

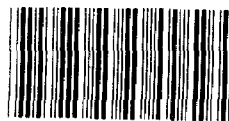
GAO

Report to the Administrator, Health Care
Financing Administration, Department of
Health and Human Services

July 1987

MEDICARE

Rehabilitation Service Claims Paid Without Adequate Information



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

Human Resources Division

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July 9, 1987

William Roper, M.D.
Administrator, Health Care Financing
Administration
Department of Health and Human Services

Dear Dr. Roper:

This report discusses the need to improve the processes Medicare fiscal intermediaries use to review claims for outpatient rehabilitation services. We undertook this review because outpatient services became an important alternative source of care under Medicare's prospective payment system when that system gave hospitals incentives to discharge beneficiaries as quickly as medically appropriate.

This report contains recommendations to you on page 35. We would appreciate receiving your comments within 30 days on whatever action you take or plan to take regarding our recommendations.

We are sending copies of this report to the Secretary of Health and Human Services, the Department's inspector general, and other interested parties.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

Executive Summary

Purpose

Medicare covers outpatient rehabilitation services, such as physical and speech therapy, only when the services can be reasonably expected, within a predictable time, to significantly improve a bodily function impaired by illness or injury. GAO wanted to ascertain (1) if, before paying claims, Medicare's claims-processing contractors had sufficient information on which to base a determination about whether the beneficiary's condition established eligibility for outpatient rehabilitation and (2) whether the services provided met the conditions of coverage.

Since 1983, when Medicare began to phase in its hospital prospective payment system, outpatient rehabilitation has become an important alternative source of therapy because prospective payment has given hospitals incentives to discharge beneficiaries to outpatient care as soon as medically appropriate.

Background

Over the years, the Congress has expanded Medicare to cover outpatient rehabilitation because these services should be less costly than rehabilitation in a hospital. Medicare coverage of outpatient physical therapy furnished by hospitals and rehabilitation agencies began in July 1968. Beginning in January 1973, rehabilitation agencies could also be paid for speech therapy services, and, starting July 1981, the Congress added Comprehensive Outpatient Rehabilitation Facilities (CORFs) to the types of providers eligible for Medicare payment. In addition to physical therapy and speech therapy, CORFs can be paid for occupational therapy and various other kinds of rehabilitation services.

As of April 1987, there were 903 rehabilitation agencies and 117 CORFs certified to participate in the Medicare program. In 1984 (the latest year for which data were available), records of the Health Care Financing Administration (HCFA) indicate that Medicare paid about \$1 billion for outpatient rehabilitation services. To assess the payment controls over these services, GAO visited three Medicare claims-processing contractors. One processed only rehabilitation agency claims; the second, only CORF claims; and the third, both. The two that processed rehabilitation agency claims accounted for about a third of all such charges. GAO randomly sampled 346 beneficiary cases and reviewed the documentation supporting the claims for them (a given case could have several claims).

Documentation needed to establish initial eligibility for rehabilitation services includes (1) a medical history providing the basis for rehabilitation, (2) an evaluation of the beneficiary's condition against which therapy goals can be measured, and (3) a treatment plan listing the therapy to be provided and its expected goals. Documentation to support the continued eligibility for rehabilitation includes progress notes on the beneficiary and an itemization of the services provided.

GAO also reviewed the internal control processes of the contractors and the actions taken to improve such processes by HCFA, which administers Medicare.

Results in Brief

The documentation, available to the claims-processing contractors when they paid outpatient rehabilitation services claims, was insufficient to determine whether the beneficiary was eligible for these services in 96 percent of GAO's sample cases. Two contractors, during a 2-year period, paid claims for about \$50.2 million in charges without the information necessary to determine eligibility for payment. A projection for CORFs could not be made because the claims-processing contractors could not identify the universe of charges submitted by CORFs.

Many of the cases in GAO's sample were of types indicating that services probably were not eligible for coverage. For example, 16 percent of the cases were for beneficiaries with diagnoses that HCFA has identified as normally having little rehabilitation potential.

HCFA has taken some actions to strengthen controls over payments for outpatient physical therapy and services provided by CORFs, but GAO believes that unless the documentation of claims is improved, these actions will not solve the problem. HCFA needs to clarify what documentation of claims must be included for outpatient physical therapy, CORF services, and other types of outpatient rehabilitation services.

Principal Findings

Eligibility for Services Not Established

GAO found that in 29 percent of the 346 sample cases reviewed, the files of the providers or claims-processing contractors lacked a patient treatment plan, an evaluation, or a medical history—all necessary for determining a beneficiary's rehabilitation potential.

In addition, GAO found that in 67 percent of the cases (94 percent of the cases that contained all three types of documentation), the documents were incomplete or not specific and, therefore, inadequate for determining the beneficiary's rehabilitation potential. For an approximate 2-year period, GAO estimated that claims with about \$50.2 million in charges were paid for rehabilitation agency services by the claims-processing contractors without sufficient documentation. (See pp. 16-20.)

GAO reviewed 1,101 claims and supporting progress data for the sample beneficiaries. The majority of them lacked sufficient information to determine the beneficiary's continued eligibility for rehabilitation services. About 9 percent of these inadequately documented claim files did not contain progress notes. For another 73 percent, documentation in the claim files did not describe the beneficiary's progress in measurable terms that could be compared with the beneficiary's treatment goals, or the progress notes did not describe the types and amounts of services that the beneficiaries received. (See pp. 22-25.)

A lack of documentation does not necessarily mean that the services provided were not eligible for coverage. To assess the likelihood of coverage of the undocumented services, GAO looked at the type of beneficiaries receiving services and the length of time services were provided. HCFA has stated that beneficiaries with certain types of diagnoses, such as Parkinson's disease and advanced arthritis, are usually not good candidates for rehabilitation services because of the progressive, debilitating nature of these illnesses.

Overall, 16 percent of the cases GAO reviewed were for beneficiaries with these diagnoses, and none of the files contained information to indicate that the beneficiaries were good candidates for rehabilitation. (See pp. 20-21.) In addition, HCFA has proposed length-of-treatment norms for certain diagnoses that occur frequently, including circulatory disorders, bursitis, and some fractures. About 43 percent of GAO's sample cases involved beneficiaries with these diagnoses, and, overall, 36 percent of them exceeded the norms. (See pp. 32-33.) GAO believes that these two factors indicate that many of the cases and services that were insufficiently documented probably were not eligible for coverage.

Additional Action to Improve Controls Needed

In response to several internal HCFA and the Department of Health and Human Services' Office of the Inspector General reports produced in 1982-83 (see pp. 28-30), HCFA took some actions to improve internal controls over outpatient rehabilitation payments. First, in 1985 HCFA

required that all CORF claims receive a medical review to determine coverage by the claims-processing contractor. However, GAO believes that this action, most likely, will be less effective than HCFA anticipated for this reason: in GAO's sample cases, there was little difference in documentation deficiencies between cases that had a medical review and those that did not. (See pp. 30-31.) Until documentation requirements are clarified, medical reviews will probably not be very effective.

Second, HCFA has developed and is planning to issue physical therapy guidelines. Although these guidelines address the adequacy and content of documentation, they only cover physical therapy, not the other forms of outpatient rehabilitation therapy. These guidelines also do not apply to physical therapy services provided by CORFs. (See pp. 31-32.)

Recommendations

The Administrator of HCFA, after complying with the appropriate regulatory clearance process, should implement the physical therapy guidelines and utilization screens already developed and require intermediaries to apply them to rehabilitation physical therapy services provided in all outpatient settings, including CORFs. The Administrator should also (1) develop and implement guidelines that clearly identify the document types and contents needed by intermediaries to make appropriate Medicare coverage decisions for the other types of outpatient rehabilitation therapy services and (2) require intermediaries to use the guidelines for reviewing providers' claims for rehabilitation services.

