United States General Accounting Office

GAO

Report to the Ranking Minority Member, Committee on Commerce, House of Representatives

March 1995

MEDICARE

Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes

GAO/HEHS-95-23

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-257663

March 30, 1995

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

The Congress enacted nursing home reform provisions in 1987 in response to widespread concern that too many nursing homes were not providing patients with adequate care. These provisions, implemented in 1990, require that the status of every resident be evaluated and appropriate services be provided when medically indicated. As interpreted by the Health Care Financing Administration (HCFA)—the agency within the Department of Health and Human Services (HHS) that oversees Medicare—these services include physical, occupational, and speech therapy.

Approximately 60 percent of nursing home residents now receive at least some type of therapy. Charges billed to Medicare by institutional providers[1] for therapies delivered in all settings, not just nursing homes, have grown dramatically, from $4.8 billion in 1990 to $10.4 billion in 1993. Concerns have been raised that part of this growth may be the result of abusive billing practices.

In light of mounting complaints from families of Medicare beneficiaries, providers, and government investigations, HCFA has acknowledged that there are problems involving billings for overpriced, inappropriate, or undelivered therapy services. You therefore asked us to determine the extent of these problems, why they persist, and what needs to be done to remedy the situation.

To respond to your request, we studied complaints received and investigations undertaken by HCFA, its contractors, selected regional offices, and other enforcement agencies; we obtained claims data and conducted our own analyses; and we met with representatives of the rehabilitation industry, nursing homes, and the elderly. While the examples we found involved a variety of inappropriate Medicare claims, we focused primarily on those associated with overcharges to the

[1]Institutional providers include hospitals, skilled nursing facilities, rehabilitation agencies, and home health agencies. Excluded are private physicians and independently practicing therapists.

program. Details of our scope and methodology are provided in appendix I.

Results in Brief

We found widespread examples of overcharges to Medicare for therapy services delivered to nursing home patients. Providers responsible for inflated charges may be rehabilitation companies, which supply therapists to nursing homes, or the nursing homes themselves. Though the data do not exist to determine the extent of overcharging and its precise impact on Medicare outlays, billing schemes uncovered in recent years by state and federal investigations suggest the problem is national in scope and growing in magnitude.

Extraordinary markups on therapy services can result from providers exploiting regulatory ambiguity and weaknesses in Medicare's payment rules. While state averages for physical, occupational, and speech therapists' salaries range from about $12 to $25 per hour, for example, Medicare has been charged $600 per hour or more. Because HCFA payment rules and procedures for thwarting abusive billings were developed when the therapy industry was much smaller and less sophisticated, they have proved no match for increasingly complex business practices that appear to be designed to generate increased Medicare revenue and skirt program controls.

Although HCFA has been aware of this growing problem since 1990, it has yet to close the loopholes in Medicare therapy reimbursement policies,[2] and actually developing and implementing new rules to accomplish this task can be a very lengthy process.

Background

The Congress enacted substantial nursing home reforms as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA). The changes included expanded requirements affecting nurse's aide training and licensing and minimum staffing standards for nursing homes. The reforms were aimed at improving the care provided to nursing home patients and raising the standards that facilities had to meet to participate in the Medicare and Medicaid programs.

[2]The Deputy Inspector General of HHS' Office of Inspector General (OIG) testified on February 6, 1995, that "because of the dollars at stake, the program will always attract unscrupulous actors who attempt to take advantage of loopholes or flout the law altogether." We use the term "loophole" in the same sense throughout this report.

Medicare's basic nursing home benefit covers a portion of posthospital costs for up to 100 days in a skilled nursing facility (SNF). SNFs are nursing homes that maintain a full-time staff of medical professionals who provide daily care for patients with complex medical or rehabilitative needs. Nursing homes that do not offer this level of care, or do not choose to participate in Medicare, are referred to in this report as nursing facilities (NF).

Under OBRA reforms, all SNFs and NFs participating in either Medicare or Medicaid were for the first time required to conduct a medical assessment of all patients, determine what services they needed to improve their condition, and make those services—including occupational, physical, and speech therapies[3]—available. Medicare pays for therapy as long as it is indicated in a patient's medical assessment and the patient steadily improves as a result of the treatment. Under Medicare, a beneficiary's coverage for therapy may continue long after the individual's basic nursing home benefit has expired. With these reforms came a sharp rise in therapies delivered in nursing homes.

Some nursing facilities—mainly SNFs—employ their own therapists. In some instances, therapists with their own private practices serve patients in nursing homes. But a recent survey, based on responses from 1,694 nursing homes nationwide, found that 75 percent of all SNFs rely on specialized rehabilitation agencies—also termed outpatient therapy agencies (OPT)—to provide therapy services.[4] These companies employ or have contracts with a cadre of therapists, who are deployed as needed to nursing homes or other settings.

Where therapy services are covered by Medicare, claims may be submitted by either the OPT or the nursing facility. The billing provider[5] must be certified by HCFA as a program participant to receive payment. Contractors, usually large insurance companies, review the claims, make the payments, and audit providers on behalf of the Medicare program.

[3]Physical therapy includes treatments—such as whirlpool baths, ultrasound, and therapeutic exercises—to relieve pain, improve mobility, maintain cardiopulmonary functioning, and limit the disability from an injury or disease. Occupational therapy helps patients learn the skills necessary to perform daily tasks, diminish or correct pathology, and promote health. Speech therapy includes the diagnosis and treatment of speech, language, and swallowing disorders.

[4]The survey, conducted by Solomon Healthcare Consulting, Baltimore, Md., was reported in 1994 and sponsored by the National Association for the Support of Long Term Care and rehabilitation agencies, in conjunction with the American Health Care Association and the American Association of Homes and Services for the Aging.

[5]Throughout this report, the term "provider" refers to suppliers of medical services—such as nursing care or rehabilitation therapies—who directly bill Medicare for these services.

Abusive Billings for Therapy Services Appear Pervasive

Spending on therapy services has risen sharply since 1990, when OBRA's nursing home provisions took effect, and the number of rehabilitation agencies providing such services has increased dramatically. This was to be expected, in light of the mandated assessment of all residents' condition and potential for improvement. However, complaints of inappropriate billings have also increased, and state and federal investigations confirm that a significant portion of this growth may be the result of abusive practices.

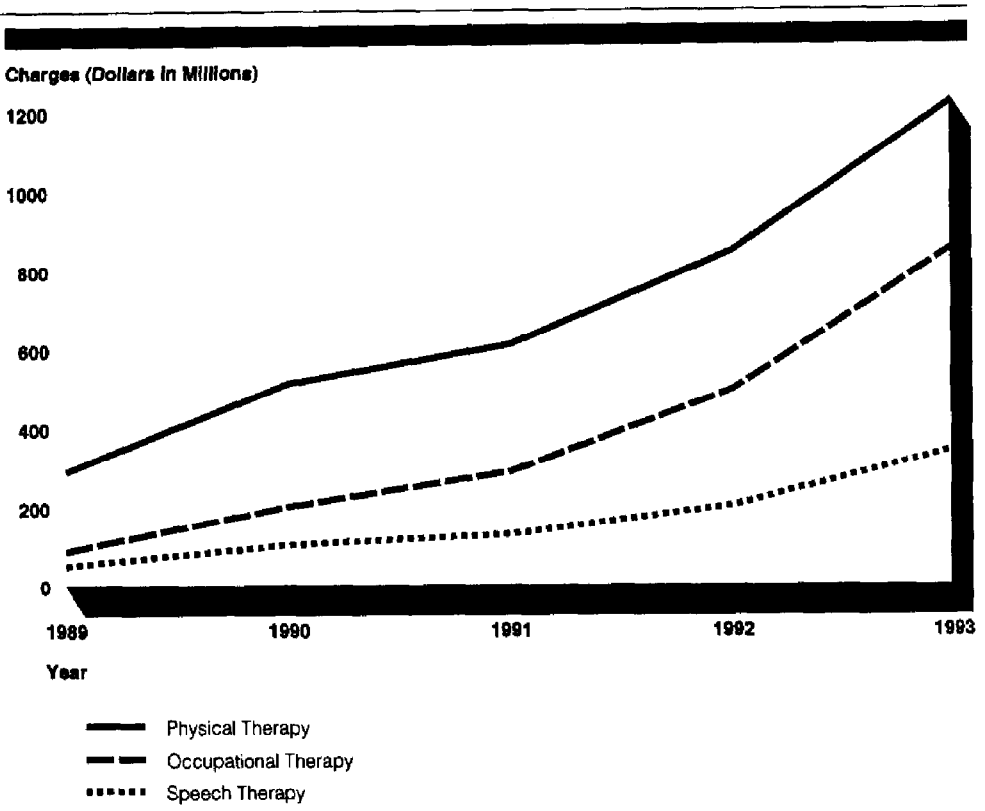
Though it is difficult to project the magnitude of billing abuses and its impact on Medicare outlays, the HCFA officials and claims processors we interviewed believe the problem has reached national proportions, and we found significant indications of providers inflating their charges for therapy services. These practices contribute to substantial differences in Medicare reimbursements for therapy, depending on the way these services are delivered and billed.

