed by CMS (then HCFA) to address aberrant medical review practices and decisions in the field by the Part A contracted-intermediaries. The OIG’s contracted reviewers utilized those very same review tactics that CMS (then HCFA) sought to correct; i.e., that of making decisions based on personal prejudices, arbitrary rules of thumb and practicing review procedures that extend far beyond the arena of medical review and breach into peer review. Subsequent to the issuing of Revision 262, CMS (then HCFA) published Program Memoranda cautioning the reviewing intermediaries and carriers to refrain from denying SNF claims based on “rules of thumb” (e.g., patient can ambulate 150 ft. as the limit of therapy services when physical safety deficits remained to be addressed). Additionally Program Memoranda were issued condemning the practice of denying SNF claims based on diagnoses and the stereotypes that those diagnoses have fostered, a form of “diagnosis profiling”, e.g. Alzheimer’s patients are not “trainable”. Those directives gave guidance to reviewers to review Alzheimer’s patients’ claim documentation and claims for other similar diagnoses to see if the patient could follow simple one and two step commands and regain lost physical functions.

CMS Manual 100-2, Chapter 8, Section 30.2.2
30.2.2 - Principles for Determining Whether a Service is Skilled
(Rev. 1, 10-01-03) A3-3132.1.B, SNF-214.1.B

- *If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the*

administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- *The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.*

The OIG reviewers made several denials based on a decision that patients could be cared for with Home Health and outpatient therapies while not taking into account the circumstances in the homes they were destined for if discharged. One previously independent patient was using a rolling walker with moderate assistance. She had been living with her daughter and the plan was to return to that environment. Home Health was totally out of question for this patient as the daughter lived in a condo with all necessary rooms (except the kitchen and dining areas) on the second floor making it impossible for her to negotiate with a rolling walker. Another patient, who had MS, had been cared for by her husband and returned to that environment when she had recovered sufficiently that he once again could manage her care with Home Health assistance. Other patients had two IV antibiotics or had varying doses of antibiotics to be administered at frequent intervals. Local Home Health agencies do not accept patients that require more than one IV medication administration per day. It is standard procedure that ongoing assessments are conducted at Heartland of Bedford as a routine part of the care planning process. Those assessments are conducted with personnel from the agencies that will receive the care referral. Patients are moved to lesser care arenas when it is appropriate and the agencies agree that the type of care needed is within their scope of practice.

CMS Manual 100-2, Chapter 8, Section 30.7
30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"
(Rev. 1, 10-01-03)
A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the intermediary considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services. As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- *An excessive physical hardship;*
 - *Less economical; or*
 - *Less efficient or effective than an inpatient institutional setting.*
- The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.*

EXAMPLE: *A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, dehydration, or malnutrition because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.*

In no instance did the OIG reviewers cite the Code of Federal Regulations (CFR) or the Skilled Nursing section of the Medicare Benefits Policy Manual, Part 100-2, Chapter 8, Section 30, as the basis for their denials. Additionally they applied 20/20 hindsight to all claims. It is blatantly obvious that these prejudices permeate the OIG contract reviewer's findings with review conclusion statements such as:

1. **OIG:** *"Given her advanced age, impaired cognition, and multiple chronically debilitating conditions, it is unrealistic to expect this pt. to attain independence with self-care and mobility it is expected that a patient with her condition would require indefinite assistance and supervision."*

This statement was used to totally deny coverage for a lady with leg wounds receiving skilled wound care, was on Oxygen following a reaction to a medication, and was on IV's to address severe dehydration that was manifest in a marked change in mental status (which improved greatly following hydration). PT & OT addressed the two levels of functional loss noted in this patient progressing toward restored independence/modified independence. Speech Therapy saw this lady to evaluate her swallowing problems and make changes in her diet and swallowing functions.

2. **OIG:** *"This disposition [original discharge to SNF] is clearly unrealistic because the family has already expressed concern that they cannot care for the pt. ...This patient required LTC, not SNF care. Her condition is chronic and cannot be expected to improve significantly within a reasonable and generally predictable time period. ...Medicare does not cover maintenance therapy or repetitive exercises for general strengthening, flexibility, endurance, or assisted ambulation in support of feeble or unstable patients." ... it is expected that he will regain strength and use of his limbs as the infection and wounds clear up."*

This statement of denial was used on a lady admitted following a prolonged period of immobility and hospitalization due to abdominal problems. She had functioned independently prior to her illness and hospitalization. When admitted to the SNF she was dependent in mobility and ADL skills. She advanced to moderate dependence before relapsing and being re-hospitalized. Another patient was admitted after severely declining at home in the care of her daughter. Prior to her decline she functioned at a modified independence level. Therapy restored her functional abilities to that of minimum assistance, a level that would permit her to live outside of a nursing facility.