Agency Comments

GAO did not obtain formal agency comments on a draft of this report. However, during its work, GAO did obtain comments from responsible officials, which are incorporated in the report.

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Abbreviations

CORF	Comprehensive Outpatient Rehabilitation Facility
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of the Inspector General, Department of Health and Human Services
OMB	Office of Management and Budget

Introduction

This report discusses claims payment controls needed to assure that rehabilitation services provided to Medicare beneficiaries are covered under the program. Rehabilitation services, such as physical therapy and occupational therapy, speech pathology, and social services, provided by rehabilitation agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs) are usually provided to beneficiaries who have been deprived of the use of one or more of their limbs by injury or illness. The services, designed to restore such use, are covered under the Medicare program if they (1) are reasonable and necessary for the treatment of a beneficiary's condition and (2) may be expected to significantly improve the beneficiary's condition within a reasonable and predictable period of time.

The Medicare Program

Medicare is a federal health insurance program that pays much of the health care costs for most Americans aged 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. Medicare, begun in 1966, provides two types of health insurance protection for the aged and disabled—part A (hospital insurance) and part B (supplemental medical insurance).

Part A covers inpatient hospital care, home health care, hospice care, and inpatient care in skilled nursing facilities. Hospital insurance is primarily financed by Social Security payroll taxes from employers, employees, and the self-employed. Part B covers physician services, outpatient hospital services, certain home health care, and other medical and health services, including rehabilitation services provided by CORFs and rehabilitation agencies. This medical insurance plan is a voluntary program financed by general revenues (75 percent of total costs) and monthly premiums paid by beneficiaries.

On July 1, 1968, outpatient physical therapy services provided through hospitals or freestanding or hospital-based rehabilitation agencies became reimbursable under part B of the Medicare program. In January 1973, rehabilitation agencies were also authorized to provide speech pathology services. By July 1985, there were 853 Medicare-certified rehabilitation agencies nationwide, a 26-percent increase over the 678 that were certified as of June 1983. By mid-April 1987, the number of certified rehabilitation agencies had grown to 903. Rehabilitation agencies may provide services at the agency's location or at another location, such as a nursing home or the beneficiary's home.

Before July 1981, outpatient occupational therapy or psychological services were reimbursable only if they were provided through hospitals, so Medicare beneficiaries needing those services could not easily obtain them if they did not live near a providing hospital. To remedy this situation, effective July 1, 1981, the Congress added CORFs to the category of providers entitled to reimbursement under the Medicare program. In addition to the physical therapy and speech pathology services that may be provided by rehabilitation agencies, CORFs may provide, in a coordinated fashion, other rehabilitation services in a nonhospital setting. A major difference between CORFs and rehabilitation agencies is that all CORF services—including physical therapy and speech pathology services—must be performed by or under the supervision of a physician at the CORF location. In February 1983, only one Medicare-certified CORF was operational. By July 1985, 72 CORFs had been certified, and, by mid-April 1987, the number had increased to 117.

The Health Care Financing Administration (HCFA) did not have records that allowed us to identify payments to CORFs and rehabilitation agencies for rehabilitation services; however, HCFA records indicate that Medicare reimbursed all outpatient providers, including CORFs and rehabilitation agencies, about \$1 billion for rehabilitative services during calendar year 1984 (the latest year for which data were available).

Program Administration

HCFA, within the Department of Health and Human Services (HHS), administers the Medicare program. This includes establishing policy for the operation of the Medicare program. HCFA contracts with Blue Cross and Blue Shield plans and commercial insurance companies, such as Aetna Life and Casualty and Mutual of Omaha, to process and pay claims for services covered by part A and for services covered by part B that are provided by institutional providers (including rehabilitation agencies and CORFs). These contractors are called intermediaries.

HCFA is responsible for developing policies, procedures, and guidance related to program beneficiaries, providers of services, and intermediaries. As they process and pay claims and make coverage decisions, the intermediaries have substantial discretion in interpreting HCFA's policy guidance.

In processing claims for rehabilitation services, an intermediary must make several determinations, including these two key ones:

- Does the beneficiary's condition at the time he or she enters a rehabilitation program make him or her eligible for Medicare-covered services?
- While in the rehabilitation program, has the beneficiary's condition changed in a way that would affect his or her continued eligibility for rehabilitation services?

Because rehabilitation services often stretch over several months, an intermediary may ask a provider to submit information only once to answer the first question. After the intermediary reviews that data and determines that the beneficiary is eligible for program reimbursement for services, subsequent claims need only demonstrate that the beneficiary remains eligible for services and that the services provided were reasonable and necessary.

Objectives, Scope, and Methodology

The objective of our review was to determine the appropriateness of Medicare payments made by intermediaries to rehabilitation agencies and CORFs for rehabilitation services under the Medicare program. We undertook this effort because, when Medicare began paying hospitals under its prospective payment system on October 1, 1983, hospitals had increased incentives to discharge beneficiaries earlier; it was anticipated that this, in turn, would increase the use of posthospital care, including outpatient rehabilitation services. We wanted to determine if adequate controls existed to assure that only covered rehabilitation services were paid for by Medicare. As pointed out on pages 8-9, there has been a large increase in the number of entities furnishing outpatient rehabilitation services since the prospective payment system was established.

We reviewed outpatient rehabilitation claims processed by the following three intermediaries:

- Aetna Life and Casualty, serving rehabilitation agencies in Florida, North Carolina, and Tennessee, as well as CORFs in Florida;
- Blue Cross and Blue Shield of Florida, Inc., serving CORFs in that state; and
- Mutual of Omaha, serving rehabilitation agencies in Alabama, California, Florida, Georgia, Iowa, Kansas, Maryland, Nebraska, North Carolina, South Carolina, Texas, and Virginia.

HCFA's June 1985 records show that Aetna and Mutual collectively accounted for about a third of the Medicare payments made to rehabilitation agencies nationwide. We could not identify the universe of payments to CORFs, but, in April 1985, HCFA had certified 66 CORFs. We

selected the two intermediaries located in Florida that served 12 of these 66—Florida Blue Cross for 7 and Aetna for the other 5.

At each intermediary, we selected a random sample of Medicare beneficiaries who received rehabilitation services. At Aetna and Mutual, we obtained computerized payment tapes for services provided, during an approximate 2-year period ending in late 1985, to all beneficiaries by the rehabilitation agencies that these intermediaries served. Aetna's payment tape contained records for 38,491 Medicare beneficiaries who received services from 114 rehabilitation agencies; Mutual's tape contained records for 22,660 beneficiaries who received services from 92 rehabilitation agencies. We reduced the size of each universe by excluding all beneficiaries who had only one or two claims and for whom the total reimbursed amount was less than \$200. The reduced universe of beneficiaries, total program charges for beneficiary rehabilitation services, and our sample size for each of the two intermediaries that served the rehabilitation agencies are shown in table 1.1.

**Table 1.1: Rehabilitation Agency
Reduced Universe and Sample Size for
Aetna and Mutual**

Intermediary	Reduced universe		Sample size	
	Beneficiaries	Charges	Beneficiaries	Charges
Aetna	25,619	\$30,444,179	84	\$93,929
Mutual	15,254	25,638,185	95	140,655
Total	40,873	\$56,082,364	179	\$234,584

Based on the results of our review of the random sample cases, we projected our findings to the universe of charges, using a confidence level of 95 percent.