Medicare Costs Soar, Industry Expands

Therapy charges for claims submitted to Medicare by outpatient rehabilitation agencies and SNFs combined have tripled, from approximately $1 billion in 1990 to $3 billion in 1993,[6] or 30 percent of the $10 billion in therapy claims from all institutional providers. Medicare is now the largest payer for all therapy services and accounts for more than half of all revenues for rehabilitation companies. The most dramatic rise has been in occupational therapy. SNF claims for these services have grown 870 percent, from $88 million in 1989 to $856 million in 1993. The rise in various therapy charges billed by SNFs following implementation of the OBRA nursing home reforms is shown in figure 1.

[6]Because of data limitations, we derived these figures by adding some fiscal and some calendar year data. HCFA officials told us that 1989 data for rehabilitation agencies are not available, so 1989 totals are not included here.

Figure 1: Increase in SNF Therapy Charges to Medicare, 1989-93



The rise in Medicare costs has been driven by not only the anticipated increase in services, but an increase in the costs of providing those services. Therapists' salaries, for example, have surged. Some hospitals have complained that they are unable to retain therapists or to match the salaries being offered by rehabilitation therapy companies to newly graduating therapists.

Changes in the way rehabilitation companies operate have also increased costs. Nursing homes now contract with large multistate therapy companies to deliver and manage patient care. Some of these businesses are composed of multilayered organizations and interconnected companies. All of these layers add costs which, like the boost in therapists' salaries, are ultimately billed to, and reimbursed by, Medicare.

Since 1989, the year before the reforms of OBRA 1987 were implemented, the number of outpatient rehabilitation companies participating in

Medicare has grown by 60 percent nationwide, reaching 1,686 facilities in 1994. While much of this growth was likely the result of providers filling a legitimate need, state and federal investigations of numerous complaints indicate that some rehabilitation companies and nursing homes have developed various strategies to overcharge Medicare.

Investigations Validate Numerous Complaints of Abusive Practices

Along with rising costs, allegations of billing abuses by rehabilitation companies and SNFs began to proliferate in 1990 (see app. II for examples). Complaints from beneficiaries and their families frequently focus on unnecessary or unprovided services; such allegations have been the target of inquiries by OIG, the Department of Justice, Medicare contractors, and HCFA regional offices. Whatever triggered them, these investigations typically revealed overcharges, as in the following examples.

A Department of Justice investigation of an operator of four northern Georgia rehabilitation companies led to a grand jury indictment of one individual for filing false claims. Additional charges of mail fraud, wire fraud, and money laundering related to the therapy businesses have also been brought.

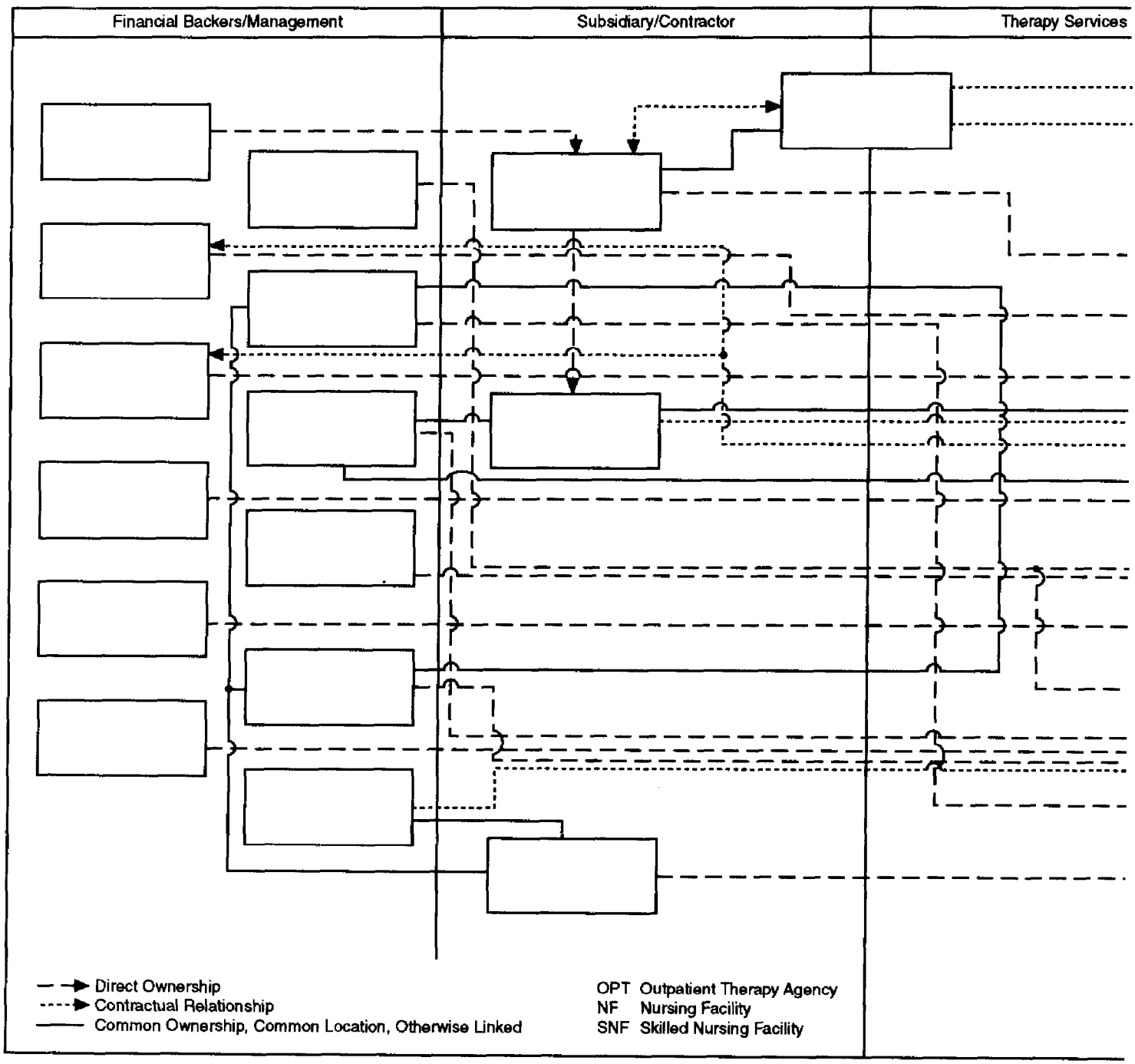
The North Carolina contractor's investigation of nursing home billings from rehabilitation companies found merit in complaints from family members of overpriced services and bills for services that may never have been delivered.

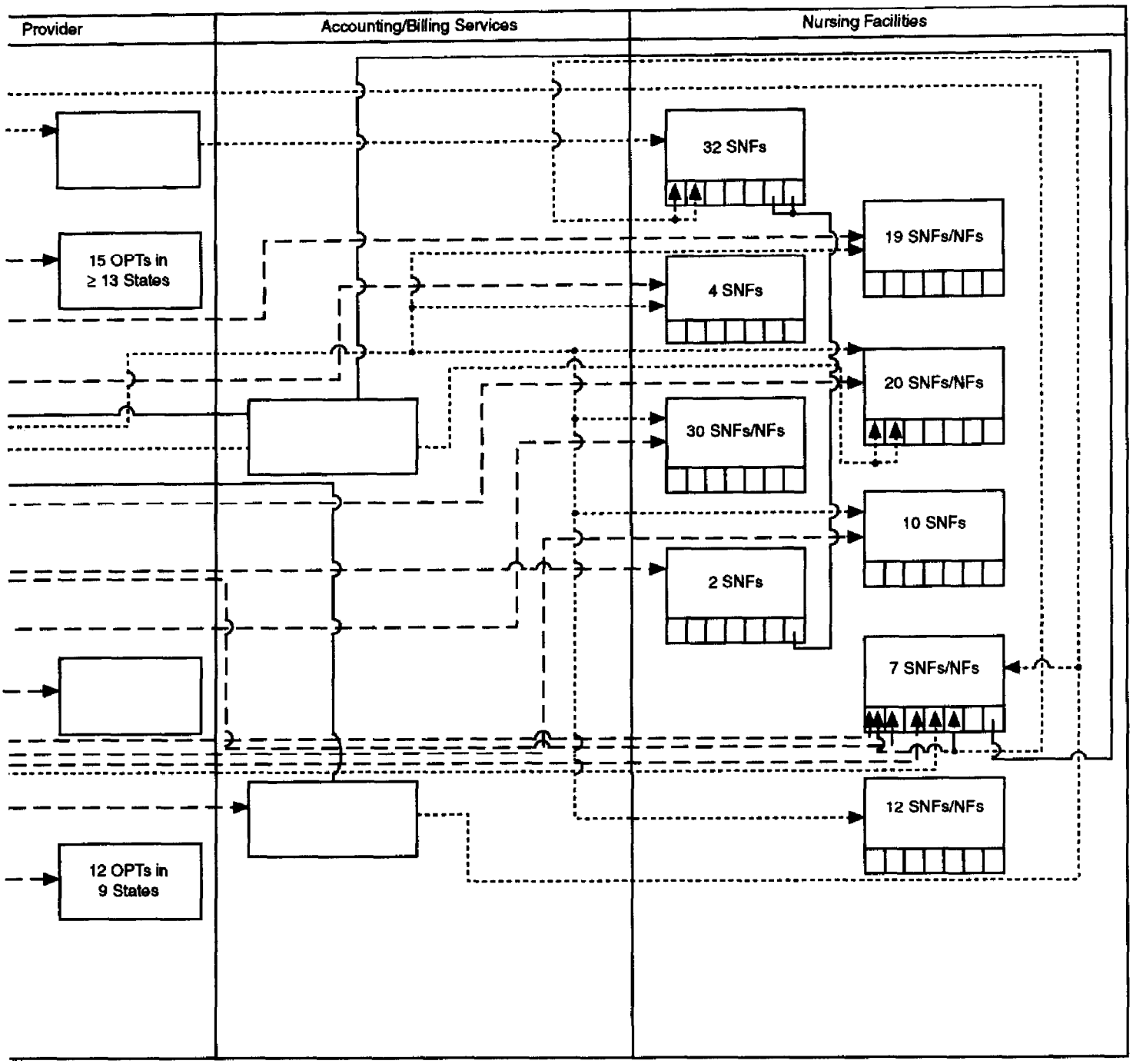
An extensive investigation by OIG and Medicare contractors of therapy billing abuses involved one company linked to a network of more than 130 providers—including nursing homes, therapy agencies, and billing companies—spread over at least 21 states. Since early 1990, this company—the complexity of which is illustrated in figure 2—has been the subject of a large volume of complaints on behalf of beneficiaries in Florida, Georgia, Arkansas, and Kansas nursing homes. Investigations of its activities uncovered several patterns of questionable practices, including systematically charging highly inflated amounts for many of its services. A typical example was an instance where Medicare was billed

