For-profit SNFs beware: OIG taking a closer look at high RUG levels

Report addresses potentially questionable billing practices

by Justin Veiga

Though it didn’t include shocking details, *Questionable Billing by Skilled Nursing Facilities*, the Office of Inspector General (OIG) report released in December 2010, probably sent a shiver down the spines of many in the long-term care industry.

The 38-page report detailed a study the OIG completed with SNF Medicare claims from 2006 to 2008. The results of the study showed that on the surface, SNFs were billing for higher RUGs in 2008 than in 2006, with similar patient populations. Although it didn’t look at individual claims, the OIG inferred that the increase in higher RUG categories meant that SNFs were likely overbilling.

According to the report,”From 2006 to 2008, the percentage of RUGs for ultra high therapy increased from 17% to 28%. The percentage of RUGs with high [activities of daily living] scores increased from 30% in 2006 to 34% in 2008.”

The results were even more prominent in for-profit SNFs, with 32% of RUGs from for-profit SNFs being for ultra high therapy RUG categories, compared to 18% from nonprofit SNFs and 13% from government SNFs. For-profit SNFs owned by chains had even higher percentages of ultra high RUG claims.

“I don’t think anyone was surprised by the report because for-profit entities have the incentive to maximize their reimbursement,“ says Wayne van Halem, AHFI, CFE, president of The van Halem Group, LLC, in Atlanta.”It doesn’t mean they are doing anything wrong, but it can give that impression, so it’s imperative they are even more careful with their documentation.”

For-profit SNFs also had higher average lengths of stay with no clear indication that they were treating a different level of patient.

“These billing patterns indicate that certain SNFs may be routinely placing beneficiaries into higher paying RUGs regardless of the beneficiaries’ care and resource needs or keeping beneficiaries in Part A stays longer than necessary,” stated the OIG report.

To get a better idea of why RUG levels have increased and to see whether there is medical necessity behind the higher claims, the OIG recommended that CMS:

- Monitor overall payments to SNFs and adjust rates if necessary
Change the current method for determining how much therapy is needed to ensure appropriate payments

Strengthen monitoring of SNFs that are billing for higher-paying RUGs

Follow up on the SNFs identified as having questionable billing

CMS agreed with three of the four recommendations in a follow-up letter, but disagreed on changing the method for determining how much therapy is needed. According to the letter, sent from CMS Administrator Donald Berwick to Inspector General Daniel Levinson, CMS does not feel it is best to rely on hospital diagnosis data in order to determine therapy services in a SNF for three core reasons:

- SNFs do not always receive information from hospitals in a timely manner
- The hospital diagnosis may not be the primary reason for post-acute SNF services
- Therapy utilization in acute care hospitals is not an accurate indicator of post-acute care therapy needs because hospitals do not provide high levels of therapy since these services are bundled into the diagnostic related group

Diane Brown, HCPro Boot Camp instructor and long-term care author, says CMS not concurring with the OIG’s second recommendation is somewhat understandable because hospitals have no incentive to give therapy, and therefore the responsibility falls on SNFs. But Brown cautions facilities whose marketing strategy is aimed at attracting ultra high therapy patients. She says these for-profit SNFs must implement a triple check process to verify that residents are receiving proper amounts and levels of therapy during their stay, especially with more therapy patients entering facilities and thus, more ultra high RUG categories being used.

“Although that’s a factor, you can’t get around the fact that by diagnosis and by age, the increase was the same,” Brown says regarding the increase in ultra high therapy between 2006 and 2008 (see Charts D-1 and D-2, p. 3). “You give what the patient needs. You can’t just give the maximum amount for a minimal result.”

The fallout

“While the report is very troubling, the OIG did not examine individual claims or medical record documentation,” says Rachel Suddarth, an attorney with Hancock, Daniel, Johnson & Nagle, PC, in Richmond, VA. “Instead, the report relied exclusively on trending data. The OIG’s planned follow-up studies, which will examine medical records and specific claims, will provide much more information about whether SNFs committed billing errors.”

The details of the follow-up studies weren’t outlined in the report, but Suddarth says she expects the OIG to look at the ultra high RUG claims and examine whether the patients’ medical record documentation supported the RUG assignments.
Suddarth cautions that SNFs should take notice of the OIG report and planned follow-up studies.

“If I worked at a for-profit SNF, especially one that is part of a chain, I’d be particularly worried that the OIG or another auditor will be examining my records,” she says. “This report should serve as a wake-up call and be used to educate everyone in the facility—administrators, billers, clinicians—on the importance of good documentation and accurate billing.”

The report should be required reading for SNFs, says Suddarth, especially those with higher-than-average ultra high RUG utilization or longer-than-average lengths of stay.

This report is just the beginning of a trend of heightened scrutiny of SNF facilities, especially those with outlier claims history.

“Any time the OIG releases a report like this, it’s going to bring additional scrutiny,” says van Halem. “It’s going to increase the budgets for auditors and bring on more audits in general.”
For-profit SNFs increased use of ultra high therapy

The increase shown in Appendix E [see charts at right] is incredibly dramatic.

—Diane Brown

The increase in audits may not come from the Recovery Audit Contractors (RAC) but instead from Zone Program Integrity Contractors (ZPIC), says van Halem. ZPICs work closely with the OIG and are better equipped to do complex reviews of medical documentation, he adds.

The ZPICs are taking over for Program Safeguard Contractors across the country and will likely be performing aggressive audits, says van Halem.

“They are responsible for fraud and abuse, and unlike the RACs, they aren’t paid on contingency,” he says. “The ZPICs will be able to look at all provider types, look at all the services billed, and analyze all the claims data. If your documentation isn’t in line, you could be hit pretty hard.”

