Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HIGHLANDS OF LITTLE ROCK WEST MARKHAM HOLDINGS, LLC: AUDIT OF DOCUMENTATION OF THERAPY RESOURCE UTILIZATION GROUPS

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Office of Inspector General

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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.

Report in Brief
Date: November 2019
Report No. A-06-18-08003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Highlands of Little Rock West Markham Holdings, LLC: Audit of Documentation of Therapy Resource Utilization Groups

Why OIG Did This Audit

Skilled Nursing Facility (SNF) claims include Resource Utilization Groups (RUGs) that identify whether a beneficiary received therapy and the range of therapy minutes provided. For example, SNF claims with a RUG that begins with "RU" or "RV" indicate that an ultra high or very high level of therapy was provided and that during a 7-day period, the beneficiary received 720 minutes or more, or 500 to 719 minutes of therapy, respectively. The higher the volume of therapy services provided, the higher the Medicare payment.

Our previous work found that SNFs billed for higher levels of therapy RUGs than were supported.

Our objective was to determine whether the therapy minutes associated with Highlands of Little Rock West Markham Holdings, LLC's claims containing ultra high or very high therapy RUGs were properly supported.

How OIG Did This Audit

Our audit covered $2.5 million in Medicare payments for 363 SNF claims for services provided from October 1, 2016, through September 30, 2017, at Highlands. We selected for review a stratified random sample of 100 SNF claims with payments totaling $882,159.

What OIG Found

Highlands did not properly support all therapy minutes because it inappropriately included unskilled time for electrical simulation therapy for 14 of the sample claims. The errors occurred because the SNF staff did not understand that unskilled time should not be included in the Minimum Data Set (MDS) minutes. As a result, the SNF was overpaid $17,430 for the sample claims. Based on the sample results, we estimate the SNF was overpaid $25,494 during our audit period.

What OIG Recommends and Highlands' Comments

We recommend Highlands:

- refund the $25,494 in questioned costs, and
- educate staff to only include skilled minutes for MDS purposes.

Highlands declined to comment on the draft report.

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INTRODUCTION

WHY WE DID THIS AUDIT

A skilled nursing facility (SNF) is an institution that provides skilled nursing care; rehabilitation services, such as physical, occupational, or speech therapy; and other services, such as assistance with eating, bathing, and toileting to beneficiaries who need skilled assistance after a hospitalization. SNF claims include Resource Utilization Groups (RUGs) that identify whether a beneficiary received therapy and the range of therapy minutes provided. For example, SNF claims with a RUG that begins with "RU" or "RV" indicate that an ultra high or very high level of therapy was provided and that during a 7-day period, the beneficiary received 720 minutes or more, or 500 to 719 minutes of therapy, respectively. The higher the volume of therapy services provided, the higher the Medicare payment.

Previous Office of Inspector General (OIG) work found that SNFs billed for higher levels of therapy RUGs than were supported. We selected for review the SNF at Highlands of Little Rock West Markham (Highlands) in Little Rock, Arkansas, because during a 1-year period, 92 percent of its RUGs were for ultra high or very high therapy, and the therapy minutes for 89 percent of those RUGs were within 10 minutes of the minimum number of minutes required to bill for ultra high or very high therapy.

OBJECTIVE

Our objective was to determine whether the therapy minutes associated with Highlands' claims containing ultra high or very high therapy RUGs were properly supported.

BACKGROUND

Medicare Part A

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services, such as SNF services, for beneficiaries after discharge.

Skilled Nursing Facility Services

SNF services must be (1) ordered by a physician and provided by, or under the supervision of, skilled nursing or rehabilitation professionals, and (2) be for a condition previously treated during an inpatient hospital stay. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis. Daily skilled services must be services that, as a practical matter, can only be provided in a SNF, on an inpatient basis (42 CFR § 409.31). Daily skilled services include physical, occupational, and speech therapy.

SNF personnel record a beneficiary's functional status and therapy services provided, if any, during 7-day assessment periods using a data collection tool called the Minimum Data Set (MDS) to classify Medicare beneficiaries into RUGs. The therapy minutes reported in MDS are a contributing factor in determining the RUGs for billing purposes. According to the Centers for Medicare & Medicaid Services (CMS) guidance:

> Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met . . .) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS.[1]

Payment varies based on the actual therapy minutes received by the beneficiary and reported on the MDS.