$8,415, of which over $4,580 was for charges added by the therapy company's billing service for submitting the claim.[7]

[7]In addition, the company used questionable billing arrangements that obscured its activities. It regularly divided patient bills among multiple providers with whom it was affiliated, making it difficult for contractors to detect overcharges and overuse of services. For example, the Arkansas Medicare contractor found that services provided to some patients in that state were billed through providers in Florida and Illinois. A Florida contractor involved in this investigation indicated it had received numerous complaints similar to these about other large rehabilitation and nursing home chains.

Figure 2: Partial Organization Chart for Major Network, June 1993




Provider
Accounting/Billing Services
Nursing Facilities
15 OPTs in ≥ 13 States
12 OPTs in 9 States
32 SNFs
19 SNFs/NFs
4 SNFs
20 SNFs/NFs
30 SNFs/NFs
10 SNFs
2 SNFs
7 SNFs/NFs
12 SNFs/NFs

Lax Medicare Rules Invite Abuse

Medicare is being overcharged for therapy services by some rehabilitation companies and SNFs that inflate their costs for providing care. Most such practices share a common origin: weaknesses in Medicare payment rules that invite exploitation. Undue flexibility, lack of specificity, and regulatory ambiguity combine to create an environment in which contractors feel obliged to pay claims, however high, in the absence of indisputable evidence that program rules have been violated.

Reimbursable Costs Are Unlimited

Medicare reimbursement for therapy services provided by SNFs and outpatient rehabilitation agencies is supposed to be based on providers' "reasonable costs." Providers must file annual reports detailing the actual costs of services that were delivered to Medicare beneficiaries and billed to the program throughout the preceding year. Those costs—such as salary, overhead, and administrative expenses—are then assessed for reasonableness and accuracy, and a determination is made about what portion of them should be paid by Medicare. HCFA contractors reconcile that amount with the interim payments made to providers throughout the year by making additional payments or collecting overpayments. (App. III provides additional detail regarding the reimbursement process and subsequent adjustments.)

In theory, this process should curb expenditures and act as a barrier to overbilling. In practice, however, HCFA's standard of "reasonableness" for these services is so vague that there is almost no limit on the type and amount of costs that Medicare will reimburse. HCFA has developed none of the benchmarks needed to produce a tangible definition of reasonable costs for occupational or speech therapy.[8] Without such benchmarks, it is nearly impossible for Medicare contractors to judge whether therapy providers overstate their costs.

For example, as with most health care services, labor is a large portion of the direct cost of providing therapy. However, HCFA has not yet issued salary equivalency standards for occupational or speech therapists.[9] As a result, there is no guidance that contractors can use to flag inflated labor costs. Surveys show that average statewide salaries for occupational, speech, and physical therapists employed by hospitals or nursing homes

[8]HCFA has taken some interim measures (discussed beginning on p. 17) while it continues to study the issue.

[9]As part of its response to recent complaints of inappropriate billings, HCFA is in the process of drafting such guidance.

range from $12 to $25 per hour.[10] Adjusting for fringe benefits adds about 40 percent, according to HCFA, increasing their average compensation to $18 to $32 per hour. Yet, HCFA has found therapy charges of $150 for a 15-minute visit, or $600 per hour.

Our analysis of a sample drawn from a survey of five contractors found that over half of the claims they received for occupational and speech therapy from 1988 to 1993 exceeded $172 per service. Assuming this was the charge for 15 minutes worth of treatment—which industry representatives described as the standard billing unit—the hourly rate for these claims would be more than $688.

In response to earlier problems, HCFA instituted some limits on how much Medicare will pay for physical therapists' salaries,[11] and SNF charges for those services have grown at a slower rate, increasing by 321 percent between 1989 and 1993 compared with 868 percent for occupational therapy and 571 percent for speech therapy. With that exception, however, Medicare rules do little more than warn providers and contractors to be "prudent buyers" of therapy services and to base their decisions about reasonableness on market forces.

Loose Billing Requirements Compound Difficulty of Applying Reasonableness Standard

In addition to therapists' salaries, the amount of time providers spend treating patients is a key determinant of therapy costs. Yet, HCFA does not require therapy companies or SNFs to specify on their claims how much therapy time they are billing for.[12] Instead, therapy companies have the choice of at least six methods by which they can bill Medicare: time-specific service units, such as the number of 15-minute intervals spent providing a service to a patient; labor-related time intervals, measuring the amount of time that therapy staff are in a facility and available to provide care; the number of patient visits or treatments; a fixed weekly or monthly rate for services; a fixed diagnosis-related rate per case; or the complexity and intensity of treatment provided.

It is often not apparent from therapy claims, however, which of these methods providers are using. Therapy claims often list the number of

[10]These rates apply to the 50 states. Rates in Puerto Rico are somewhat lower.

[11]Medicare establishes limits on what it will reimburse SNFs for physical therapy services provided by outside therapists—effectively limiting what rehabilitation companies can charge. As of June 1993, this would mean an hourly rate of $29.26 (plus a travel allowance of $14.63 and additional travel expenses of $2.50). Therapy companies, however, do not have such limits when they bill Medicare directly.

[12]HCFA has taken some interim measures (discussed beginning on p. 17) while it continues to study the issue.

items or units being charged without describing what those items or units are. For example, a bill for three therapy treatments may simply cite a charge for three units. There is no way for Medicare contractors to glean from such claims the amount of time involved in delivering therapy services or what the service was. As a result, Medicare contractors often have no idea what they are being asked to reimburse on a therapy claim, making it all the more difficult to detect inflated charges and identify unreasonable costs.

One Georgia company, for example, bills Medicare $200 for each speech therapy treatment. With no defined unit of time attached to the charge, there is no way to tell whether the treatment lasted an hour or a minute. Thus, there is no apparent way to assess the reasonableness of billed amounts. Contractor records we reviewed showed actual "per service" charges as high as $261 for one provider of occupational therapy and others close to that figure. With no indication of duration, however, it is difficult to tell whether this charge is unreasonable. Another company operating in Ohio and elsewhere billed Medicare $206 per visit for a patient's occupational therapy. Upon checking, the patient's wife found that at least three "visits" could be accomplished in 30 minutes. Extrapolated to an hourly basis, then, the charge for these services would be $1,236.

Rehabilitation Companies and SNFs Use Weaknesses in Medicare Rules to Overcharge Medicare

Rehabilitation companies and SNFs can overbill the Medicare program using a variety of business practices designed to make the most of weaknesses in Medicare rules. Three of these practices illustrate how, under current rules, providers can easily inflate the charges and costs for which they are reimbursed by Medicare.

Contractual Relationships Benefit Rehabilitation Companies and SNFs

Some rehabilitation companies and SNFs have formed business arrangements that can help both parties maximize Medicare reimbursement. Among the most common of these mutually beneficial practices are contractual agreements under which a rehabilitation company supplies the SNF with therapists.

