

Questionable Billing by Skilled Nursing Facilities

An editorial view of the Office of Inspector General's Report on billing practices in Skilled Nursing

Late in December, 2010, the OIG issued 2 reports, one on services provided in the outpatient (OPT) setting and the other in the Part A SNF setting. This article addresses the SNF findings along with editorial comments.

In recent years the OIG has found a number of problems with SNF billing for Part A services. One of their reports found that 26% of claims submitted were *not supported* by the medical record representing over \$500 million in potential overpayments. Along with these findings the Medicare Payment Advisory Commission raised concerns over facilities *improperly billing for therapy in order to obtain additional Medicare payments*. (Now just who would do such a thing I have to ask?) This OIG study was based on analysis of claims from 2006 to 2008.

Here is a synopsis of the findings.

1). During the timeframe under review, *SNFs increasingly billed for higher paying RUGs, even though the beneficiary characteristics remained almost the same*. Ultra High therapy increased from 17% to 28% and high ADL scores increased from 30% to 34%, even though beneficiaries ages and diagnoses on admission were largely unchanged. This shift to higher paying RUGs increased payments for Ultra High from \$5.7 billion to \$10.7 billion, an increase of over 90%. The resultant decrease in the other levels reduced those payments by nearly \$750 million showing a decrease of 19% in non-therapy RUGs. Although billing was increased significantly for the higher paying RUGs, the beneficiary characteristics of ages and diagnoses in admission were largely unchanged. The average age remained almost the same 79.9 to 79.8 and the top 20 admitting diagnoses were identical and amounted for over 50% of all admissions. (see appendix at the end of this report for diagnoses.)

2). *For-profit SNFs were more likely to bill higher paying RUGs than nonprofit and government SNFs*. In for profit SNFs, 32% of RUGs were in the Ultra High categories, compared with 18% in nonprofit and 13% in government SNFs. For profit SNFs also had a higher use of RUGs with high ADL scores and had a longer length of stay (LOS) than the other two types of SNF. There was no apparent difference in beneficiary population AND for profit SNFs owned by large chains were more likely to bill higher RUGs than those owned by small chains or individuals.

For profit SNFs accounted for 69% of all SNFs in 2008. In defining a large chain, the OIG benchmarked at over 100 facilities for large chains. The report also noted that the billing for SNFs purchased by large chains changes soon after the purchase. They also identified that nine large for profit chains acquired 159 SNFs during the period under review. In all 9, the percentage for Ultra High RUGs increased in the new SNFs and in 3, the increase was at least 9%. In 8 of the chains the ADL levels increased with 3 chains having at least 5% increase. It also noted that in 6 of the chains the average LOS increased with the average ranging between 1 and 15 days. (Unfortunately, the report does not identify these chains but I am sure that those of you in the field know just who they are!)

3). *A number of SNFs had questionable billing in 2008, frequently billing for higher RUGs and having longer LOS than other SNFs*. Based on these billing patterns, the OIG determined that these SNFs (the top 1%) may be *routinely* placing beneficiaries into higher paying RUGs, regardless of the beneficiaries care and resource needs or keeping beneficiaries longer. The OIG identified 348 SNFs that were in the top 1% for the use of Ultra High therapy, RUGs with high ADL scores, or long average LOS. (309 were for profit with more than 50 owned by 4 chains).

On average, in three quarter of SNFs, up to 39% of RUGs are in the Ultra High categories and up to 43% have high ADL scores. In this top 1% group, at least 77% were in the Ultra High and 76% had high ADL scores. Also the average LOS for most SNFs is 34 days, in this group the average LOS was at least 48 days.

Conclusion by the OIG.

These finding raised concerns about the potentially inappropriate use of higher paying RUGs, especially the Ultra High category and deduced that the payment system offered incentives to place beneficiaries into these categories when that level of care was not needed. The report acknowledged that a new payment system was being introduced but felt that MORE needed to

be done to reduce this potential for abusive billing practices. The OIG provided four recommendations to CMS of which CMS concurred with three.

The OIG Recommendations:

1) ***Monitor overpayments to SNFs and Adjust rates if necessary.*** CMS should monitor overall payments to SNF and make adjustments annually to the RUG rates.

CMS response: It will assess the impact of recent changes as data becomes available and would expect to recalibrate RUG rates as appropriate

2) ***Change the current method for determining how much therapy is needed to assure appropriate payments.*** CMS should consider requiring each SNF to use the beneficiary's hospital stay diagnosis and other information from the hospital stay to better predict the beneficiary's therapy needs. Also CMS should consider requiring that therapists with no financial relationship to the SNF determine the amount of therapy needed throughout the beneficiary stay as well as considering developing guidance that specifies the type of patients for whom each level of therapy, including Ultra High, is appropriate.

CMS response: CMS did NOT concur but stated that is committed to pursuing additional improvements to the payment system. They had concerns with relying on the hospital stay to determine the beneficiary needs.

3) ***Strengthen monitoring of SNFs that are billing for higher paying RUGs.*** CMS should instruct its contractors to monitor SNFs' use of higher paying RUGs using the indicators discussed and develop thresholds for the indicators and instruct its contractors to conduct additional reviews of SNFs that exceed them. If SNFs from a particular chain frequently exceed the thresholds, then additional reviews should be conducted of the other SNFs in that chain.

CMS response: CMS concurred and will determine whether additional safeguards should be put in place by Medicare contractors

4) ***Follow up on the SNFs identified as having questionable billing practices.*** The OIG will send CMS a separate memorandum to list the identified SNFs with questionable billing for CMS to follow up on.