Table 1: Therapy Categories and Number of Therapy Minutes

Therapy Level	Therapy Minutes Received During the 7-day Period
Ultra High	720+
Very High	500–719
High	325–499
Medium	150–324
Low	45–149

HOW WE CONDUCTED THIS AUDIT

Our audit covered $2,542,216 in Medicare payments for 363 SNF claims for services provided from October 1, 2016, through September 30, 2017, at Highlands. We selected for review a stratified random sample of 100 SNF claims with payments totaling $882,159. We utilized a medical review contractor to review each 7-day assessment period associated with our sample of 100 claims to ensure minutes were supported in the records.

We did not review the overall internal control structure at Highlands. Rather, we limited our review of internal controls to those applicable to ensuring SNF therapy claims were supported.

[1] CMS *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,* Versions 1.13 (October 2015) and 1.14 (October 2016), chapter 3, page O-27.

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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains the sampling results and estimates.

FINDING

Only time that is skilled shall be recorded on the MDS. Therapist time during a portion of a treatment that is unskilled may not be included.[2]

Highlands did not properly support all therapy minutes because it inappropriately included unskilled time for electrical stimulation therapy for 14 of the sampled claims. The errors occurred because the SNF staff did not understand that unskilled time should not be included in the MDS minutes. As a result, the SNF was overpaid $17,430 for the sampled claims. Based on the sample results, we estimate the SNF was overpaid at least $25,494 during our audit period.

RECOMMENDATIONS

We recommend that the skilled nursing facility at Highlands of Little Rock West Markham:

- refund the $25,494 in questioned costs, and
- educate staff to only include skilled minutes for MDS purposes.

HIGHLANDS' COMMENTS

Highlands declined to comment on the draft report.

[2] CMS *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, Versions 1.13 and 1.14, chapter 3, page O-19.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $2,542,216 in Medicare payments for 363 SNF claims for services provided from October 1, 2016, through September 30, 2017, at Highlands. We selected for review a stratified random sample of 100 SNF claims with payments totaling $882,159. We utilized a medical review contractor to review each 7-day assessment period associated with our sample of 100 claims to ensure minutes were supported in the records.

We did not review the overall internal control structure of Highlands. Rather, we limited our review of internal controls to those applicable to ensuring SNF therapy claims were supported.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS guidance;
- held discussions with SNF officials to gain an understanding of therapy services, medical documentation, and billing;
- reviewed the SNF's internal controls related to therapy claims;
- obtained paid SNF claims and MDS therapy minutes for the audit period;
- selected for review a stratified random sample of 100 SNF claims;
- obtained and compiled medical records necessary to support each sampled claim;
- engaged a medical review contractor to review the medical records;
- repriced claims that contained unsupported minutes using CMS's SNF Pricer Program;
- estimated the dollar value of overpayments based on our sample results; and
- held discussions with CMS and discussed the results of our audit with SNF officials.

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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of paid SNF claims for this facility, with dates of service between October 1, 2016, and September 30, 2017, where each claim had an ultra high or very high rehabilitation RUG and covered at least 8 days of services.

SAMPLING FRAME

We obtained a data file that contained 392 paid SNF claims. We removed claims that contained non-covered and leave of absence days, did not have at least one ultra high or very high RUG, and were identified as being reviewed by the Recovery Audit Contractor. The resulting sampling frame contained 363 claims totaling $2,542,216.

SAMPLE UNIT

The sample unit was a paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We selected a stratified random sample of 100 claims from three strata described in Table 2.

Table 2: Stratified Random Sample

Stratum	Strata Bounds (Claim Payments)	Number of Paid Claims	Value
1	> $358 and < $6,982	197	$761,595.30
2	>= $6,982 and < $10,817	105	927,628.51
3	>= $10,817 and < $33,421	61	852,992.07
Total		**363**	**$2,542,215.88**

We selected 34 claims from Stratum 1, 33 claims from Stratum 2, and 33 claims from Stratum 3.

SOURCE OF RANDOM NUMBERS

The random numbers were generated using the OIG-OAS statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the claims within each stratum. After generating the random numbers for each stratum, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the dollar value of overpayments. We also used this program to calculate the lower limit of the 90-percent confidence level.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Frame Value	Sample Size	Sample Value	Number of Claims with Overpayments	Values of Overpayments in Sample
1	197	$761,595.30	34	$116,635.23	3	$749.52
2	105	927,629.51	33	297,801.58	5	3,911.91
3	61	852,992.07	33	467,722.61	6	12,768.56
Totals	**363**	**$2,542,215.88**	**100**	**$882,159.42**	**14**	**$17,429.99**

ESTIMATES

Estimated Value of Unsupported Claim Amounts
(Limits Calculated for 90-Percent Confidence Interval)

Point estimate	$40,392
Lower limit	$25,494
Upper limit	$55,291