SNFs are required by law to make therapy services available to patients who need them. Rather than incur the cost of hiring their own therapists, the facility may contract with outside rehabilitation companies to deliver services. Often, under these contractual arrangements, the therapy

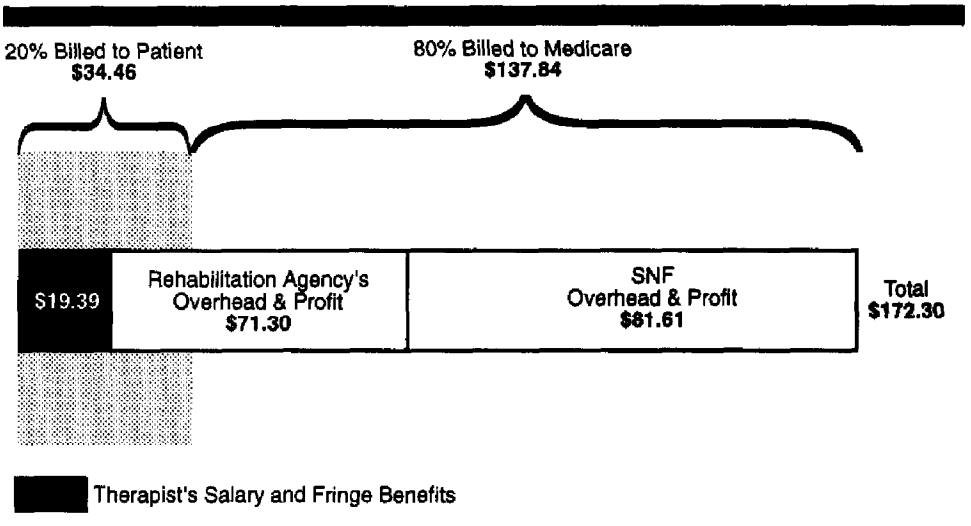
company bills the nursing home for its services and the SNF in turn bills Medicare for those charges. While this billing procedure is not inherently abusive, it can be used to maximize Medicare revenue for both the rehabilitation company and the SNF.

Under Medicare rules, charges by the rehabilitation agency for occupational and speech therapy are reimbursable to the SNF as long as they are "reasonable." HCFA and contractor officials told us that because there are no clear guidelines that define what is reasonable, Medicare generally pays the SNF whatever it was charged for therapy services rendered by the therapy company, regardless of how inflated those charges might be. Reacting to the current problems, HCFA is in the process of developing such guidance, but meantime, the rehabilitation company can continue to overcharge and still be confident of full payment. Under existing guidelines, the rehabilitation agency is usually not audited by the Medicare contractor because it is not the billing provider.

Paying higher amounts to the rehabilitation agencies also benefits the SNFs as a result of rules whereby the program pays providers a portion of their overhead expenses, based on the percentage of their total business that is Medicare-related. For example, if 10 percent of a SNF's costs are attributable to Medicare, then it can charge the program for 10 percent of its allowable overhead expenses in addition to its direct costs. The higher the Medicare-related payments to the rehabilitation agencies, therefore, the more Medicare business a SNF can claim, and the higher percentage of its overhead can be charged to the program. There is no incentive to "shop around" for a better bargain—in fact, the opposite is true.

Contract arrangements such as these have been found to result in markups of 800 percent or more over the direct cost of the therapy service. This was the effect of a contract between a Tennessee rehabilitation company and the SNF that was using, and billing for, the company's services. Moreover, for therapy and other services requiring a copayment, Medicare beneficiaries must pay 20 percent of provider charges. In this case, charges were so inflated that the revenue obtained just from the 20-percent copayment was more than the therapy company paid its therapists, as shown in figure 3.

Figure 3: Factors Contributing to High Therapy Charges



Shell Organizations Used to Pad Administrative Costs

Medicare rules allow only certified therapy providers to bill the program for services. While HCFA grants the certification, it does so on the basis of recommendations from designated state agencies, which survey the providers before HCFA will issue them provider numbers enabling them to bill Medicare. Premises, personnel, and procedures are evaluated during these surveys, but the "premises" can consist—for example—of a dedicated area in a nursing home, and the personnel may work under contract. Consequently, in practice, some providers that receive HCFA certification are shell organizations that bill Medicare for therapy services others provide. Though shell companies have little or no involvement in providing therapy services, they may charge Medicare exorbitant administrative costs. These circumstances are generally revealed only during the course of contractor audits.

One such shell is a Georgia company that was certified in 1993 by Medicare to bill for therapy services even though it had no salaried therapists. It was essentially a storefront office operated by one clerical employee who billed Medicare for services provided to nursing home residents. The shell company subcontracted with two therapy companies to provide its services, neither of the companies being certified by Medicare. This billing arrangement allowed the shell company to add to its claims an 80-percent markup over what it paid the therapy agencies.

Another shell company we identified had no staff. Simply by creating a "paper organization," with no space or employees, an entrepreneur added

$170,000 to his Medicare reimbursements over a 6-month period. The entrepreneur simply reorganized his nursing home and therapy businesses so that a large portion of his total administrative costs flowed through the shell therapy company and could thus be allocated directly to Medicare. (See app. IV for details.)

Third-Party Billings Evade Controls, Boost Costs

Another mutually beneficial business practice is that of therapy companies using the SNF's provider number to bill Medicare. Under such an arrangement, the therapy company bills Medicare as if a patient had received services in that nursing facility, although the patient may be anywhere in the country.

This practice benefits therapy companies by enabling them to evade Medicare controls that might flag overbilling. For example, while there are no explicit limits on the number of therapy treatments a patient can receive, Medicare contractors often give greater scrutiny to claims that exceed a certain threshold, such as 21 treatments per patient for the same condition. It becomes impossible to detect when services are over the limit, however, when therapy companies split a patient's claim among multiple SNFs, each of which may have a different Medicare contractor. One therapy company, for example, divided a Texas patient's $10,950 claim for physical therapy between nursing homes that were linked to two different Medicare contractors in North Carolina and Florida.

Although therapy companies sometimes use a SNF's provider number without the facility's consent, nursing homes often agree to the arrangement because of the substantial benefits available to them. Like some contractual agreements, this billing practice boosts the amount of business that a SNF can ascribe to Medicare, which in turn increases the portion of administrative costs it can bill to the program. One Tennessee nursing home increased its Medicare revenues by nearly 30 percent in a single year by essentially selling its provider number to a therapy company. From 1990 to 1993, the SNF reaped an additional $366,000 without supplying any additional services.

Regulatory Ambiguity, Multistate Organizational Structure Thwart Investigations

However aberrant the billing patterns of some rehabilitation agencies and SNFs might be, many of the common practices we have described—such as use of multiple provider numbers—are not clearly precluded by regulations. As a result, investigators have had difficulty finding a basis for taking action against providers engaged in questionable activities. The complex network illustrated earlier, for example, was the target of a battery of investigations by federal and state agencies. Despite these multiple investigations—some of which are still ongoing—many companies and individuals affiliated with this network continue to operate in their established fashion. Others have changed ownership or gone out of business.

One related OIG investigation ended in early 1993 with a warning to the company about several questionable incidents. OIG did not pursue the effort partly because of concerns that there were too many unresolved Medicare regulatory issues for the case to have a solid foundation for civil or criminal actions. For example, it is unclear under what circumstances a nursing home may legitimately bill for services to an out-of-state resident. No clear prohibitions exist against the complicated billing arrangements used by the company, nor were there limits on how much the company could bill Medicare for care.

An Arkansas State Attorney General's investigation of this same network was hampered when one provider involved moved out of the state and other individual targets of the investigation either went out of business or severed ties with the network. Similar problems stalled Medicare contractors' investigations. Because the company operated in many states and used many different affiliates to bill for services, two contractors had to launch a major initiative to begin getting a full picture of the company's operations. It took contractors in North Carolina and Florida 9 months to identify 130 separate but related entities that were billing them for services. From 1990 through 1992, these entities billed a combined total of $96 million for therapy services. Yet, it was not until the contractors began piecing the network together that they realized there was any connection among these companies. Some of the companies had already gone out of business by the time the contractors recognized their involvement in providing overpriced or otherwise questionable services.

HCFA has been of little assistance in alerting its contractors to providers such as these, whose billing practices warrant close scrutiny, because its

current computerized information systems lack the ability to link claims from multiple providers for related therapies to the same beneficiary.[13]

HCFA Striving to Resolve Problems

HCFA has been aware of problems with rehabilitation therapy reimbursement since at least 1990 but only intensified its efforts to curb excessive or inappropriate billings in 1993 after additional concerns were raised by contractors served by its Atlanta Office (Region IV). HCFA's short-term strategy has focused on alerting all contractors to the problem and providing guidance in identifying aberrant providers. It has also appealed to physicians to resist pressures from SNFs to prescribe unnecessary or ineffective therapy protocols. Recognizing the need for stronger measures, HCFA also intends to promulgate salary guidelines for occupational and speech therapists similar to those currently applicable to physical therapists.

Initial Focus Is on Contractor Oversight

HCFA has sent its contractors a series of memorandums since October 1993, advising them of the nature of existing problems—such as inflated therapy service charges—and providing guidance on how to focus their review activities. These reviews are two-fold: contractors conduct a medical review of claims to determine whether services were medically necessary, according to established criteria (spelled out in their medical policies), and contractors perform audits to determine whether the costs providers charge to Medicare are reasonable and allowable.