CMS response: Concurred with the recommendation and will send the list to the appropriate contractor for follow-up.

What should we do based on this report?

What has happened with the advent of MDS 3.0 and RUGs IV is presently too early to tell. The first RUGs report under the new system would have normally be posted by the middle of February. If we will get it soon we will have to see, but it should start to provide an idea of where the LTC companies are planning to go. We can be sure that the pressure will be on the Medicare contractors to perform more Medical Reviews and, based on the report, we should have a reasonable idea of whether the companies we work for will be in that target areas. This report can be found on the CMS website at

http://www.cms.gov/MDSPubQIandResRep/07_rugsreport.asp#TopOfPage

Enter the quarter you want and submit. The first page shows the national averages for all RUG levels. Scroll to the bottom of the page and select your State. You can then compare your facility stats with those nationally and statewide.

Looking at the red flags: large percentage of patients in the high paying RUGs, patients with high ADL scores, C, X and L. and long lengths of stay. Dramatic changes in provision of therapy services in and out of the observation periods. Therapy for patients with predominantly nursing diagnoses.

What can we learn from the OIG report?

What the report indicated was what many of the therapists working in SNFs have been dealing with for years. The pressure to place patients in the high therapy levels has lead in some instances to a feeling of complacency among many. This pressure is even more apparent for the contract therapy companies that want to provide the most appropriate level of services and be compliant with the Medicare regulations but are informed that if they (the contract company) won't put the patient in high RUGs or keep them longer then they will get another contract company that will.

The end result is that if we don't change the way that we perform in the SNF, CMS will do it for us. For those of us around in the 90's, it was a time of plenty. Through being reimbursed for our cost and the lack of Government oversight created a mindset

that the facilities could do what they wanted. The use of the whole 100 day Medicare benefit was not the rarity. The pendulum swung the other way with the advent of PPS in 1999 and the profitability of owning SNFs was not sure. In the last 10 years, the pendulum has swung almost all the way back to pre-1999, with Long Term Care Companies gobbling up small facilities and almost disdain for the Medicare guidelines or even the beneficiary. The quality of care has also decreased as the push to get everyone into that Ultra or Very High levels and productivity expectations have risen to over 100% (I even heard of a 200% expectation).

My recommendations are to make sure you and your staff:

1. Are aware of the Medicare coverage guidelines and regulations for skilled therapy as identified in the RAI manual.
2. Obtain your own copy of the RAI manual to ensure YOU know what's right. Don't depend on your management, especially if working for a large chain
3. Educate the patient on what Medicare will and will not cover, remember, just because they have a 100 day benefit period doesn't mean that Medicare is automatically cover them for long periods.
4. Consider utilizing restorative nursing for maintenance/non-skilled services. For those of you in facilities that cater to a clientele that expects to have lots of therapy when that cannot be justified, this can be an appropriate compliant alternative,
5. Remember you are the professional and should do what is clinically appropriate for the beneficiary. Only you can protect your license.
6. Document what you do that is skilled to support the time you are spending with the patient. In the RAI manual it clearly identifies only skilled therapy minutes can be entered on the MDS. Make sure you know what skilled minutes are.

And Finally!

Not sure if you are up to date with the Medicare guidelines and documentation standards and if you would withstand review? Then plan on attending our live workshops or think about having customized training for your staff.

A copy of the OIG report can be found on our website in the Guidelines and Resource section (formerly Items of Interest) in the SNF section

Table C-2: The Distribution of Beneficiaries' Diagnoses at Admission From 2006 to 2008				
Beneficiaries' Admitting Diagnoses*		Percentage of Part A Stays		
		2006	2008	Percentage-Point Difference**
Top 20 Diagnoses (International Classification of Diseases, Ninth Revision)				
V57	Care involving use of rehabilitation procedures	12.1%	17.0%	4.9
V54	Other orthopedic aftercare	3.7%	4.2%	0.5
486	Pneumonia organism unspecified	4.3%	4.1%	-0.2
428	Heart failure	4.4%	3.8%	-0.6
780	General symptoms	3.6%	3.8%	0.2
599	Other disorders of urethra and urinary tract	3.1%	3.1%	0.0
820	Fracture of neck or femur	3.4%	2.7%	-0.7
496	Chronic airway obstruction not elsewhere classified	2.1%	2.0%	-0.1
V58	Encounter for other and unspecified procedures and aftercare	1.9%	1.9%	0.1
728	Disorders of muscle, ligament, and fascia	1.4%	1.9%	0.5
715	Osteoarthritis and allied disorders	2.1%	1.8%	-0.3
401	Essential hypertension	1.7%	1.7%	0.0
438	Late effects of cerebrovascular disease	1.7%	1.6%	-0.2
250	Diabetes mellitus	1.8%	1.6%	-0.3
436	Acute but ill-defined cerebrovascular disease	1.9%	1.4%	-0.5
427	Cardiac dysrhythmias	1.4%	1.4%	-0.1
682	Other cellulitis and abscess	1.4%	1.3%	-0.1
719	Other and unspecified disorders of joint	1.3%	1.3%	0.0
781	Symptoms involving nervous and musculoskeletal systems	1.1%	1.2%	0.1
799	Other ill-defined and unknown causes of morbidity and mortality	1.3%	1.2%	-0.1
All Other Diagnoses		44.2%	41.1%	-3.1
Total**		100.0%	100.0%	

* The diagnoses are sorted in descending order by the frequency in 2008.

** Percentages may not sum to 100 percent and may not equal the percentage-point difference because of rounding.

Source: Office of Inspector General analysis of Part A skilled nursing facility claims, 2010.