3. **OIG:** *"...this action plan does not make sense given that hospice exists to provide palliative care, not curative care. This pt's condition is not curable ..."*

This statement was used to deny coverage to a patient being treated with seven (7) stage III & IV wounds. PT was ordered for wound care as Physical Therapists are the only professionals in a SNF whose scope of practice includes debridement and other facets of wound care. As for Hospice it is a beneficiary electible benefit and the family chose to not elect to use the Hospice benefit.

4. **OIG: "There is absolutely no background information on this pt. ...The documentation is wholly insufficient to determine medical necessity of the services rendered. This reviewer would question why this pt. would even need SNF care following two weeks of inpatient rehab."**

Background information is not a regulatory requirement for admission and coverage in a Skilled Nursing Facility. Medical review decisions are to be based on the current condition of the patient and the skilled services required and ordered to address those conditions and problems. The regulations require that the physician certify at the time of admission the need for skilled services.

5. **OIG: "ST was not medically necessary as this pt. was normally confused, and one cannot expect to 'cognitively retrain' a pt. with Alzheimer's dementia".**

This particular stereotype was addressed by a CMS directive that prohibits denial of services based on rules of thumb or diagnosis. This statement justifying the denial of therapy services for a Diabetic patient with Peripheral Vascular Disease (PVD) and Peripheral Neuropathy who was admitted with two (2) stage III wounds on her feet with orders for Physical Therapy to debride and treat. PT and OT progressed this formerly independent lady from total dependence to minimal assistance with some tasks and restored independence in others. Speech Therapy was ordered to address swallowing problems not cognition. All therapies were denied, thereby reducing the payment RUG classification to SE from RVB but only Speech was noted in the denial statement and for reasons other than for what the patient was being treated.

***CMS Manual 100-2, Chapter 8, Section 30.2.2
30.2.2 - Principles for Determining Whether a Service
is Skilled (Rev. 1, 10-01-03) A3-3132.1.B, SNF-214.1.B***

- *The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.*

6. **OIG: "There are discharge [hospital] orders dated 7/28/02 that do not reflect a disposition or any skilled care".**

Background information is not a regulatory requirement for admission and coverage in a Skilled Nursing Facility. The regulations require that the physician certify at the time of admission the need for skilled services. Hospital discharge orders rarely designate the future level of care for a patient.

7. **OIG: "There are no discharge orders indicating the need for SNF care, nor is a discharge summary submitted."**

Background information is not a regulatory requirement for admission and coverage in a Skilled Nursing Facility. The regulations require that the physician certify at the time of admission, or as soon thereafter as is reasonable and practicable, the need for skilled services. Hospital discharge orders rarely designate the future level of care for a patient.

***CMS Manual 100-2, Chapter 8, Section 40
40 - Physician Certification and Recertification
of Extended Care Services (Rev. 40, Issued: 11-18-05;
Effective: 10-01-05 Implementation: 02-16-06)***

Payment for covered posthospital extended care services may be made only if a physician, nurse practitioner (NP) or clinical nurse specialist (CNS) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care

8. **OIG: “She demonstrated a generalized decline in function with her hospitalization... She could have been assisted by staff to increase her overall strength and endurance.”**

This criterion for denial of physician certified and therapist justified skilled rehabilitation services do not exist in the US Code of Federal Regulations, 42 U.S.C. §409.30 thru §409.35, or in the Medicare Benefits Policy Manual Part 100-2, Chapter 8, Section 30. This statement was used to deny a patient admitted with Pneumonia and orders for two different doses of antibiotics. Therapy services restored functional abilities lost secondary to her illness and hospitalization. This is precisely the indicator that skilled services are appropriate.

***CMS Manual 100-2, Chapter 8, Section 30.4.1.1.
30.4.1.1 - General***

EXAMPLE 1

“An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief

period of daily skilled Physical Therapy to restore lost functions, those services are reasonable and necessary.”

9. **OIG: “...this reviewer would downcode to SE111 and allow payment but deny RVB07. However, the order clearly states LTC. Deny.”**

Background information is not a regulatory requirement for admission and coverage in a Skilled Nursing Facility. The “LTC” statement was made on the transfer sheet. This designation is frequently noted on transfer sheets as most hospital physicians and nurses do not know the difference between the acronyms “SNF” and “LTC”. The regulations require that the physician certify at the time of admission, or as soon thereafter as is reasonable and practicable, the need for skilled services – not that the SNF use hospital documentation. Hospital discharge orders rarely designate the future level of care for a patient.