HCFA's October 1993 memorandum advised its contractors to

- intensify their review of therapy claims by requiring providers to submit additional documentation to help demonstrate that services are medically necessary;
- single out for special review those providers that are not located in the same state as their patients;
- increase the scope of therapy company audits[14] to better assess the reasonableness of costs claimed for Medicare reimbursement, which could include assessing the time spent by a provider's therapists in actually providing the therapy relative to the costs claimed for those services, and evaluating whether the costs claimed for management services are

[13]HCFA told its contractors in October 1993 that revisions would be made to add this capability. However, as of November 1994, these plans were "on hold."

[14]Rehabilitation agencies that are certified as Medicare providers are subject to audit. However, those whose charges are passed through as costs to the nursing facilities are not normally audited.

reasonable and necessary compared with what other area management companies charge; and

- consider auditing any provider with reimbursable therapy costs exceeding $95 per hour.[15]

Current Medicare regulations require that contractors conduct some level of these activities. Each of the contractors we reviewed had begun intensifying these activities by 1992 in response to their burgeoning problems with therapy providers. As a result, these contractors were already complying, to the extent possible, with the stepped-up activities outlined in the HCFA memorandum. Their efforts, however, were nominal relative to the problems faced. Reviewing claims and auditing providers are labor intensive. Since contractors work within limited budgets, there are constraints on how much time and effort they can focus on a single area.

HCFA funds contractors who process therapy claims from institutional providers at a level that enables them to review only 3 to 5 percent of the claims they receive for medical necessity. Without additional funding, intensifying reviews in one area—such as therapy services—means reducing them in another—such as home health services. (While HCFA planned to provide additional funding, on request, to support the contractor activities called for in its October 1993 memorandum, it warned that other reviews might need to be curtailed to make up any shortfall.) Moreover, the criteria for determining the medical necessity of therapy are not clear, limiting the effectiveness of medical review efforts.[16] Therefore, as long as providers meet documentation requirements, claims are difficult to deny on that basis.

Similar problems exist with contractors' audit efforts. Funding constraints limit audits to a small percentage of skilled nursing homes and therapy companies. For example, one contractor, serving 33 states, processes and pays claims for 1,525 SNFs and 189 rehabilitation agencies. In 1993, it performed full audits (some of which revealed examples of overcharging cited in this report) on 63 of these providers. These represented less than 4 percent of the total providers for which it had responsibility. Furthermore, even when audits are done, there is a substantial lag between the time a contractor reimburses a provider and the time it audits

[15]An official at HCFA's Central Office told us their preliminary analysis indicated additional field audits would not be cost-effective for charges below $95 per hour. Region IV officials had recommended no more than $50, based on a salary survey and comparison with home health service guidelines.

[16]As in any issue involving professional judgment, definitive criteria are difficult to articulate.

the provider's supporting cost reports. In late 1994, for example, at least one contractor was still auditing 1992 cost reports.

HCFA's suggestion that contractors audit claims whose costs exceed $95 per hour, meanwhile, has caused considerable concern among program and claims administrators, as the threshold

- cannot be used as a limit, and therefore will not in itself provide contractors the basis they need to disallow exorbitant costs;
- is difficult to implement because many providers do not bill on a time-related basis; and,
- is far above the $12 to $25 per hour salary of therapists and thus can be construed as condoning providers' current charge levels.

In general, Medicare's current audit process is ill-suited to combating expansive, fast-moving schemes involving overcharges such as those currently associated with therapy services. To deal with such problems, contractors need clear criteria that they can use to determine whether claims are reasonable.

The effectiveness of HCFA's October 1993 memorandum is not clear. The contractors who were previously aware of the problems told us they were already taking the recommended actions. Other contractors have at least now been alerted.

Physicians Urged to Resist Industry Pressure

HCFA has also issued an informal appeal for greater vigilance by physicians. In an article published in the April 6, 1994, Journal of the American Medical Association, the HCFA Administrator urged physicians to resist any pressure they may receive from SNFs to order unneeded therapy services for patients.

"In certain facilities, HCFA has learned that physicians are being pressured to order and approve resident evaluations and related services performed by physical, occupational and speech therapists for Medicare-covered residents, regardless of whether the services are medically necessary. This is a flagrant abuse of Medicare."[17]

Proposed Regulatory Changes Sound but Slow

HCFA is in the process of establishing salary equivalency guidelines for occupational and speech therapy that would help contractors gauge the reasonableness of providers' costs. Such guidelines would enable

[17]It is too early to judge the effects of this appeal.

Medicare contractors to limit a provider's reimbursable costs to an amount consistent with the cost of employing full- or part-time therapists. This would help reduce incentives to develop complicated delivery and billing arrangements that allow much higher costs to be passed on to Medicare. Judging from past efforts to develop similar reimbursement guidelines, however, drafting and implementing them could be a very lengthy process. Delays are inherent in the rulemaking process governed by the Administrative Procedures Act as well as the complexities of intra-agency and intra-departmental coordination.

Conclusions

HCFA has been stifled by its own rules from doing what any prudent purchaser would be expected to do when confronted by inflated bills—refuse to pay what it considers to be inflated claims. It must first prove that they are inflated, yet lacks the data to do so within a reasonable time frame. HCFA's failure to take decisive and timely action to resolve serious problems with Medicare reimbursement policies for rehabilitation therapy services raises concerns about the agency's ability to respond to an increasingly entrepreneurial marketplace. HCFA has yet to initiate any regulatory actions to close the loopholes in Medicare rehabilitation therapy reimbursement policies—a time-consuming task, judging by past experience.

As HCFA has been planning its strategy for ultimately correcting Medicare's problems with rehabilitation therapy, the therapy industry has flourished and excessive reimbursement has become a major concern for Medicare. Overpayment for services promotes an oversupply and ultimately more services being delivered than are needed. Without HCFA's prompt and decisive action to correct therapy billing problems, unwarranted payment and service levels could gradually become accepted as the norm. This would permanently add unnecessary costs to the nation's already staggering long-term care expenditures.

Moreover, significant regulatory changes will be required to enable HCFA to purchase rehabilitation services prudently. At present

- there are no dollar limits on Medicare reimbursements for occupational and speech therapists' salaries;
- accountability is compromised because charges for therapy services are not linked to the amount of time spent with the patient and the treatment provided;

- certification is not linked to serving patients or supervising the provision of services; and
- there are no limits on providers' ability to bill for services to patients in other states (existing requirements for on-site supervision of services and accountability are difficult to enforce).

Moreover, the slow response to problems of inappropriate billings for rehabilitation therapies indicates systemic weaknesses. HCFA lacks a process that would allow it to stop program losses expeditiously. Addressing these deficiencies requires substantial changes that are already overdue.

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to (1) set explicit limits to ensure that Medicare pays no more for therapy services than would any prudent purchaser; (2) strengthen certification requirements to better ensure that those entities billing Medicare are accountable for the services provided to beneficiaries; and (3) define billable therapy service units so they relate to the time spent with the patient.

Agency Comments and Our Evaluation

In its February 21, 1995, comments on our draft report, HHS generally agreed with our findings and conclusions, stating that our concerns about inappropriate billing and delivery of therapy services support its own concerns. The Department also agrees with our recommendations that HCFA be directed to (1) establish explicit cost limits on occupational and speech therapy services and (2) develop a standard unit for billing these services, which would allow comparisons of different providers. In both instances HHS is investigating ways to implement these recommendations. HHS did not, however, comment on our recommendation that HCFA strengthen its certification requirements for therapy companies.

HHS believes we should characterize the problems we cite with Medicare's reimbursement for therapy services as "potential" rather than actual problems. We do not agree. The problems we identified are widely acknowledged throughout HCFA, by the insurers that contract with HCFA to pay Medicare therapy claims, and by OIG staff who have been investigating similar therapy service abuses since 1989.

The payment system to fund therapy for nursing home residents currently encourages maximizing costs charged to Medicare. Along with this phenomenon is the proliferation of middlemen whose most apparent

contribution is to increase costs unnecessarily. Unfortunately, what we learned from our field work and discussions with Medicare auditors and claims processing contractors is that these middlemen's added costs generally get paid in full by the program.

The consequences of such program exploitation extend well beyond a financial impact on Medicare. In this regard, we agree with the following comments made by the HCFA Administrator discussing the therapy service problems:

"... First, quality of care is jeopardized by submitting residents to unnecessary evaluations and therapy that may cause discomfort or create false hopes for improved quality of life. Second, this ... also generates a needless and unjustified expense for both beneficiaries and the federal government."[18]

HHS also raised several concerns regarding the data we developed to illustrate how much Medicare pays for therapy services. HHS would have preferred that we use in our examples what Medicare actually paid the providers instead of what they charged. We would have preferred this, too, but the unavailability of such data—what Medicare actually paid providers—is at the very crux of the problem. Under the program's method of reimbursement for therapy services, HCFA does not know how much Medicare pays for a unit of service, or how much it pays overall for services provided to residents of nursing facilities. All it knows, reliably, is what providers charge. When a claim is submitted, providers receive only an interim payment (on average, in 1994, 70 percent of the initial claim) subject to adjustment at the end of the year. If the provider is audited, final settlement may be delayed as long as 4 years. Even then, the unit of service is not always apparent.