Neither Aetna nor Florida Blue Cross had established computerized payment systems for CORF claims. Thus, for each of those intermediaries, we manually generated a universe of beneficiaries who received CORF services during an approximate 1-year period, ended in late 1984 (Aetna) and early in 1985 (Blue Cross), and randomly selected cases for review. However, because we could not establish a reliable universe of provider charges (or a universe of claims payment amounts) for these beneficiaries, we did not attempt to project the results of our review of the CORF sample cases. The universe of CORF beneficiaries and our sample size for each of these intermediaries are shown in table 1.2.

Table 1.2: Florida CORF Universe and Sample Size for Aetna and Blue Cross

Intermediary	Reduced universe		Sample size	
	Beneficiaries	Charges	Beneficiaries	Charges
Aetna	841	^a	88	\$65,022
Blue Cross	735	^a	79	174,594
Total	1,576		167	\$239,616

^aNot available.

For each beneficiary selected, we identified and reviewed all claims and supporting documentation for services provided by rehabilitation agencies and CORFs. Florida Blue Cross did not have all the documentation needed for our review; therefore, we obtained most of the documentation directly from the providers that intermediary served. Our comparisons of the data we obtained from the providers with the data submitted to Aetna and Mutual by providers showed that both data sets included essentially the same information.

We summarized the information on all rehabilitation services claims, including the beneficiary's medical condition, treatment, charges, reimbursements, and the intermediary's review and approval action. Based on this information and our assessment of it, we evaluated whether the documentation supporting the claims was adequate to determine whether the services provided were covered under the Medicare program. Our sample included 346 beneficiaries. About 88 percent of them received physical therapy services, and about 60 percent of the charges in our sample were for physical therapy services. The beneficiaries also received speech pathology services, occupational therapy, and social services.

Intermediaries did not require providers to submit claims in chronological order; thus, the first claim received by the intermediary for a beneficiary was not necessarily for the first services provided to that beneficiary. Furthermore, intermediaries generally processed claims in isolation from other claims; that is, the intermediary claims reviewers did not routinely look at prior treatment records when processing a claim for services. When we reviewed claims, we (1) collected all claims for a beneficiary and (2) reviewed them together in chronological order.

Because certain aspects of our review required medical judgment, we consulted with our chief medical advisor, a medical doctor. From our total sample of 346 beneficiaries, we provided him with a random sample of 100 beneficiary cases; he independently assessed the adequacy of the documentation supporting the claims for the 100 cases, reviewing

the same documents that our evaluators reviewed in the field. We then compared our chief medical advisor's review with our evaluators'. Concerning the adequacy of the documentation for the beneficiaries' eligibility for services, our medical advisor and evaluators agreed on the adequacy in 96 percent of the cases. The 100 cases referred to our medical advisor had 261 claims. For 60 percent of the claims, our medical advisor and evaluators agreed on the adequacy of the documentation supporting those claims.

We also identified and reviewed the results of studies conducted by other agencies that dealt with Medicare payments to providers of outpatient rehabilitation services. Information from these studies is included in our report (see ch. 4).

While at the intermediaries, we reviewed the manuals and guidelines they use for making coverage determinations. We discussed procedures for processing and paying claims for rehabilitation services with intermediary officials. We discussed our findings with representatives of the intermediaries, and their comments are included in this report where appropriate.

At HCFA's central office in Baltimore and its regional offices in Atlanta and Chicago, we reviewed correspondence and other guidance provided to intermediaries about program coverage of rehabilitation services. We also discussed our objectives and the scope of the review with central and regional office officials.

We did not obtain formal agency comments on a draft of this report. However, we obtained the views of HCFA officials and representatives of the intermediaries, and their views are incorporated in the report where appropriate.

Our fieldwork was done during the period March 1985 through December 1986, in accordance with generally accepted government auditing standards.

Rehabilitation Services Provided to Beneficiaries Whose Eligibility Was Not Adequately Documented

The first question an intermediary needs to answer before it pays a claim for rehabilitation services is this: "Does the beneficiary's condition meet the Medicare requirements for coverage of rehabilitation services?" That is, will providing services to the beneficiary significantly improve his or her condition within a reasonable and predictable period of time? Covered rehabilitation services must be (1) for the purpose of restoring a lost or impaired bodily function and (2) of a complexity and sophistication that can only be safely and effectively performed by or under the supervision of a qualified therapist. Services to help people maintain functions or those that do not require skilled personnel to administer or supervise are not eligible for Medicare reimbursement.

In our opinion, documentation for about 96 percent of the 346 sample cases and 98 percent of the sample charges that we reviewed was not adequate for determining whether the patient had potential for significant rehabilitation within a reasonable, predictable period of time. The results of our review of \$234,584 in sample charges for 179 of the sample cases are projectable to the universe of charges submitted by rehabilitation agencies to Aetna and Mutual over an approximate 2-year period. Therefore, we estimate that about \$50.2 million in charges for outpatient rehabilitation services were submitted by these rehabilitation agencies and processed by these two intermediaries without sufficient documentation to properly determine the beneficiaries' eligibility for the services.

Criteria for Determining Whether Rehabilitation Services Are Covered

Title XVIII of the Social Security Act, which established Medicare, requires that physical therapy and speech pathology services must be (1) for the purpose of improving the functioning of a malformed body part, (2) provided under the supervision of a physician, and (3) provided under a written plan of treatment. Further, HCFA's Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual requires that a treatment plan (1) be established before treatment is begun; (2) prescribe the type, amount, frequency, and duration of services to be furnished; and (3) indicate the diagnosis and anticipated goals.

Beyond the treatment plan, HCFA regulations identify two other items that are important in determining if a beneficiary is likely to benefit from rehabilitation services. One is an evaluation of the beneficiary's condition, which describes his or her current condition (baseline) and provides some estimate of the amount of improvement possible. The other is a medical history (including any prior therapy history) which,

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in conjunction with the evaluation, should state the date of onset for the condition being treated. If the therapy does not follow immediately after the date of onset, the medical history should (1) describe what change in the beneficiary's condition occurred that makes skilled rehabilitation services necessary and (2) give the date the change occurred.

In implementing the Medicare provisions that added CORFS to the category of providers entitled to reimbursement under Medicare, HCFA established beneficiary coverage criteria, similar to the physical therapy requirements, for occupational therapy and other services provided by CORFS.

In our review of beneficiary files, we looked for documentation necessary to establish the beneficiary's eligibility for services and to describe the baseline against which the beneficiary's progress could be measured.

Specifically, we looked for the following items of documentation:

- a medical history that specified the date of onset of the beneficiary's condition and, if therapy was not initiated within 6 months¹ of the date of onset, some indication in the history of what change had occurred between the date of onset and the date therapy began to indicate that rehabilitation services were necessary and would be effective;
- a therapy evaluation that described in measurable terms the beneficiary's baseline at the time therapy began; and
- a treatment plan that described in measurable terms what the goals of therapy were and gave some estimate of when those goals might be achieved.

We did not review the file documents in isolation; that is, if, for example, the date of onset was recorded in the therapy evaluation rather than the medical history, we considered that acceptable. In sum, we were more concerned that the proper information was present than with the mere presence of a certain number of documents. HCFA's regulations do not specifically say that goals and baseline data must be stated in measurable terms, but we believe that such information should be in measurable terms if the intermediaries are to properly determine beneficiary eligibility for services.

¹HCFA has not issued guidelines for determining whether treatments began immediately after the onset date. We selected 6 months as a reasonable time. Thus, when reviewing files, if therapy began more than 6 months after the date of onset, we looked for some justification in the file for beginning therapy at that time.

In addition, a task force within HCFA cited the purpose and necessity of these documents and recommended, in June 1985, that they be used for determining whether beneficiaries were eligible for rehabilitation services. Those task force recommendations were based, in part, on studies of rehabilitation services conducted by HHS's Office of the Inspector General (OIG) and HCFA's Chicago regional office. HCFA developed guidelines from those studies and the task force recommendations, but those guidelines have not been implemented. Additional details on the development of those guidelines are in chapter 4.