10. **OIG: “The IVF were for maintenance purposes (to prevent dehydration) not for an acute condition.”**

IV Fluids are listed as one of the “Direct Skilled Services” in the US Code of Federal Regulations and in the Medicare Benefits Policy Manual, Part. 100-2, Chapter 8, Section 30:

***CMS Manual 100-2, Chapter 8, Section 30.3
30.3 - Direct Skilled Nursing Services to Patients
(Rev. 1, 10-01-03) A3-3132.2, SNF-214.2***

*Some examples of direct skilled nursing services are:
Intravenous or intramuscular injections and intravenous feeding*

Opinion as to purpose of administration is not a liberty of the regulations granted in the verbiage or intent of those regulations and breaches peer review. This statement was used to deny therapy services to a patient who had compression fractures of T-12 & L-1 of the spine as well as aspiration issues. Speech therapy worked with the patient to reduce aspiration risks and improve swallowing ability. PT & OT progressed this patient from dependence to modified independence, taught him how to transfer safely to a wheelchair and develop safe wheelchair mobility. These goals would never have been attained in an LTC facility.

11. **OIG: “This disposition [original discharge to SNF] is clearly unrealistic because the family has already expressed concern that they cannot care for the pt.”**

This criterion for denial of skilled services does not exist in the US Code or the Skilled Nursing Facility Manual. The regulations require a determination and a certification by the attending physician.

It appears that the reviewers did not account for the presumption of coverage afforded patients who have had specific treatments, conditions and/or diagnoses in the hospital as being presumed covered upon admission to a SNF as they are presumed to be at a higher medical risk and in need of post-hospital skilled care to provide and promote medical safety. The current reimbursement process mandates that in determining the RUG for new admissions hospital events such as specific treatments, conditions and/or diagnoses be noted and accounted for in the admission MDS tool and those specific treatments, conditions

and/or diagnoses in the hospital create a guaranteed payment RUG. This Medicare skilled coverage presumption was placed in the MDS/RUG process as CMS deemed patients leaving the hospital with certain treatments (such as IV's, oxygen, etc.) or having had those treatments within the days preceding discharge are a group of patients at higher risk for medical complications.

CMS Manual 100-2, Chapter 8, Section 30.1

30.1 – Administrative Level of Care Presumption

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (ARD) for the 5-day assessment prescribed in 42 CFR 413.343(b), when correctly assigned to one of the Resource Utilization Groups (RUGs) that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care.

The OIG report recommends that in addition to refunding the Medicare program \$158,210, that Heartland “provide training to its staff to ensure that it fully understands and complies with SNF medical necessity and documentation requirements so that future claims comply with these requirements”. Medicare education is a regular part of the operations of all the facilities owned by HCR ManorCare and are given at the direction of this author who was a main contributing consultant to HCFA (now CMS) in the development and drafting of Revision #262 to Section 214 of the Skilled Nursing Facility Manual (now CMS Medicare Benefits Policy Manual, Part 100-2, Chapter 8, Section 30 of the CMS online manuals); that revision redefined what constitutes skilled care and continues to be the current standard criteria for defining skilled care. These regulations are and will continue to be the basis for all facility in-services concerning Medicare coverage policies, procedures and regulations.

In most cases the Heartland patients were quite ill with multiple problems that increased their total instability, medical risk and need for care by licensed caregivers and therapists. The majority of patients made significant progress with both their medical needs and in their physical rehabilitation programs. The Skilled Nursing section of the Medicare Benefit Policy Manual clearly describes inpatient skilled services and gives examples of patients who have fewer needs and greater stability but illustrates that the complicating factors make them higher risk patients who should receive their medically necessary skilled care and rehabilitation as inpatients in a Skilled Nursing Facility (see especially the example below):

CMS Manual 100-2, Chapter 8, Section 30.2.2

30.2.2 - Principles for Determining Whether a Service is Skilled

(Rev. 1, 10-01-03) A3-3132.1.B, SNF-214.1.B

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.*

- *The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.*
- *A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and nursing or therapy notes.*

EXAMPLE:

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

Conclusion

The manual citations in this response clearly demonstrate that the OIG contract reviewer, TriCenturion, used inappropriate criteria in reviewing these claims. It appears it did not use the Medicare Benefits Policy Manual Part 100-2, Chapter 8, Section 30. It appears other criteria such as that published by the InterQual Corp., which is widely used by HMO's, was inappropriately applied. After repeated reviews of the claims involved in this audit it is our continued position that these residents required and received necessary and appropriate inpatient skilled care as outlined in the federal regulations and guidelines and as was the intent when HCFA (now CMS) conducted the project to review coverage criteria and published the revised criteria as Revision 262 to section 214 of the Skilled Nursing Facility Manual. That manual section is now part of the Medicare Benefits Policy Manual, Part 100-2, Chapter 8, Section 30, sections of which have been cited throughout this response and in that manual the coverage issues as revised by Revision 262 remain the standard for determining inpatient skilled care.

We thank you for this opportunity to respond to the findings of the OIG contract review agency and hope the numerous concerns identified throughout this response will encourage the OIG to reconsider and re-evaluate the conclusions reached in its December 10, 2007, draft report.

Sincerely,



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