To avoid any misunderstanding related to the twin issues of charges versus payments and ill-defined units, we have revised the report by removing a table of comparative reimbursements and now point out more explicitly that Medicare generally pays less than providers charge.

HHS would also have preferred that we explain in greater detail how Medicare pays for therapy services provided to nursing home residents—specifically how residents can receive the services under either parts A or B of the program. We elected not to do this because, as HHS points out in its comments, "the problem of overcharges for therapy may apply whether the services are covered under either Part A or Part B." The

[18]Journal of the American Medical Association, Vol. 271, No. 13 (Apr. 6, 1994), p. 974.

added detail, we believe, would do more to confuse than clarify the report's underlying message—therapy services under Medicare's reimbursement rules are extraordinarily vulnerable to abuse. We have, however, provided additional detail in appendix III relating to Medicare's process of paying for therapy services.

HHS also made several technical comments that we have considered and incorporated in the final report as appropriate. (See app. V for a copy of HHS comments on our draft report.)

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that time, we will send copies of this report to the Secretary of HHS, the Administrator of HCFA, interested congressional committees, officials who assisted our investigation, and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of Edwin P. Stropko, Assistant Director, Health Financing and Policy Issues. Please call him at (202) 512-7108 or Audrey Clayton at (202) 512-7133 if you have any questions about this report. Ann White also contributed to this report.

Sincerely yours,

Jonathan Ratner

Jonathan Ratner
Associate Director,
Health Financing Issues

Contents

Abbreviations

BCBS	Blue Cross Blue Shield
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NF	nursing facility
OBRA	Omnibus Budget Reconciliation Act of 1987
OIG	Office of Inspector General
OPT	outpatient therapy provider
OT	occupational therapy
PT	physical therapy
SNF	skilled nursing facility
UPIN	unique provider identification number

Scope and Methodology

To develop the information contained in this report, we visited HCFA's Region IV Office in Atlanta, since officials there first surfaced the issue of inappropriate billings for rehabilitation therapies, and HCFA was referring all inquiries to that office. We also visited Medicare claims processing contractors' offices in Arkansas, Florida, Georgia, and North Carolina. Between them, these contractors serve providers in at least 33 states and the District of Columbia. They process claims for more than 24 percent of all U.S. rehabilitation agencies participating in Medicare and 22 percent of the nation's SNFs, as shown in table I.1.

Table I.1: Skilled Nursing Facilities and Rehabilitation Agencies Covered by Contractors in GAO Sample

	Skilled nursing facilities		Rehabilitation agencies	
Contractor	Number covered	Percentage of U.S. total (n=11,443)	Number covered	Percentage of U.S. total (n=1,686)
Blue Cross Blue Shield of Arkansas	85	1	NA	NA
Blue Cross Blue Shield of North Carolina	320	3	36	2
Aetna of Florida	550	5	175	10
Mutual of Omaha	1,525	13	189	11
Total	**2,480**	**22**	**400**	**24**

Legend
NA=Not applicable.

Note: Totals affected by rounding.

In addition, we interviewed officials at HCFA's central office in Baltimore, the HHS Office of the Inspector General, the Department of Justice, and related trade associations. These groups represented nursing homes, rehabilitation agencies, state long-term care ombudsmen, and elderly citizens.

We obtained from these sources documentary examples of beneficiary and provider complaints, internal investigations and analyses, medical records, and other information to support officials' concerns. We did not independently verify the accuracy of this information.

We requested from HCFA nationwide data that would enable us to track rates of increase of Medicare costs for rehabilitation therapies for nursing home residents and to evaluate the validity of complaints of overcharging and excessive reimbursements.

We focused on therapy claims submitted to Medicare contractors by the providers—SNFs and rehabilitation agencies—that chiefly serve the elderly nursing home population. This was the most direct way of identifying increasing charges, since HCFA does not compile therapy data based on whether the beneficiary resides in a nursing home.

In analyzing these trends, we could not obtain consistent data sets because HCFA maintains SNF claims data on a fiscal year basis and rehabilitation agency claims on a calendar year basis. Consequently, we combined these data, adding a cautionary notation.

We used the nationwide HCFA data to the extent possible in computing average Medicare costs and identifying outliers. However, HCFA could not provide us with rehabilitation therapy charges for SNFs in terms of "units of service" (although contractors told us they report such data to HCFA). Accordingly, we combined data from a number of sources and—in our computations—made "best estimates" of unit costs using various assumptions explicitly identified at appropriate points in the report.

In some instances, after reviewing our draft, HCFA's Office of the Actuary provided us with data they believed to be more representative. We have substituted these numbers wherever appropriate.

Sample Complaint Letters

HCFA contractors shared with us their files of complaint letters received from a variety of sources, including beneficiaries and their families, physicians, and other providers. Emphasis shown was present in the originals. The excerpts reproduced here were selected because they include direct allegations of overcharging. As noted in the body of the report, investigations frequently reveal overcharges even when the complainant focuses on quality of care.

Beneficiary and Family Complaints

"I am writing this letter to Protest these charges . . .. I didn't have 'physical therapy' as the word implies. I was called in to purchase a 'dynamic splint' which in itself was a joke for the price of $900. I refused to accept the splint on behalf of my honest duty as a citizen for Medicare. The short time I spent at [the nursing home] with . . . the manager was to show me the splint which I refused to accept in name of Medicare. If this charge to Medicare is not corrected by your office I will make an official complaint to Medicare of this uncalled for charges. This uncalled for charges must be stopped and the problems brought to the surface. . .."

"I am writing you concerning a bill that was charged to my mother who was a patient at . . . nursing home in . . . North Carolina. At the time of this speech therapy, my mother was 95 years old and could not communicate with anyone so how they could give her speech therapy is beyond me . . .. They were paid $2,550 for doing nothing."

"As you can see the [nursing home] is trying to collect $1350 from my BCBS [Blue Cross Blue Shield Medigap policy]. I have never had a bill from them—the amount is exorbitant. The occupational girl spent only a few days giving me a bath . . . and a basket for my walker which she said Medicare would pay for. This charge is not right."

"I am writing because I think Medicare is being billed too much for the services rendered. My husband . . . is a patient in [a nursing facility] in . . . Ohio . . .. He suffered a stroke in April of 1990, . . . is paralyzed on one side and unable to communicate. Occupational therapy . . . was started in November, 1991 . . .. From November 20 through November 29, there were 13 visits or units which cost $2,678. From December 2 through December 31, there were 18 more visits or units which cost $3,708 . . ..

"I looked at the treatment chart and learned what a 'visit' consisted of. If the therapist goes into a room and hands my husband a comb for grooming, that is considered one 'visit' and [my husband] is billed $206. If she gives him a toothbrush to use, that is another 'visit' and another $206. If she gives him a washcloth so that he can wash his face, it's another 'visit' and another $206. If all three are done on the same day, the bill totals three 'visits' for the day and $618. I think that is too much for 1/2 hour of work . . .. My husband [also] has a splint on his right hand. If a therapist goes into his room to put the splint on his arm, the bill is $206. If she goes back later that day to see if the splint fits properly, it is another $206 . . ..

"I have been told not to worry about the expense because 'Medicare and your secondary insurance company will pay the bill'. But, I feel that there should be an investigation made to see if these charges are in line with services rendered."

"I thought you might be interested . . .. At [a tertiary care hospital where this writer, himself a physician, is employed], speech evaluations are all accomplished within one hour, most within a half hour. The charge for one half hour is $74, for one hour is $120. [The rehab agency serving the nursing home where his mother resides] charged $450 for an evaluation. [It] charged $85 per daily session for my mother's alleged occupation [sic] therapy. Ninety percent of occupational therapy visits at [the hospital] are for one-half hour and their charge is $66. The service at [the hospital] is given by a certified occupational therapist. My mother's [is given] by an untrained occupational therapy tech and counter-signed by an occupational therapist.

"In short, [the agency's] charges are usurious. If you are so naive as to be unaware of this, it would do yourself and your Board well to have such knowledge which can be gotten rather easily. Also, there is little need to contract with an outside-the-state organization [such as this agency]. I have checked with both hospitals in Manhattan and each provides outpatient [therapy] services in nursing homes in the . . . area."

Complaint From a Nursing Home Administrator

"Documentation is enclosed regarding two . . . residents who questioned the charges billed to Medicare by [a rehabilitation agency] . . .. In one case a 98 year old who has used a hearing aid for years is evaluated for hearing rehab potential 'at no charge,' the therapist told the nurses. Regardless, $450 is an outrageous charge for a hearing test.

"The other resident is an alert, 81 year old retired university professor who was in our SNF following surgery . . .. Here we have billings coordinated with documentation of events which did not occur! Also, the charges are for visits needlessly spread to various days most probably to increase the amount.

"The adaptive equipment charges over a three day period were for a long handled bath brush; long handled shoe horn; elastic shoe laces and shoe tongue tabs; plus a simple reaching device. From a catalogue of OT [occupational therapy] supplies we find that collectively the highest price of these items is nearly $85. Instead Medicare is charged $85 per each item in addition to the visits which are documented as 1st and 2nd modalities for three days. The visits were of the OT evaluation, simple delivering of the supplies, and other minimal contacts . . .. Too, the PT [physical therapy] charges are high for an uncomplicated hip replacement. You'll have comparative charges available, I'm sure . . .. We do not intend to renew the [rehabilitation agency] agreement for a third year.