The intermediaries' personnel with whom we discussed the scope of our work generally agreed that the documentation and types of information that we were reviewing were necessary to establish that rehabilitation services for a beneficiary were covered. The lack of a certain document does not necessarily mean that the services provided were not eligible for coverage. To assess the likelihood of coverage of the services, we collected information on the patients' diagnoses and length of treatment. HCFA's proposed guidelines list certain diagnoses that may be poor candidates for rehabilitation because of the progressive, debilitating nature of the disease; the guidelines also contain suggested length-of-treatment norms for several physical therapy cases. Under the guidelines, cases with treatment exceeding the norms should be suspended from the normal claims process and reviewed for medical necessity. We believe many of the cases that were insufficiently documented probably were not eligible for coverage. (See pp. 20-21 and 32-33.)

Insufficient Documentation to Determine Rehabilitation Potential

For about 29 percent of the 346 sample cases we reviewed, the intermediaries' files, or those of the providers, lacked at least one of three data elements (treatment plan, evaluation, or medical history) that are necessary for determining a patient's need for services and his or her rehabilitation potential. In addition, we found that 94 percent of the 245 cases that did contain all three data elements were deficient because the data for at least one element were incomplete or not specific. Thus, about 96 percent of the sample cases we reviewed (332 of 346) lacked sufficient documentation to determine whether the beneficiary had the potential to significantly improve because of rehabilitation therapy. These 332 beneficiaries accounted for about 98 percent of charges included in our sample.

The results of our findings are projectable to the universe of charges submitted to Aetna and Mutual by rehabilitation agencies over an approximate 2-year period. Charges submitted by CORFs and processed

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by Aetna and Florida Blue Cross were not projectable (see p. 11). Thus, based on charges of \$234,584 for the rehabilitation agency claims that we reviewed, we estimate that about \$50.2 million in charges for outpatient rehabilitation services were submitted by these rehabilitation agencies; the charges were processed by Aetna and Mutual during an approximate 2-year period, ending late in 1985, without adequate documentation to determine whether rehabilitation services were covered for the beneficiaries. The sampling error of our estimate is plus or minus \$8 million, at a confidence level of 95 percent.

Our specific findings concerning medical histories, therapy evaluations, and treatment plans follow.

Medical Histories

HCFA's regulations discuss the importance of a medical history, which is needed to document the need for and expected benefits of rehabilitation services. For a patient whose condition was first diagnosed several months before therapy began, the regulations say the history should show what changes have occurred between the onset date and the beginning of treatment to justify therapy.

Medical histories were missing for 87 (25 percent) of the 346 sample beneficiaries. In addition, the medical histories for 98 (28 percent) of the beneficiaries either did not show the onset date of the beneficiaries' conditions or did not describe changes in medical problems, diagnosed more than 6 months earlier, that would indicate that therapy was necessary and was likely to be effective. The results of our evaluation of medical history files for the sample beneficiaries are shown in table 2.1.

Table 2.1: Adequacy of Medical History Files for Sample Beneficiaries

Adequacy of medical history files	Number of beneficiaries			Percent of total
	Rehab. agencies	CORFs	Total	
No medical history	62	25	87	25.1
Medical history did not show onset date or problem changes ^a	31	67	98	28.3
Medical history was complete	86	75	161	46.5
Total	179	167	346	

^aFor diagnoses made more than 6 months before treatment began.

Therapy Evaluations

HCFA's regulations also say that therapy evaluations are important and, according to HCFA's proposed guidelines,

"The physical therapy evaluation establishes the baseline data necessary for assessing rehabilitation potential, setting realistic goals, and measuring progress. The evaluation must include objective tests and measurements which at a minimum, should include strength, range of motion (ROM) assessments and function assessments. If strength or [range of motion] is normal, there should be evidence of this assessment in the initial evaluation or progress notes, e.g., 'within normal limits.' Additional information may include assessment of activities of daily living, endurance testing, distance of ambulation, girth measurements, nerve conduction velocity tests, and measurements of decubitus. If the goal for a [cerebral vascular accident or stroke] patient is to increase strength and range of motion, the evaluation must measure the patient's starting strength and range of motion."

In addition, speech pathology coverage guidelines developed by Aetna say that (1) the provider's initial evaluation of a beneficiary should include test scores as baseline data for use in measuring progress, (2) the prognosis or restorative potential of the beneficiary should be based on the functional communication skills that he or she is likely to attain, and (3) significant improvement must be expected in a reasonable and predictable time period. We believe that Aetna's guidelines for speech pathology are a reasonable extension of HCFA's proposed guidelines for physical therapy evaluations.

Claim files did not contain initial evaluations for about 11 percent of the 346 beneficiaries. Further, about 20 percent of the available evaluations did not contain baseline data. Thus, about 31 percent of the beneficiary files we reviewed either lacked evaluations or the evaluations did not describe the beneficiary's baseline condition. The results of our assessment of the evaluation reports that we reviewed are shown in table 2.2.

Table 2.2: Adequacy of Therapy Evaluations for Sample Beneficiaries

Adequacy of therapy evaluations	Number of patients			Percent of total
	Rehab. agencies	CORFs	Total	
No evaluation	15	23	38	11.0
Evaluation did not contain baseline data	47	23	70	20.2
Evaluation did contain baseline data	117	121	238	68.8
Total	179	167	346	

An example of an evaluation that contained baseline data was for a beneficiary with rheumatoid arthritis. The therapy evaluation supporting

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her physical therapy treatment plan contained the following baseline data:

“[Range of motion for] both upper extremities are within normal limits except for left elbow extension (-35°), right wrist extension 50° and right wrist flexion 50°. Strength in both upper extremities is generally within functional limits—difficult to test left elbow and both wrists due to pain.”

By contrast, the evaluation for a beneficiary with a broken hip did not include baseline data, such as range of motion, muscle strength, or ability to get in or out of a chair or walk. The therapy goals for this individual were not written in measurable terms, but were to increase the range of motion, increase strength, improve gait, and increase independence. Without knowing the beneficiary’s status at the beginning of treatment, it would be difficult to tell when those goals were achieved.

Treatment Plans

HCFA’s regulations for physical therapy and speech pathology provide that treatment plans must include the type, amount, frequency, and duration of the services and must indicate the beneficiary’s diagnosis and anticipated goals.

We identified treatment plans for 329 of the 346 beneficiaries (95 percent). In our opinion, 313 of the 329 plans (95 percent) contained treatment goals, but for 285 beneficiaries (91 percent of the 313 who had treatment plans), plans either did not describe the goals in measurable terms or did not provide estimates of when the goals should be achieved. The results of our evaluations of the treatment plans for the beneficiaries in our sample are summarized in table 2.3.

Table 2.3: Adequacy of Treatment Plans for Beneficiaries

Adequacy of treatment plans	Number of patients			Percent of total
	Rehab. agencies	CORFs	Total	
No treatment plan	8	9	17	4.9
Plan did not contain goals	6	10	16	4.6
Plan did not state goals in measurable terms ^a	151	134	285	82.4
Plan was adequate	14	14	28	8.1
Total	179	167	346	

^aIn addition, no estimates of when the goals would be achieved were included.

One 69-year-old beneficiary in our sample had suffered a stroke, which left her with partial paralysis on the right side of her body and impaired

speech. Her speech pathology treatment plan, which we believe was sufficient, included a long-term goal to develop communication methods other than speech. A short-term goal was to develop and implement the ability to use a communication board, with a specific goal of identifying pictures of wants and needs with 90-percent accuracy. Her treatment plan estimated that she would need therapy 5 times a week for 2 months to reach her short-term goal.