Putting up a defense

One positive of the OIG report is that it should encourage SNFs to focus on improvement. The best way to do this is to set up audits of your medical records to ensure that you have the documentation to justify the RUG level you billed at, says van Halem.
Detailed findings from the OIG report

The Office of Inspector General’s (OIG) December 2010 report, Questionable Billing by Skilled Nursing Facilities, which can be found at http://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf, is based on an OIG study from 2006 to 2008. During that time, the OIG looked at SNF Medicare claims with three objectives in mind:

1. To determine the extent to which billing by SNFs changed
2. To determine the extent to which billing varied by type of SNF ownership in 2008
3. To identify SNFs that had questionable billing in 2008

The OIG found that the percentage of RUGs for ultra high therapy increased from 17% to 28% between 2006 and 2008. In addition, “32% of RUGs from for-profit SNFs were for ultra high therapy, compared to 18% from nonprofit SNFs and 13% from government SNFs,” according to the report.

Lastly, the report stated that a number of SNFs did in fact have questionable billing in 2008.

The figures that follow are from the OIG report and depict its findings. They are in order of appearance within the 38-page report.

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### Table 1: Average Payment Rates for Each Level of Therapy, 2008

<table>
<thead>
<tr>
<th>Level of Therapy</th>
<th>Number of Minutes per Week of Therapy</th>
<th>Average Per Diem Payment for RUGs in 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra high therapy</td>
<td>720 or more</td>
<td>$511</td>
</tr>
<tr>
<td>Very high therapy</td>
<td>500 to 719</td>
<td>$407</td>
</tr>
<tr>
<td>High therapy</td>
<td>325 to 499</td>
<td>$356</td>
</tr>
<tr>
<td>Medium therapy</td>
<td>150 to 324</td>
<td>$382</td>
</tr>
<tr>
<td>Low therapy</td>
<td>45 to 149</td>
<td>$283</td>
</tr>
</tbody>
</table>

Source: OIG analysis of FY 2008 unadjusted per diem urban rates.

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### Chart 1: Changes in SNF Billing From 2006 to 2008

“I’d recommend that every for-profit SNF in the country do an audit of their highest RUG patients to make sure the documentation is there,” he says. “If you get audited by a contractor, your documentation is your only defense for the high categories.”

You’ll want to be sure it’s very clear how the patients qualified for the services and what treatments they received, van Halem adds. If you’re finding the documentation isn’t there, you’ll want to implement corrective action to make sure it is in the future.
Although the OIG study looked at claims from 2006 to 2008, facilities may want to focus on more recent claims as part of their self-audits. Unfortunately, at this point, facilities are stuck with the billing and documentation errors they committed one, three, or five years ago, says Suddarth. Facilities would be best served by examining their current operations to ensure compliance with all documentation and billing requirements.

“In order to ensure current operations are compliant, I recommend using the implementation of MDS 3.0 as a starting point for smaller-scale internal audits,” Suddarth says. “MDS 3.0 marks a clear point in time when a facility’s documentation requirements and protocols likely changed. Additionally, it will not be overwhelming for facilities to go back through documentation from October to the present to determine compliance.”

SNFs often do not have the resources to perform full extensive audits, so limiting the time frame can help make the auditing process affordable.

Performing internal audits correctly and impartially is also important, says Suddarth. Although it may be easier and less costly to simply have your MDS coordinator perform the audit, this individual is typically the one who prepared or reviewed the initial MDS and billing data.

“If you have someone with a lot of expertise on your staff who can perform the audit, that is great, but sometimes it is worth it to bring in an outside consultant to get a different perspective,” says Suddarth. “Also, if you use an external auditor and you later undergo a governmental audit review, it can be very helpful to show that the facility’s records and protocols were previously examined by an outside expert.”

If you do find missing documentation or errors during your internal audit, you can make addendums to the documentation as long as you include the current date and note that you’re making an addendum so there’s no appearance of fraud, says van Halem. Although addendums don’t always hold up during an audit, they can help in appeals as they show you made an effort to improve and fully document the event.

“Being able to provide a contractor performing an audit with a copy of your internal audit is a good step in avoiding penalties and repayment,” says van Halem.

Moving ahead
A report like the OIG’s tends to scare SNFs into worrying any time they use ultra high RUGs, says Suddarth, but facilities do have residents who qualify for ultra high RUG levels and they shouldn’t avoid proper billing for these residents.

“So long as the facility has the medical record documentation to support its claims, the facility should code, bill, and receive payment for the higher-level RUG categories,” she says.
“What many facilities fail to realize is that they can become an outlier by underbilling, just as they can for overbilling. Additionally, by underbilling, they are leaving legitimate reimbursement on the table,” Suddarth points out. “If the facility does a good job documenting and follows payer protocols, it can be confident in its claims, even if they are for higher-level services.”

Brown recommends that all facilities track and trend their own statistics, including length of stays. She suggests beginning with 2006 or 2007, setting a benchmark, and then looking at the numbers to see if there has been a steady increase in ultra high RUGs. In addition, Brown agrees that both internal and external audits can and should be completed. The SNF must be able to explain, through its documentation, any trends in ultra high RUG use. Residents who received the same exact amount and level of therapy from admission to discharge without apparent functional improvement will most certainly stand out in an audit because it’s not a normal occurrence, Brown says.

“Reviewers will be analyzing that component of it,” Brown says. “Look at the nursing notes, which should be addressing reduced burden of care, ongoing progress toward greater independence, and improvement demonstrated by the task segmentation of an ADL.”

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