"Frankly, since we initiated the contacts with your office and placed restrictions on the therapists' contact with residents the services have been very passive. In fact, we have found it necessary to arrange alternate speech therapy services due to [the rehabilitation agency] therapists being unavailable . . .."

A Physician's Complaint

"We are being urged even more vigorously to treat nearly every resident nearly continuously . . .. We were notified that a new group would be screening the residents for rehab potential . . . without consulting us, orders were written for evaluation and treatment of residents, which . . . we were supposed to sign without question since their 'screening' showed 'potential'. There were orders for speech therapy for chronically demented people who had been there for years!

"When an emergency meeting was arranged by us . . . we were told not to worry. They would be more than happy to write all the orders since 'most doctors don't have the time to write them and that orders had to be written according to guidelines'. . .. We were told 'don't worry, these services will all be paid by Medicare, Part B'. . .. I may be mistaken, but this seems like a self-referral issue with us supplying only our signatures and UPIN [unique provider identification] numbers . . .. The particularly disturbing fact . . . is that speech therapy orders and treatment plans include 6-12 months expected treatment. The cost of the therapy would dwarf all the other

costs of caring for the patient . . .. Potentially, every dementia patient could have 15-30 minutes of speech rehab five days a week at a weekly cost of $225-300 per week . . . this group wants to screen everyone in the facility every 6 months so any decline can be noted immediately and treatment done as soon as possible and extended as long as possible, in my opinion.

"Occupational therapy is a similar problem. Some specific examples include, a patient had a finger fracture. We ordered a splint. Two months later we discover that they were still following this patient with 'treatment rendered' 5 days a week . . . if we order splints for contractures, rather than measuring and ordering the splints and then beginning therapy, the patient is seen for the 2 to 4 weeks they say it takes for the splint to arrive and then therapy is continued for varying periods thereafter. The positioning devices that are recommended are incredibly expensive, according to family, and often plain pillows along with good nursing care would be just as beneficial. If costs are addressed, we are looked at with disbelief that this would be an issue and are told that they 'have to bill this amount because that is what Medicare allows . . .'

". . . Because of the OBRA mandates 'forbidding contractures,' we are being approached by orthotic companies to fit patients, who MIGHT have a problem in the future, with braces . . .. We have heard suppliers tell us not to worry because they intend to take what Medicare pays as payment in full. They will bill, but will not expect the patient to pay . . .."

Further Discussion of Medicare Reimbursements for Therapy Services

Medicare's system for processing and reimbursing therapy claims is complex. Reimbursement rates and procedures vary according to the patient's circumstances, who provides the services, and who submits the bills to Medicare. These factors also affect the type of contractor who reviews and processes the claims.

The Medicare program has two parts: Medicare part A (hospital insurance) helps pay for hospital care, inpatient care in a SNF, home health and hospice care. Part B (medical insurance) helps pay for doctors' services, outpatient hospital services, and other medical services and supplies not covered by part A. Either may cover therapy for nursing home residents, depending on the individual circumstances.

Beneficiaries meeting certain conditions—including a prior hospital stay and a need for skilled nursing or rehabilitation on a daily basis—may be covered by Medicare part A for a limited period during a SNF stay. This coverage would extend to necessary rehabilitation therapies, and no beneficiary copayment would be required. Beneficiaries residing in a SNF or NF who are not covered by part A, or whose benefits have been exhausted, may be entitled to receive the same therapies under part B but are required to pay a 20-percent copayment.

In general, Medicare-covered residents of any nursing home may receive therapy services provided by independently practicing therapists or by therapists employed by the nursing home or a rehabilitation agency.

The first option, according to HCFA, is rarely exercised. When it is, these claims are processed by a different type of contractor (termed a "carrier" by HCFA) that handles exclusively those services covered under part B. The therapist is reimbursed based on a fee scale established by Medicare and may receive no more than $900 per year, per patient. In 1993, the average charge for occupational therapy delivered by such therapists was $63.70 per hour (including record-keeping as well as time with patient).

All therapy services billed by an institutional provider, including SNFs and rehabilitation agencies, are processed by another type of contractor ("intermediary"), regardless of whether the services are covered under part A or part B. Where services are provided by nursing home employees, reimbursement is on the basis of "reasonable cost." Interim payments are made and reconciled at the end of the year through the nursing home's cost report (subject to the possibility of subsequent audit and further adjustments). In 1993, salaries for therapists employed by nursing homes,

adjusted for fringe benefits and other expenses, ranged from $17.60 to $36.66 per hour.

Therapy services provided by rehabilitation agencies may be charged to the SNF, which in turn bills Medicare, or billed directly by the agency if it has been certified as a Medicare provider. In the first instance, the SNF pays the agency its full charge and receives an interim payment from Medicare that is adjusted at year's end (and, potentially, after a subsequent audit) based on a review of its documented costs. If the rehabilitation agency bills Medicare directly, it is subject to the same process of interim payments and subsequent settlement.

Based on HCFA's 1993 data, the average charge billed to Medicare for a therapy treatment or visit under either of these options was $129 (which again includes record-keeping as well as time with patient). However, as noted in the body of this report, it is not possible to determine exactly what services were provided or the amount of time spent providing the service.

Illustration of the Financial Advantages of Shell Companies

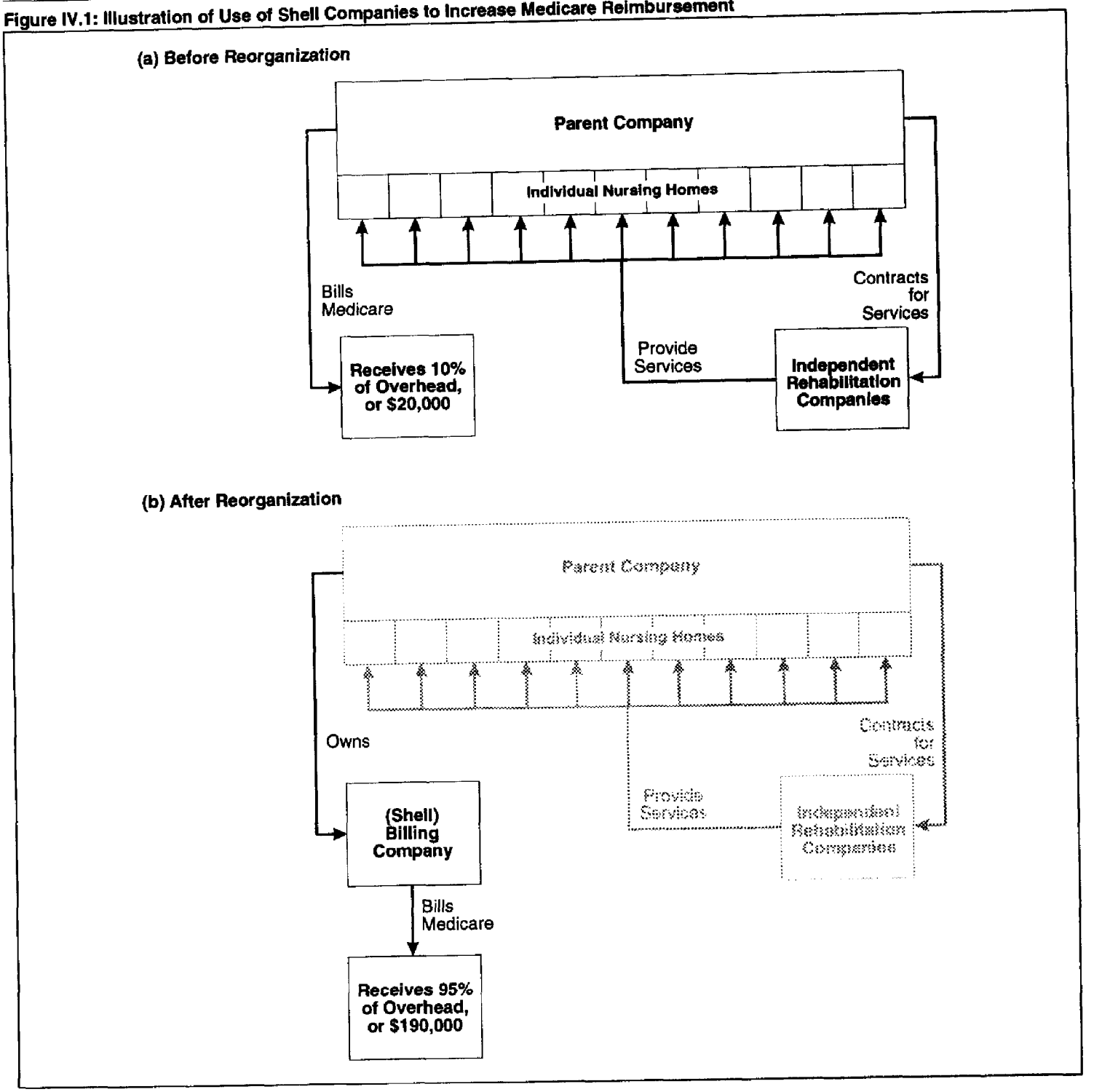
All providers reimbursed on the basis of reasonable cost can bill Medicare for a portion of their overhead. The computation of the precise percentage is complex, but it essentially reflects the proportion of the provider's total business that relates to Medicare-covered services. Where a nursing home parent corporation contracts for therapy services for its nursing home residents, the parent corporation frequently handles the billing for those services. In addition to the cost of the therapy, the corporation would receive Medicare reimbursement for a portion of its overhead—typically a low percentage, since therapy is only a small percentage of the total services delivered by nursing homes.