In contrast, the speech therapy goals of another beneficiary with a similar condition were stated in less specific terms, such as, "decrease apraxia [loss of coordination]; improve expressive language, length of phrase repetition and utterance, memory, volume level and writing." Her plan included giving therapy 3 times a week, but no estimate of the total length of time that treatment would be necessary was given.

Rehabilitation Potential of Some Beneficiaries Was Questionable

Screens developed by HCFA headquarters but not yet implemented (see ch. 4) provide that intermediaries' reviewers should be alert for diagnoses, such as arthritis, multiple sclerosis, or Parkinson's disease, where the beneficiaries' rehabilitation potential may be an issue. The screens further provide that beneficiaries with certain conditions that do not clearly indicate the need for physical therapy, such as arteriosclerosis, congestive heart failure, diabetes, or hypertension, may require very close medical review. Fifty-six (16 percent) of the beneficiaries in our sample had one of these conditions as a primary diagnosis, and, in our opinion, their files did not contain information to demonstrate that they were good candidates for rehabilitation.

Records of 36 of the 56 beneficiaries with these chronic conditions contained onset dates. Although 20 of the 36 had been sick for more than a year, the records for 11 of the 20 contained no evidence to show what recent changes had occurred in the beneficiaries' conditions that would make them good candidates for rehabilitation therapy. In addition, the treatment goals for 45 of the 56 beneficiaries were expressed in nonmeasurable terms, such as to increase strength, range of motion, or endurance or to reduce pain.

Records for 37 of the 56 beneficiaries showed that they had been discharged from the rehabilitation program. The reason cited by the provider for discharge of 14 of these beneficiaries was that they had reached their rehabilitation goals. But, in five cases, the records for each showed that the beneficiaries' functional level did not improve before he or she was discharged. We could not determine from the records of the

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other 18 beneficiaries whether they did or did not reach their rehabilitation goals before being discharged.

Summary

For the vast majority of the beneficiaries in our sample, the intermediaries processed and paid claims for rehabilitation services without sufficient information to know whether the beneficiaries' conditions made them eligible for the services provided. Therefore, there is no assurance that only covered services were paid for.

Need for Improved Documentation to Process and Pay Claims for Rehabilitation Services

In chapter 2, we discussed how intermediaries were paying outpatient rehabilitation claims without initially determining whether the beneficiary's condition made such services eligible for coverage under Medicare. In this chapter, we discuss how the intermediaries were paying individual claims without determining whether the beneficiary's condition continued to make him or her eligible for the services under Medicare; that is, even if the intermediary had determined that the beneficiary initially had a condition eligible for coverage, it did not know if the beneficiary's condition had changed in a way that would affect continued eligibility for rehabilitation services. Overall, the majority of the 1,101 claims submitted for the 346 sample beneficiaries lacked either all or part of the progress information necessary to determine continued eligibility for coverage of rehabilitation services.

Criteria for Determining Continued Eligibility

The Social Security Act requires that clinical records be maintained on all beneficiaries who receive services from rehabilitation agencies and CORFS. HHS's implementing regulations say that the records should be complete and accurate and contain observations, progress notes, and reports of treatments and clinical findings. If, at any point in the treatment of an illness, it is determined that treatment goals will not be realized, the rehabilitation services will no longer be considered reasonable and necessary and therefore should be excluded from coverage, according to HCFA's Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual. In expanding on and clarifying those requirements, HCFA's proposed guidelines for physical therapy services say that progress notes are essential for determining whether the beneficiary is making significant progress in a reasonable period of time; thus, the progress notes should include objective data that update the baseline information given in the initial evaluation.

Insufficient Documentation to Determine Beneficiaries' Progress

We reviewed 1,101 claims and supporting documentation; in our opinion, only 194 claims (about 18 percent) contained documentation that clearly described beneficiaries' progress in terms that could be used to measure whether the beneficiaries were progressing as expected. Documents supporting 102 claims (about 9 percent of the total) did not include any data to indicate whether the beneficiaries were making progress toward their rehabilitation goals. Documentation supporting another 805 claims (about 73 percent of all claims) contained some progress notes, but those notes did not describe the beneficiaries' progress in measurable terms for comparison with rehabilitation goals or did not describe the types

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and amounts of services provided the beneficiaries. Instead, beneficiaries' progress was described in vague, nonspecific language. The results of our evaluations of the adequacy of the supporting documentation submitted to the intermediaries are summarized in table 3.1.

Table 3.1: Adequacy of Progress Notes Submitted With Claims

Adequacy of progress notes	Number of claims			Percent of total
	Rehab. agencies	CORFs	Total	
No progress notes were on file	20	82	102	9.3
Progress notes were not stated in measurable terms	210	243	453	41.1
Progress notes did not describe types and amount of services	64	11	75	6.8
Progress notes were not stated in measurable terms and did not describe services	116	161	277	25.2
Progress notes were adequate	135	59	194	17.6
Total	545	556	1,101	

We had our chief medical adviser independently review a subsample of 261 of the 1,101 claims (see pp. 12-13). He found 56 percent of the claims to have insufficient data regarding progress to enable determining whether continued eligibility for services was justified. Although he found that a higher proportion of the claims had adequate progress data, we believe that his findings substantiate those of our evaluators and that the majority of claims were paid without adequate progress notes.

Progress notes often described the beneficiaries' progress in general terms, such as "patient is showing improvement," "some decrease in pain," or "strength continues to improve." Objective measurements of a beneficiary's strength, range of motion, distance of ambulation, or other functions for which therapy was being provided were often omitted from the progress notes.

The difference between progress notes stated in measurable terms versus progress notes in nonmeasurable terms can be seen in examples from our sample of claims. Our sample of rehabilitation agency claims at Mutual included two beneficiaries, each with a fractured left hip. Progress notes supporting claims for the physical therapy services provided to one beneficiary contained few specifics; they were written in subjective, nonmeasurable terms such as "... the patient was able to increase

mobility in bed with increased motion. . . .” The therapy goals established for this patient also were stated in nonmeasurable terms, such as “increase strength and mobility of lower extremity.”

The other beneficiary also received physical therapy, but, by comparison, the progress notes supporting this beneficiary’s claims were stated in measurable terms, such as “[range of motion] of knees has increased from 35 degrees of extension to 20 degrees of extension.” The rehabilitation goals against which the beneficiary’s progress was measured also were stated in specific terms, such as “. . . increase lower extremity strength to fair+ to good- and increase [range of motion] of lower extremity by 10 degrees.”

Our sample of CORF claims reviewed at Florida Blue Cross also included claims with beneficiaries’ progress notes written in general and nonmeasurable terms. For example, the initial evaluation for a beneficiary who had had a stroke provided objective measurements of the flexibility of the knee. The evaluation also stated that while walking, the beneficiary’s knee joint would buckle. However, the therapy goals established for this beneficiary were stated in general terms, such as “increase strength and increase ambulation endurance in lower extremities.” Likewise, the progress notes did not provide any measurements to indicate that the beneficiary was making progress. Instead, the notes said that the “patient increased functional ambulation”; “patient continued to tolerate strengthening exercises to lower extremities well”; and “endurance in ambulation is increasing.”

By comparison, the progress notes supporting another beneficiary’s claims submitted to Florida Blue Cross were stated in measurable terms. The beneficiary received physical therapy treatments for stiffness in the neck. The initial evaluation indicated that the beneficiary had “slight [range of motion] limitation in neck rotations; neck flexion normal, extension 6 cm.” The rehabilitation goals for this beneficiary were to “relieve pain in cervical area, increase strength of the neck muscles to good and increase [range of motion] of neck by 1.0 cm.” The progress notes supporting this beneficiary’s claims were stated in terms such as “patient was receiving moist heat to cervical area [to relieve pain],” “noted approximately 75 percent relief with therapy,” and “achieved increased neck [range of motion] by 1 cm.”

Progress notes also lacked information describing the type and amount of services provided to beneficiaries. As shown in table 3.1, progress notes for 352 of the 1,101 claims did not, in our opinion, adequately

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describe the services. The differences we found can be illustrated with two examples from claims processed by Mutual. Each beneficiary received therapy for a fractured hip. One beneficiary had therapy administered twice a day, which included training in bed mobility, sitting balance, transfers (i.e., bed to chair), and exercise and gait training. By contrast, the progress notes for the other beneficiary said simply that the beneficiary received "physical therapy."

Intermediaries Need Better Guidelines for Claims-Processing Documentation Requirements

HCFA has been aware, for several years, of the nature and extent of the claims documentation problems discussed in chapters 2 and 3 of this report. Studies conducted by its central and regional offices and by OIG (reported on during 1982 and 1983) had findings similar to ours concerning the inadequacy of documentation to assess the appropriateness of outpatient rehabilitation therapy services provided to Medicare beneficiaries. Projections by OIG, based on the results of a 1983 study, indicate that, nationwide, claims for inappropriate outpatient physical therapy services could cost the Medicare program as much as \$81 million a year when projected to 1984 program charges.

HCFA has attempted to correct some of the problems identified in those studies by issuing revised claims-processing procedures for CORFs and developing new claims-processing procedures and utilization screens for outpatient physical therapy services provided by rehabilitation agencies, skilled nursing facilities, hospitals, and home health agencies. The revised CORF claims-processing procedures most likely will be less effective than anticipated by HCFA, and the proposed physical therapy claims-processing procedures have been delayed because of clearance requirements of the Paperwork Reduction Act.

Intermediaries' Claims-Processing Systems

Considerable variation existed in actual review procedures for claims submitted by rehabilitation agencies and CORFs at the three intermediaries, both in terms of the documentation they required in support of services billed and in the procedures, guidelines, and personnel used to review claims.

At all three intermediaries, claims were subject to a clerical review. For this review, clerks basically check the claims for billing errors and determine whether the information required by the intermediary is included with the claim.

A medical review is another level of review, usually done by health care professionals. The purpose of the medical review is to assure that the services provided are covered under the Medicare program, do not exceed the beneficiaries' needs, and could not have been provided at a lower level of care. Mutual of Omaha's medical personnel reviewed 100 percent of all claims. Its physical therapist reviewed all outpatient physical therapy claims, and registered nurses reviewed all speech therapy claims for services provided by rehabilitation agencies. At Aetna, licensed practical nurses or registered nurses reviewed all of the CORF claims, but they reviewed only a sample of rehabilitation agency claims.

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According to an Aetna official, the relatively small volume of CORF claims had allowed them to conduct a medical review for all claims since the beginning of the CORF program. Florida Blue Cross used screening parameters developed by its medical review staff, based on dollar amount and patient diagnosis, to select certain claims for medical review. Claims exceeding the parameters were suspended from the claims process and reviewed by registered nurses. In November 1985, Florida Blue Cross began medical review for all CORF claims in accordance with new claims-processing procedures issued by HCFA (see p. 30).

The intermediaries requested different types and amounts of medical information from providers in support of services billed. For example, Mutual and Aetna requested providers to submit beneficiaries' progress notes in a standard format. These intermediaries designed their own forms to collect data, such as the beneficiaries' diagnosis, the problem's date of onset, type of therapy and number of times rendered, and a brief statement of the beneficiaries' progress during the service period covered by the claim.

All three intermediaries generally processed and paid claims in the order they were received from the providers of services; thus, the first claim received by the intermediary for a beneficiary was not necessarily for the first services provided to that beneficiary. Furthermore, claims were generally processed in isolation from other claims; that is, the clerical and medical claims reviewers did not routinely look at the beneficiary's prior treatment records when processing a claim for services.

For the claims that were included in our review, Florida Blue Cross did not routinely require providers to submit any documentation with their claims. According to Florida Blue Cross officials, it was not worth the cost to providers to have them submit copies of beneficiaries' medical records, particularly because the intermediary did not review every claim. Instead, Florida Blue Cross requested certain medical data only for those beneficiaries whose claims were suspended awaiting medical review.

Physicians' orders and initial therapy evaluations were not routinely required by the intermediaries. Although Aetna required physicians' orders and therapy evaluations with the initial claim, Mutual said that its standard forms required providers to certify that those documents were on file at the providers. However, Mutual's medical review staff had no procedures, such as on-site inspections, to verify that the information was on file.

HHS Studies Show Inability of Intermediaries to Identify Claims for Unnecessary Therapy Treatments

HCFA's headquarters and Chicago regional office and HHS's OIG have issued reports on the inability of some intermediaries to identify claims for overused and inappropriate physical therapy services. The reports, issued between April 1982 and November 1983, indicate that claims for unnecessary services may be costing the Medicare program millions of dollars each year.

HCFA, based on its review of 330 sample beneficiaries' records at three intermediaries, reported in January 1983 that \$44,095 (31 percent) of the total charges, \$142,020, for these beneficiaries' Medicare services was for noncovered services. Based on these findings, HCFA projected that \$43.5 million of total charges for outpatient physical therapy services in fiscal year 1980 represented potential payment for noncovered services.

The records reviewed by HCFA had been submitted by six different providers—two hospitals, one home health agency, one nursing home, and two rehabilitation agencies. Of the total charges included in the sample, \$47,233 was for services provided by the two rehabilitation agencies, and \$16,682 (35 percent) of this amount was for noncovered services. HCFA found that 80 percent of the beneficiaries who were provided noncovered services by these two agencies either did not require the services of a physical therapist or had no significant rehabilitation potential. The remaining charges for noncovered services were (1) for services in excess of the beneficiaries' needs, (2) not adequately supported by medical data or a physician-approved plan of treatment, or (3) inappropriate for the beneficiaries' conditions.

HCFA's Chicago regional office conducted two studies involving therapy services provided Medicare beneficiaries by 109 different rehabilitation agencies and several hospitals. The results of one study, summarized in a report issued in April 1982, showed that 83 percent (\$332,216) of total charges billed by eight Michigan rehabilitation agencies were for physical therapy services the HCFA region considered not necessary. The services were not covered because 56 percent (\$224,505) of the charges were for services provided to beneficiaries with no significant rehabilitation potential and 27 percent (\$107,711) of the charges were for excessive or inappropriate services. All 521 beneficiaries included in the study resided in nursing homes and clearly required care and assistance in daily living and maintenance functions, but these services could have been provided by nursing home personnel.

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A second study conducted by the Chicago region, completed in September 1983, included the review of 442 physical therapy and 154 speech therapy claims submitted by 101 rehabilitation agencies and several hospitals in Illinois, Indiana, Minnesota, and Ohio. In this study, 45 percent (199) of the physical therapy claims were for services that were not necessary, did not require a therapist, or were questioned because of lack of sufficient documentation. Of the 154 speech therapy claims reviewed, 84 percent (129) were questioned for these reasons: (1) the beneficiary's condition did not require the skills of a speech therapist, (2) the beneficiary lacked restorative potential, or (3) the frequency or duration of the services was excessive. Most of the beneficiaries included in this study also resided in nursing homes and had chronic debilitating illnesses. Thus, many of the services were to maintain function and could have been provided by nursing home personnel rather than skilled therapists.

In June 1983, OIG initiated a review of 897 beneficiary records at 14 intermediaries because there was no evidence of any substantive HCFA policy changes resulting from the headquarters and regional office reviews. During fiscal year 1982, the sample beneficiaries received physical therapy services from 30 different providers, including 6 hospitals, 6 skilled nursing homes, 5 home health agencies, and 13 rehabilitation agencies. In the report, sent to the HCFA Administrator in November 1983, OIG stated that \$2.6 million of the \$8.3 million (about 31 percent) in physical therapy charges submitted by these 30 providers was for noncovered services. As shown in table 4.1, OIG projections based on these findings show that the Medicare program could have lost \$80.9 million nationwide in calendar year 1984.

Table 4.1: OIG's Estimated CY 1984 Medicare Program Expenditures for Noncovered Physical Therapy Services

Provider type	Sample error rate (in percent)	Estimated cost avoidance for CY 1984
Home health agency	30.1	\$29,474,149
Hospital	35.2	35,476,813
Nursing home	49.7	8,535,558
Rehabilitation agency	27.9	7,438,829
Total		\$80,925,349

OIG's report noted that 391 (44 percent) of the beneficiary records included services not medically necessary because many of the beneficiaries appeared to have reached a plateau in functional status or were on a maintenance program.

Generally, the studies conducted by HCFA and OIG concluded that intermediaries had developed their own therapy claims-processing system, but the system lacked specific procedures or guidelines for reviewing claims. In the absence of these, therapy claims were paid even though supporting documentation was not sufficient to demonstrate the beneficiaries' rehabilitation potential or progress. Evaluations and progress notes concerning the beneficiaries did not include objective measurements to allow claims reviewers to determine whether (1) the goals were realistic, (2) the beneficiaries had restorative potential, or (3) the beneficiaries were making progress.

Efforts by HCFA to Correct Problems of Overutilization and Inappropriate Utilization

In November 1985, HCFA issued revised medical review procedures for intermediaries to follow when reviewing claims submitted by CORFs. Those procedures require intermediaries to conduct a medical review of all CORF claims instead of reviewing a statistical sample of claims or those claims identified for medical review through claims-processing screens, parameters, or computer edits. The procedures state that the purpose of the medical review is to assure that reimbursement is made only for covered services; the procedures emphasize the importance of assuring that (1) the treatment plan describes the type, amount, frequency, and duration of services, and (2) the beneficiary has rehabilitation potential and is making progress in attaining rehabilitation goals. HCFA guidelines and federal regulations for CORFs in effect before November 1985 already required the beneficiary's rehabilitation potential, treatment plan, and progress toward treatment goals to be adequately documented. Thus, claims that intermediaries selected for review before November 1985 should have been reviewed for essentially the same documentation as required by the November 1985 procedures.

Of the two intermediaries included in our review that were processing CORF claims (Aetna and Florida Blue Cross), Aetna already was performing a medical review for all of its CORF claims. An Aetna official advised us that Aetna had followed this policy of reviewing all CORF claims since the beginning of the CORF program. In addition, Mutual of Omaha officials said that it was their policy to perform a medical review for all rehabilitation agency claims. Of the 346 cases included in our review, 88 CORF cases at Aetna and 95 rehabilitation agency cases at Mutual of Omaha (a total of 183) had received a 100-percent medical review for all claims documentation. The remaining 163 cases were subjected to a medical review only if the intermediaries' screening or sampling process identified them for medical review.

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We compared the adequacy of the documentation supporting the 183 cases that received a 100-percent medical review with the documentation supporting 163 cases that did not receive a 100-percent medical review (table 4.2).

Table 4.2: Comparison of Documentation for 183 Cases That Received 100-Percent Medical Review With Documentation for 163 Cases That Received Less Than a 100-Percent Medical Review

Figures in percent

Documentation	Cases that received	
	100-percent medical review	Less than 100-percent medical review
Treatment plans		
On file	98.4	91.4
Adequate	10.0	6.7
Medical histories		
On file	71.0	79.1
Adequate	70.0	55.0
Evaluations		
On file	95.6	81.6
Adequate	74.9	80.5
Progress notes		
On file	92.9	89.1
Adequate	19.5	19.3

As can be seen, the adequacy of the documentation for the two groups of cases was similar. Most of the differences were not significant and, in our opinion, confirm that a 100-percent medical review did not greatly enhance overall quality of the claims documentation. Thus, to subject more cases to medical review without improvements in the content of the documentation available to the medical reviewers would not enable intermediaries to make better Medicare coverage decisions.

In August 1983, HCFA's Chicago regional office provided its intermediaries with physical therapy guidelines to (1) assist them in identifying claims for potentially overused and inappropriate services and (2) promote consistency in claims review policies and procedures by intermediaries in that region (however, the use of these guidelines was optional). In August 1984, HCFA's headquarters, using the Chicago regional office guidelines, began developing documentation guidelines and utilization screens for all intermediaries to use in processing physical therapy claims and in identifying overused physical therapy services.

The HCFA guidelines state that the intermediary is responsible for determining that physical therapy services meet Medicare requirements prior

to reimbursement, and, to do this, it is essential that each claim be supported with adequate documentation. The guidelines provide a clear description of the necessary content of documents needed for adequate medical review by intermediaries; the guidelines point out that documentation must be written in specific terms rather than general terms and should comprise

- the beneficiaries' medical history, as well as a history of prior therapy treatment for current conditions, including the date of onset for the particular injury or illness;
- the therapist's evaluation, including an assessment of rehabilitation potential (using objective tests and measurements to establish baseline data for the beneficiary), the setting of realistic goals, and the measurement of progress;
- the plan of treatment, including specific statements of both long-term and short-term goals, together with reasonable estimates of when the goals will be reached; and
- therapy progress data, including objective data to update the baseline data established during the initial evaluation.

HCFA sent draft copies of these guidelines and screens to several intermediaries and the American Physical Therapy Association for comments. Based on responses from these organizations, HCFA's headquarters compiled a set of proposed utilization screens for 67 diagnoses that occur frequently. HCFA issued these guidelines to intermediaries in November 1986, to be effective January 2, 1987. The guidelines did not apply to physical therapy services furnished by CORFs and home health treatment plans.

HCFA was instructed by the Office of Management and Budget (OMB) to delay implementing the guidelines because, according to OMB, the guidelines should have been submitted through OMB's regulatory review process before they were implemented. In February 1987, the HCFA official responsible for obtaining OMB clearance told us that HCFA was preparing a justification for the guidelines. He could not give us an expected period of time for completing this project. As of the end of April, HCFA had not yet completed its work on that justification.

Need for Utilization Screens

The proposed guidelines list, for various diagnoses, the number of services and duration of physical therapy treatments normally necessary to regain lost functional levels. The guidelines note that although the figures for the number of services and treatment periods are averages,

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treatment periods that are longer than these averages may indicate poor rehabilitation potential or lack of significant progress. To illustrate the potential effect of these utilization screens, we applied HCFA's proposed physical therapy screens for length-of-treatment periods to 150 CORF and rehabilitation agency therapy cases in our sample that had one of those diagnoses; we then compared these screens with the actual length-of-treatment periods for beneficiaries with certain diagnoses. The results of this comparison are shown in table 4.3.

Table 4.3: Comparison of Actual Physical Therapy Treatment Periods With HCFA's Proposed Treatment Period for Beneficiaries With Certain Diagnoses

Primary diagnosis	HCFA's proposed screen (in days)	Beneficiaries in sample	Exceed screen	Days screen exceeded	
				From	To
Cardiovascular and other peripheral vascular diseases	92	55	13	3	317
Parkinson's disease	42	11	8	66	409
Osteoarthritis and rheumatoid arthritis	60	40	17	6	252
Fractured pelvis, clavicle, humerus, or radius	30	14	10	6	211
Fractured femur	90	25	2	27	215
Fractured tibia or fibula	30	1	1	6	•
Fractured ankle	42	1	1	4	•
Bursitis	30	3	2	12	50
Total		150	54		

Of the 150 beneficiaries that received physical therapy, about 36 percent received treatments in excess of the time period that HCFA's proposed screens said should be the norm, as shown in table 4.3.

The claims documentation submitted by providers and reviewed by us did not explain the need for the length-of-treatment periods. Implementation of HCFA's proposed utilization screens should enable intermediaries to better identify potential problem cases and determine the appropriateness of the services received by beneficiaries over extended periods of time.

Conclusions and Recommendations

Conclusions

The three reviewed intermediaries processed many claims for rehabilitation services although the claims lacked documentation from the providers; that is, the documentation was not adequate to show initial eligibility—that the services would significantly improve the beneficiary's condition within a reasonable and predictable period of time. Documentation as to initial eligibility was deficient for about 96 percent of the beneficiaries and 98 percent of the provider charges that we reviewed. About 60 percent of the charges for beneficiaries in our sample were for physical therapy services, but speech pathology services, occupational therapy, and social services were also included in our sample and were covered by our findings. Additionally, the intermediaries continued to process and pay claims for rehabilitation services after the beneficiaries had been allowed initial coverage, even though the claims documentation did not show whether the beneficiaries' conditions had changed in a way that would affect continued Medicare eligibility for the services.

Reviewed charges of \$234,584 on claims for 179 rehabilitation agency patients were projectable to the universe of all charges from rehabilitation agencies served by Aetna and Mutual. We believe that about \$50.2 million in charges for services of rehabilitation agencies may have been submitted to and processed by Aetna and Mutual over an approximate 2-year period without sufficient documentation. (The sampling error of our estimate is plus or minus \$8 million, at a confidence level of 95 percent.)

Our findings are similar to those of HCFA and OIG, which were reported on during 1982 and 1983. HCFA has been aware of this problem for several years and has taken some actions to correct the problem. Two important actions were implementation of new procedures for processing CORF claims and development of new procedures for processing physical therapy claims.

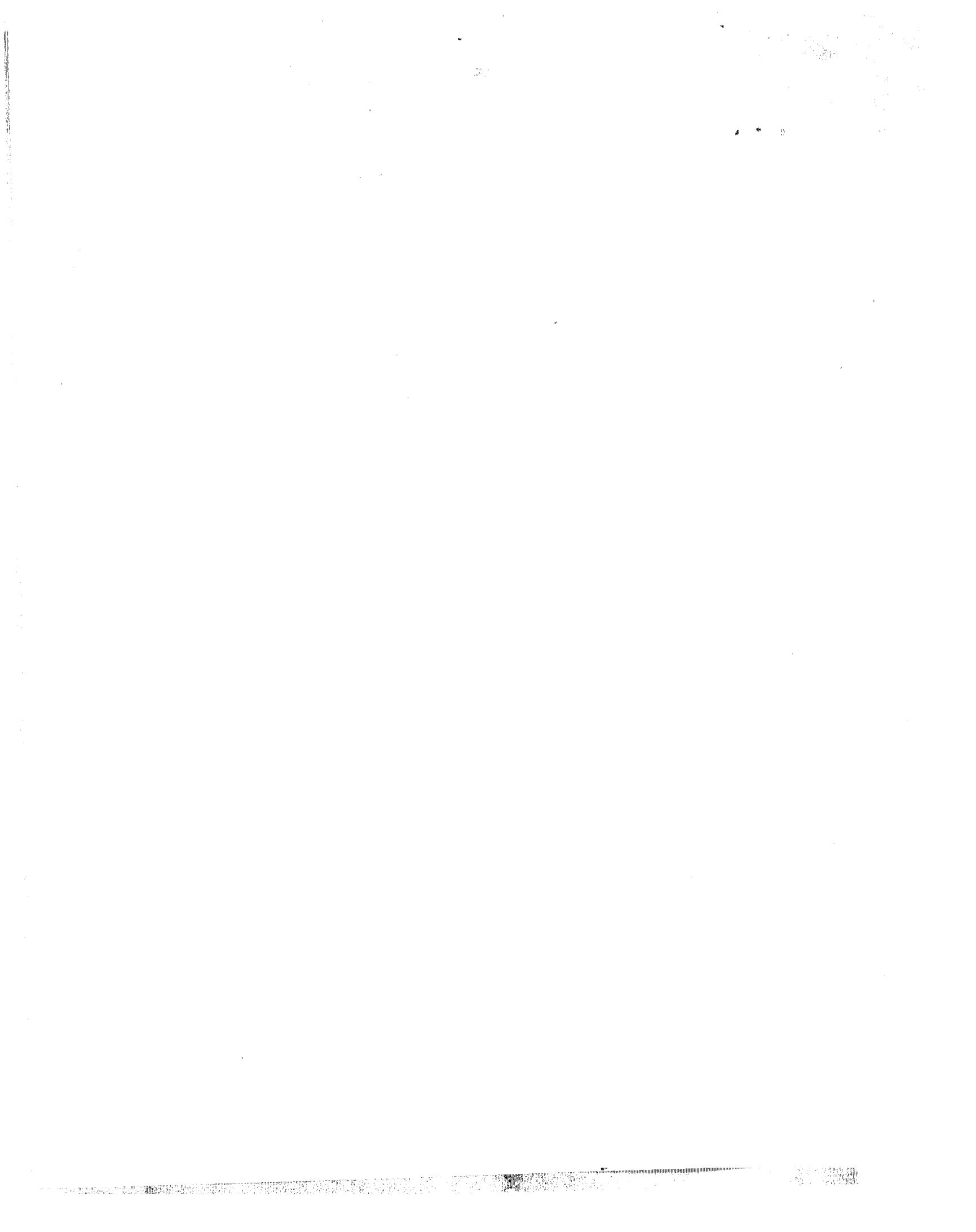
To ensure that CORFs are only reimbursed when they provide medically necessary services, HCFA required 100-percent medical review of all CORF claims for Medicare beneficiaries, but that procedure may be less effective than anticipated. Using our sample, we compared the adequacy of the documentation supporting 183 CORF and rehabilitation agency cases that received 100-percent medical review with the documentation for the other 163 cases; we found no appreciable difference in the adequacy of documentation for the two groups. Thus, we believe that the quality of the supporting documentation available for review must be improved

before intermediaries can make appropriate coverage decisions for Medicare outpatient rehabilitation services provided by CORFS.

HCFA developed proposed medical review physical therapy guidelines and utilization screens, but the agency has encountered some delays in implementing these screens because of the clearance requirements of the Paperwork Reduction Act. HCFA's proposed guidelines establish standards for the content of the supporting documentation and provide screens to assist intermediaries in identifying, for selected diagnoses, beneficiaries with poor rehabilitation potential or those making insignificant progress. When implemented, these guidelines should significantly enhance intermediaries' ability to make appropriate physical therapy coverage decisions. However, the proposed guidelines and screens apply to only one type of rehabilitation service—outpatient physical therapy services—and do not apply to services provided by CORFS. It is likely, therefore, that intermediaries will not have available to them adequate documentation for use in rendering coverage decisions on CORF services and on rehabilitation services other than outpatient physical therapy.

Recommendations

We recommend that the Administrator of HCFA, after complying with the appropriate regulatory clearance process, implement the physical therapy guidelines and utilization screens already developed and require intermediaries to apply them to rehabilitation physical therapy services provided in all outpatient settings, including CORFS. The Administrator should also (1) develop and implement guidelines that clearly identify the document types and contents needed by intermediaries to make appropriate Medicare coverage decisions for the other types of outpatient rehabilitation therapy services and (2) require intermediaries to use the guidelines for reviewing providers' claims for rehabilitation services.



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