However, we found that Medicare rules created a strong financial incentive for one owner of a nursing home chain to establish a separate "rehabilitation agency," certified by Medicare, to handle its billings for therapy services. Because this agency's business was almost exclusively Medicare-related, it was entitled to reimbursement for a correspondingly high percentage of its overhead costs.

In 1992, the parent company owning both rehabilitation agencies and a chain of nursing homes incurred about $200,000 in overhead costs. Because of its structure—including a billing company recently established as a shell—Medicare reimbursed approximately 95 percent of these costs, or $190,000. Had these same costs been incurred a year earlier, prior to the establishment of the shell, Medicare would have reimbursed only about 10 percent, or $20,000, to the nursing home corporation for its home office overhead.

Figure IV.1 illustrates these two structures for providing and billing services. The original set-up is shown in section (a). At that time, the parent company billed Medicare for services provided to its nursing home residents. It was allowed a portion of its overhead corresponding to the percentage of Medicare-covered services as a share of its total business—about 10 percent.

Figure IV.1: Illustration of Use of Shell Companies to Increase Medicare Reimbursement



The structure following the reorganization is shown in section (b). Medicare billings were then handled by the billing company, certified as a rehabilitation agency. Because this shell company catered almost exclusively to Medicare patients, the allowable portion of overhead was about 95 percent. Thus, instead of $20,000, the parent company now received $190,000.

The difference in reimbursement level is attributable solely to the type of entity billing Medicare. Establishing the shell netted the parent company an additional $170,000 from Medicare, yet it incurred no additional costs. The shell was strictly a paper organization, with no separate employees or other expenses. The expenses reimbursed to the parent company were, in both cases, incurred at the home office of the nursing home corporation.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

FEB 21 1995

Ms. Sarah F. Jaggar
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Enclosed are the Department's comments on your draft report, "Medicare: Tighter Rules Needed to Limit Overcharges for Providing Therapy to Nursing Home Residents." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

June Gibbs Brown
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office (GAO) Draft Report, "Medicare: Tighter Rules Needed to Limit Overcharges for Providing Therapy to Nursing Home Residents

We have reviewed GAO's draft report on ways the Health Care Financing Administration (HCFA) could curb Medicare losses on payments for rehabilitation therapies provided to nursing home residents. We believe that GAO should emphasize that its report identifies a **potential** problem; the GAO report does not present findings of actual problems. In general, GAO's concerns about inappropriate billing and inappropriate delivery of therapy services support our concerns in this area. As GAO acknowledges in its report, we have taken a number of actions to prevent problems from arising, and we are developing still further measures.

We believe that one of the most effective means of controlling payments to providers is through reasonable cost limits on these services. GAO points out that without salary equivalency guidelines for all therapy services provided under arrangements to nursing homes, Medicare has no control over payments to providers. We believe that the application of salary equivalency guidelines to physical and respiratory therapy services furnished under an arrangement with an outside contractor has helped to control these costs. Therefore, HCFA has initiated the development of guidelines for speech language pathology and occupational therapy services.

While these reasonable cost limits are under development, we have initiated several additional efforts to curtail potential abusive practices. HCFA has provided instructions to the regional offices on methods for intermediaries to: identify abusive practices; disallow costs; and educate the provider community to correct these practices. HCFA has also developed audit instructions for intermediaries to use in reviewing therapy services claimed by providers and has held other intermediary conferences regarding appropriate billing of therapy services. These guidelines apply to contracted services provided to nursing homes, outpatient physical therapy providers, comprehensive outpatient rehabilitation facilities and home health agencies.

We believe the HCFA initiatives outlined above in addition to a strict application of program policy provide safeguards under the current payment rules that enable Medicare to limit the amount paid for services furnished under arrangements or by provider employees. Provider costs are subject to the test of reasonableness as required by regulations at 42 CFR 413.9, Cost Related to Patient Care, and Chapter 21, Costs Related to Patient Care, of the Provider Reimbursement Manual (PRM). As pointed out in PRM section 2103B, Prudent Buyer-Application of Prudent Buyer Principle, intermediaries may employ various means for detecting and investigating situations in which costs seem excessive.

Included may be such techniques as comparing the prices paid by providers to the prices paid by others. Intermediaries, in applying the prudent buyer principle, compare the price paid by providers for services with the amount paid by other purchasers of similar services.

The amounts paid by carriers can be used by Fiscal Intermediaries as an indication of what a prudent buyer would pay for such services. Therefore, in making prudent buyer determinations, the amount billed to a provider by the supplier may be compared with the amount paid by the carrier when the supplier bills the carrier for the same services. Also, providers should be prudent buyers in paying salaried employees for services. Accordingly, the prudent buyer policy should be applied to those costs.

GAO also recommended that a universal billing unit be determined for therapy services that would relate to the time spent in delivering these services. We agree that a standard unit of comparison would facilitate cost comparisons across units of service. We note that HCPCS (CPT-4) codes are used to describe services furnished by independent therapists and hospital outpatient departments. Since these codes have relative value units associated with them, they may be more appropriate than unit of service codes based on time only. We are investigating the feasibility under current statutory authority of requiring that the codes be used by all therapy providers.

Although we generally agree with GAO that nursing homes may be claiming substantial amounts of unallowable or unreasonable costs for services provided to Medicare beneficiaries, we believe that the GAO report does not present concerns about Medicare therapy charges and Medicare payments to providers on behalf of nursing home residents in a complete fashion, and may lead to misunderstanding. We have three notes of caution about the GAO report. First, we are concerned about GAO basing its findings on therapy **charges**, rather than actual payments. The basis for determining Medicare payments is intermediary audited reasonable **costs**, rather than charges made to nursing homes by suppliers. By basing its report on therapy charges, GAO implies that Fiscal Intermediaries pay the astronomical charges it has reported. Yet GAO does not report any findings that these charges have actually been paid by a Fiscal Intermediary. For example, the information contained in Table 1, Page 9, regarding Medicare reimbursement, may not be supportable. That is, GAO cannot definitively support the finding that Medicare is paying rehabilitation agencies and nursing homes $413 per hour for therapy. GAO acknowledges that these data have not been audited to determine Medicare's actual payment. We believe that GAO should clearly explain that the report identifies a **potential** problem, rather than an actual problem based on actual findings.

Table deleted from final report.

2

Second, to further understanding, it should be noted that Medicare pays for therapy services provided to nursing home patients under either Part A or Part B. Currently, services furnished to skilled nursing facility (SNF) patients can be billed to Medicare by either the SNF itself or by outside suppliers. If therapy services are billed by independent therapists, claims are paid under Part B and processed by Medicare carriers and paid under a fee schedule. If therapy services are billed by skilled nursing facilities, they can be paid under either Part A or Part B, and the services are paid by Fiscal Intermediaries on the basis of reasonable costs. Thus, the problem of overcharges for therapy may apply whether the services are covered under either Part A or Part B.

Third, we believe that the report needs to be clarified regarding total expenditures for therapy services. The report states, "Approximately 60 percent of nursing home residents now receive at least some type of therapy, and Medicare's expenditures for these services have grown dramatically, from $4.8 billion in 1990 to $10.4 billion in 1993." However, in a footnote, it is indicated that these totals apply to therapies delivered in all settings, not just nursing homes. The GAO report should clearly explain that these expenditures cover a wide range of services provided in many settings, and not just therapy services provided in nursing homes. To determine the extent of Medicare payments for therapy services in nursing homes, it is important to determine Medicare Part A and Part B payments to nursing homes for therapy services, and Medicare Part B payments to other rehabilitation providers furnishing services to Medicare nursing home patients. This explanation should be in the body of the report, not in a footnote.

Technical Comment

The GAO report suggests that the problem of overbilling for therapies is national in scope. In fact, the incidence of very high Medicare therapy costs (charges in excess of $3,501 per stay for therapies delivered as part of a Part A SNF stay) vary considerably across the States. The problem appears to be concentrated in a few States where the Medicare population is largest and where access to therapy services is greatest; approximately 37 percent of 'high end' stays occur in three States--California, Florida and Pennsylvania.

It is important to bear in mind that the Omnibus Budget Reconciliation Act of 1987 nursing home reforms were designed to improve the access to therapy for Medicare beneficiaries. What the research cited above suggests is that access to therapy for Medicare beneficiaries is still sporadic, depending mostly upon one's area of residence.

3

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (301) 258-4097 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Mail
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested