

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**ASSESSMENT AND EVALUATION
PRACTICES AT
MISSION NURSING AND
REHABILITATION CENTER**



May 11, 2018
OIG Report No. AUD-18-015



HHSC OIG

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SERVICES COMMISSION
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WHY THE OIG CONDUCTED THIS AUDIT

Nursing facilities provide institutional care to Medicaid recipients whose medical conditions regularly require the skills of licensed nurses. For Medicaid residents in nursing facilities who are members of a managed care organization (MCO), the state makes a capitation payment to the MCO for each resident. The MCO, in turn, reimburses the nursing facility a daily rate for the resident. Under the fee-for-service model, HHSC pays nursing facilities a daily rate.

Capitation rates differ based on the resources needed for each resident, as measured by items collected on the Minimum Data Set (MDS) assessment. Resource Utilization Group (RUG) levels are established when a facility reports information from a seven-day “look-back period” set by the facility.

The objectives of this audit were to (a) assess the accuracy of therapy related payments and reimbursements, and completeness of supporting documentation, and (b) determine whether therapy services were provided consistent with physician orders, in accordance with resident assessments and evaluations, and in compliance with federal and state requirements.

WHAT THE OIG RECOMMENDS

HHSC should implement program policy changes to prevent therapy RUG levels and payments based on more therapy than that which is documented in a physician’s written order and, if therapy decreases, an amount of therapy that would not qualify for a therapy RUG level.

The OIG referred the documentation issues to CMS, since the Medicare program reimburses Mission for the cost of therapy services supported by this documentation.

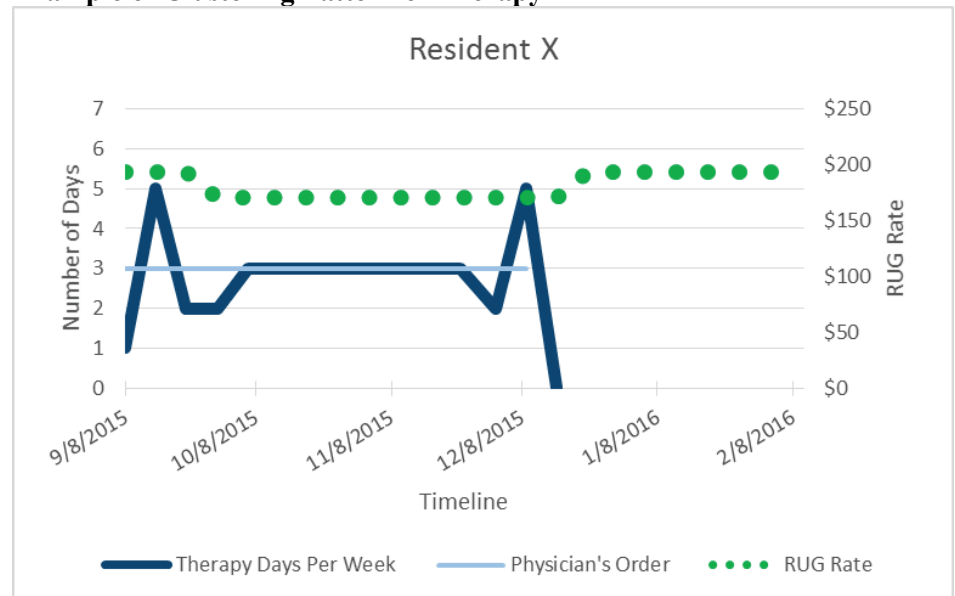
For more information, contact:

OIG.AuditDivision@hhsc.state.tx.us

WHAT THE OIG FOUND

For all 30 resident files tested at Mission Nursing and Rehabilitation Center (Mission), a long-term care nursing facility, the number of therapy days and minutes reported, due to a practice of clustering therapy session during look-back periods, was greater than the amount of therapy prescribed per week for that resident. The therapy provided in the weeks following the look-back period was reduced either to the amount of therapy prescribed, reduced to a lower amount or, in many instances, stopped completely. This clustering of therapy services within the look-back period resulted in higher RUG levels, and therefore higher daily RUG reimbursements to Mission, than would have been paid if the facility reported an amount of therapy equal to the prescribed amount, or an amount equal to what was provided in non-look-back weeks.

Example of Clustering Pattern of Therapy



Total RUG reimbursements resulting from clustering were \$692,952, which represents 36 percent of the total RUG reimbursements to Mission for the 30 residents between March 2015 and March 2017.

Mission’s clustering of therapy sessions during the look-back period, which often captured portions of two consecutive therapy weeks, did not violate physician’s orders, and is not prohibited by Medicaid rules or policy. However, because the practice leads to an inefficient use of resources, it creates waste.

Additionally, medical records for all 30 of the selected resident files were missing required documentation, such as signed and dated physician’s orders, documentation for necessity of therapy, or the resident’s certified and recertified plans of care.

Medicaid and CHIP Services, in its management response, indicated it had formed a workgroup to review potential policy and procedure changes to mitigate the impact on RUG levels resulting from the clustering of therapy sessions by long-term care nursing facilities.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of assessment and evaluation practices at Mission Nursing and Rehabilitation Center (Mission). Mission is owned by Senior Care Centers, LLC in Mission, Texas.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objectives and Scope

The objectives of this audit were to (a) assess the accuracy of therapy related payments and reimbursements, and completeness of supporting documentation, and (b) determine whether therapy services were provided consistent with physician orders, in accordance with resident assessments and evaluations, and in compliance with applicable federal and state requirements.

The scope of this audit included Mission's practices for assessing, evaluating, and billing for therapy services during the period from March 1, 2015, through March 31, 2017, and selected information technology (IT) general controls through the end of fieldwork in October 2017.

Background

Nursing facilities provide for the medical, social, and psychological needs of each resident, including room and board, over-the-counter medication, medical supplies and equipment, therapy services, and personal needs items. The Medicaid and CHIP Services (MCS) promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract (UMCC). MCS is also responsible for the contract oversight of Medicaid managed care organizations (MCOs). The Long-term Care Regulatory Department regulates long-term care facilities, agencies, programs, and individual providers. The Long-term Care Regulatory Department is responsible for provider licensure and certification; survey operations; policy, rules, and curriculum development; and enforcement activities for nursing facilities and other long-term care programs.

In Texas, nursing facilities are reimbursed by MCOs through a managed care model or, in some instances, such as when a resident is transitioning between facilities, are reimbursed directly by HHSC under a fee-for-service model. Under both the managed care and fee-for-service models, nursing facilities are reimbursed a daily rate, based on an assigned Resource Utilization Group (RUG) level, for each resident. The RUG level is based on the resource intensity of the resident as measured by items reported on Minimum Data Set (MDS) assessments. Table 4 in

Appendix C contains a list of the Texas Medicaid RUG levels and their corresponding RUG category labels. The payment amount associated with a specific RUG level is determined by HHSC. Under the managed care model, the state pays a capitated rate to the MCO for each Medicaid member residing in a nursing facility. The MCO in turn reimburses the nursing facility based on the assigned daily RUG level. Similarly, under the fee-for-service model, nursing facilities are reimbursed by HHSC based on the assigned daily RUG level.

The MDS assessment provides a comprehensive summary of the resident's mental and physical states, and contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. Assessments are required for residents quarterly, annually, when the resident experiences a significant change, and upon admission to and discharge from the nursing facility. All assessments must be completed within specific guidelines and time frames. Medicare and Medicaid certified nursing facilities are required to collect the resident assessment data that comprises the MDS using guidelines specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS).¹ Facilities must follow the instructions provided by the Resident Assessment Instrument (RAI) when entering information into the MDS assessment.² When reporting a resident's health information on the MDS, facilities are required to use a seven-day look-back period for therapy that is based on the date the facility elects to assess a resident.

Activities of Daily Living³ (ADL) scoring on the MDS assessment reflects a nursing facility's evaluation of the level of resident need for assistance with physical mobility and dexterity. In addition to ADL scoring, facilities are also required to report the frequency (number of days) and duration (number of minutes) of therapy provided to a resident. ADL scores, the frequency and duration of therapy, and other information is used to classify residents into RUG levels. The look-back period ends on the assessment reference date (ARD) and is used to report the amount of therapy provided during that period. When the number of therapy sessions and the number of minutes of therapy provided during the look-back period qualifies a resident for a therapy RUG, the ADL score will determine the specific therapy RUG level. In summary, the RUG level, which can be determined in large part by the ADL scoring and therapy reported, dictates the amount of money per day the MCO will reimburse the nursing facility for a resident's stay. RUG levels, once established, are valid until the next MDS assessment establishes

¹ 42 C.F.R. § 483.20(b)(1) and (c) (July 16, 2012 through Sept. 5, 2016).

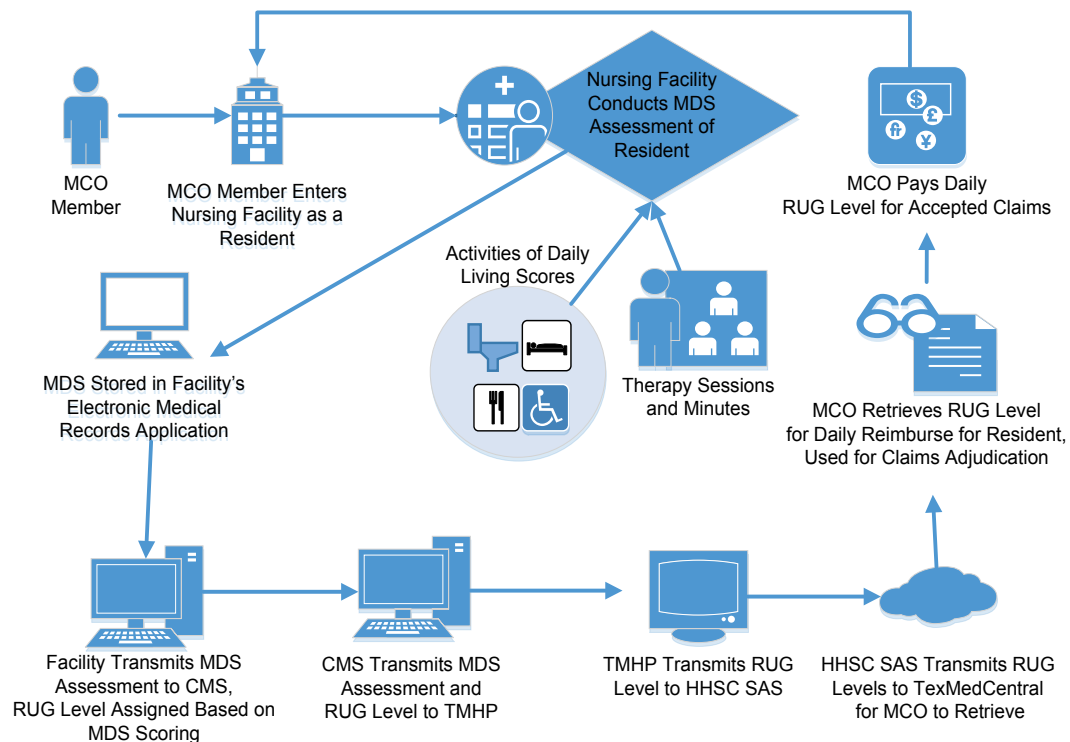
² 40 Tex. Admin. Code § 19.801(2)(A) (June 1, 2006 through Aug. 31, 2015).

³ Activities of Daily Living (ADLs) are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

a new RUG. A new MDS assessment should be completed, according to the RAI, at least every 92 days.⁴

MDS assessment information is transmitted electronically by nursing facilities or billing agents to the national MDS database at CMS. The RUG reimbursement level is assigned by software at CMS after receipt of a complete MDS assessment. CMS sends the MDS assessment and the assigned RUG level to the Texas Medicaid and Healthcare Partnership (TMHP). TMHP updates the assigned RUG level in the HHSC Service Authorization System (HHSC SAS), which acts as the system of record for nursing facilities residents' RUG levels. The HHSC SAS automatically transmits, on a daily basis, RUG levels for residents to a TMHP repository called TexMedCentral. The assigned RUG levels are used by MCOs (under managed care) or by HHSC (for fee-for-service) when paying nursing facilities. Each MCO retrieves RUG level information from TexMedCentral for each resident for the applicable service period. Figure 1 depicts the flow of MDS assessment information for Medicaid managed care members who are residents in Texas nursing facilities. The process flow for fee-for-service payments is not included in Figure 1.

Figure 1: Flow of MDS Assessment Data and Assignment of RUG Levels



Source: OIG Audit Division

⁴ Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.12 (Oct. 1, 2014) and v. 1.13 (Oct. 1, 2015).

Many nursing facility residents are eligible for both Medicare and Medicaid benefits. The audit focused on residents whose RUG levels were paid by Medicaid (either through fee-for-service or an MCO), and whose therapy was paid by Medicare or Medicaid.⁵ Therapy services at Mission are provided through a contractor, Senior Rehab Solutions, a subsidiary of Senior Care Centers, LLC. Pursuant to its contract with Mission, Senior Rehab Solutions evaluated residents' therapy needs and supported the rehabilitation department at Mission by providing an on-site rehabilitation director and professional staff to deliver physical, occupational, and speech therapy services.

The OIG Audit Division tested MDS assessments, therapy services charts, resident medical records, RUG levels assigned to residents, and physicians' orders and certifications for therapy services. Also, the OIG Audit Division examined authorizations for user access and group permissions for the MDS assessment application at Mission, and user's access authorization and group permissions for the application of its subcontractor of therapy services. The audit was conducted in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States.

The OIG Audit Division presented audit results, issues, and recommendation to MCS and to Mission in a draft report dated February 21, 2018. Each was provided with the opportunity to study and comment on the report. The MCS management response is included in the report following the recommendation. Mission's comment letter on the audit is included in Appendix E.

⁵ Therapy services for Medicaid residents are paid primarily by Medicare, although Medicaid is the payer of last resort. Consequently, Mission must comply with applicable Medicare authorization and documentation requirements.

AUDIT RESULTS

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) reported by Mission during look-back periods on MDS assessments frequently established a therapy RUG level of payment. However, the OIG Audit Division's examination of 30 residents' files over the course of the therapy RUG payment period indicated that, in 43 percent of weeks outside of the look-back period, residents received fewer therapy days than required for the therapy RUG level established by and paid to Mission. In some cases, therapy was discontinued completely soon after the look-back period because the doctor's order expired, and frequently therapy was not ordered again until just prior to the subsequent look-back period.

Mission failed to ensure that resident medical records contained required documentation and failed to ensure that documents in the resident medical records contained required signatures.

There were no reportable IT control exceptions related to user accounts for the subcontractor's therapy computer application or for Mission's MDS assessment computer application. Users were assigned reasonable permissions based on the least privilege concept,⁶ and segregation of duties controls were consistent with state and federal requirements.

Waste is defined as "practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services."⁷ Given that therapy RUG payments are established based on reported therapy, and given that therapy RUG payments continue regardless of whether therapy continues for a resident, the potential for waste exists under current Medicaid policy.

⁶ The concept of least privilege is the practice of limiting access rights for computer users to the minimum permissions they need to perform their work. Computer users are granted permission to read, write, or execute only the files or resources they need to do their jobs.

⁷ 1 Tex. Admin. Code § 371.1607(94) (Apr. 15, 2014, through Sept. 30, 2015), 371.1607(93) (Oct. 1, 2015, through Apr. 30, 2016), and 371.1(97) (May 1, 2016, through Feb. 11, 2017).

CLUSTERING AND SUSPENSION BRIDGE PATTERN OF THERAPY

The RAI provides instruction for completing the MDS. The RAI requires facilities to perform MDS assessments of residents at the time of admission to the facility, and then quarterly, annually, and whenever the resident experiences a significant change in status.⁸ The RAI also provides instruction to facilities regarding possible selections for the ARD. The ARD establishes the look-back period, which, for the purposes of the audit, is defined as the ARD and the six days prior to the ARD. Facilities must use information from the look-back period when reporting on the MDS assessment, and facilities are required to ensure that assessments accurately reflect the resident's status.⁹

The RAI requires facilities to report the number of therapy days and the number of therapy minutes provided during the look-back period. To qualify for a therapy RUG level, a resident must have at least 5 calendar days and 150 minutes of therapy during the look-back period.

The days that constitute a look-back period are determined by the instructions contained in the RAI manual and are therefore dependent on when an assessment took place for a given resident. There is no requirement for the days that compose a look-back period to match the days that compose a therapy week. A therapy week is defined as a seven-day period beginning the first day rehabilitation therapy is given to a resident.¹⁰

For all 30 of the selected resident files (100 percent) the OIG Audit Division tested, the number of therapy days and minutes provided during the look-back period exceeded the number of days and minutes delivered during most other weeks within the therapy RUG payment period.

⁸ Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.12 (Oct. 1, 2014) and v. 1.13 (Oct. 1, 2015).

⁹ Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.12 (Oct. 1, 2014) and v. 1.13 (Oct. 1, 2015).

¹⁰ 40 Tex. Admin. Code § 19.101(146) (Oct. 31, 2013, and Aug. 31, 2015), 19.101(148) (July 21, 2016), and 19.101(156) (Mar. 27, 2017).

Issue 1: Clustering of Therapy During the Look-Back Period

The OIG Audit Division reviewed medical records for 194 MDS assessments corresponding to 30 residents. The audit focused on residents who had claims based on a therapy RUG level between March 1, 2015, and March 31, 2017. In 135 of 194 MDS assessments (70 percent) included in all 30 of the selected resident files, therapy days and minutes provided during a look-back period were greater than therapy days and minutes provided outside of a look-back period, indicating a pattern of clustering.

Specifically, in 78 percent of 1,448 weeks outside of a look-back period that established a therapy RUG level, Mission did not provide at least 5 calendar days and 150 minutes of therapy, both of which are required to qualify for a therapy RUG level. In 18 percent of the weeks, Mission provided 150 or more minutes of therapy, but did not provide 5 calendar days of therapy. In only 61 (4 percent) of the weeks outside of a look-back period did Mission provide therapy at a frequency and duration required to qualify for the RUG level it had established, and was paid, for the resident.

Mission's scheduling of resident evaluations, ARDs, and therapy allowed the inclusion of clustered therapy days and the establishment of therapy RUG levels. This clustering of therapy services within the look-back period resulted in higher payments to Mission than would have been paid if the MDS reflected an amount of therapy equal to the prescribed number of days per week for that resident.

The number of therapy days scheduled in the weeks following the look-back period was reduced either to the number of therapy days prescribed, or in many instances, was reduced to less than what was prescribed. Therapy was clustered again during the next look-back period. When displayed graphically, the clustering and subsequent waning of therapy in non-look-back weeks created a peaking and declining picture, referred to in this report as a suspension bridge pattern.

Examples of Clustering Practice

Table 1 presents one example of the therapy days and minutes provided before, during, and after the look-back period for Resident X. In this example:

- For the look-back period of September 9, 2015, through September 15, 2015, the resident received 5 therapy days totaling 250 minutes. The amount of therapy, combined with the resident's ADL score, established a therapy RUG level of RAC¹¹ (\$170.79), after which

¹¹ Table 4 in Appendix C contains a list of the Texas Medicaid RUG levels including therapy RUG levels (RAD, RAC, RAB, and RAA) and their corresponding RUG category labels.

therapy services continued through December 2, 2015, at the same RUG level.

- For the next look-back period of December 3, 2015, through December 9, 2015, the resident received 5 therapy days totaling 252 minutes. The amount of therapy, combined with the resident's ADL score, established a therapy RUG level of RAD (\$193.36), after which therapy services were discontinued for 9 weeks, but the RUG rate continued at the same therapy RUG level of RAD.

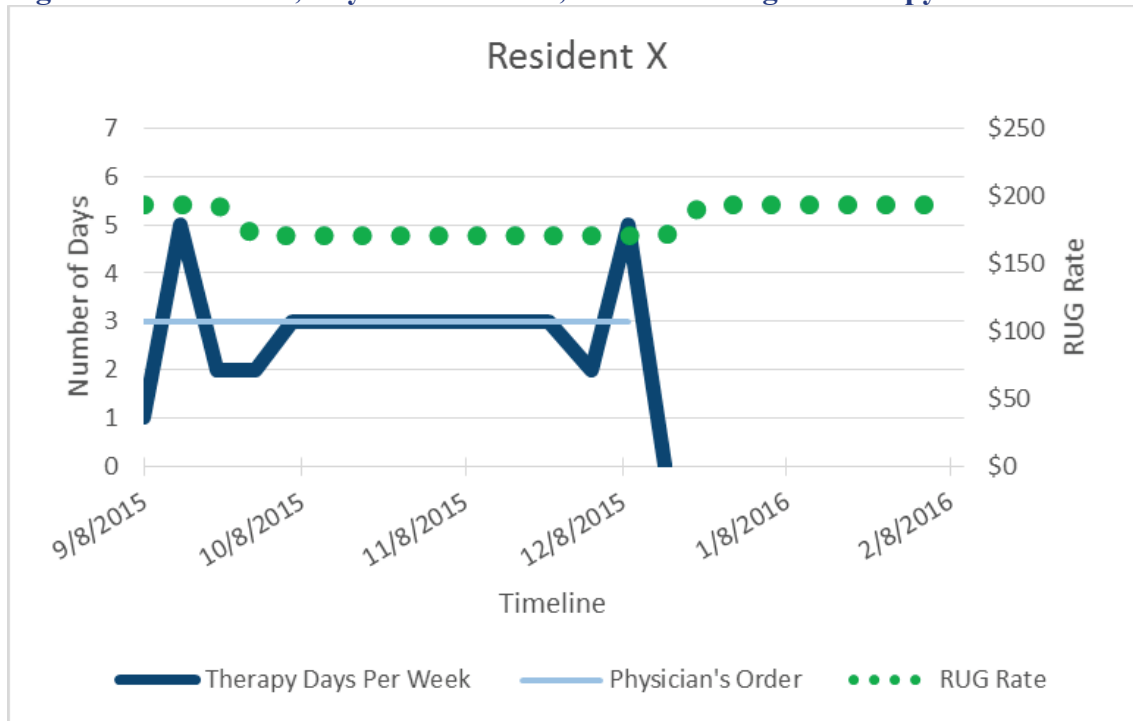
Table 1: Clustering Pattern of Therapy

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
PT	Pre ARD Look-back Week	9/8/2015	1	3	75	\$193.36
PT	ARD Look-back Week	9/15/2015	5	3	250	193.36
PT	Post ARD Week 1	9/22/2015	2	3	76	193.36
PT	Post ARD Week 2	9/29/2015	2	3	78	170.79
PT	Post ARD Week 3	10/6/2015	3	3	159	170.79
PT	Post ARD Week 4	10/13/2015	3	3	146	170.79
PT	Post ARD Week 5	10/20/2015	3	3	129	170.79
PT	Post ARD Week 6	10/27/2015	3	3	119	170.79
PT	Post ARD Week 7	11/3/2015	3	3	119	170.79
PT	Post ARD Week 8	11/10/2015	3	3	159	170.79
PT	Post ARD Week 9	11/17/2015	3	3	129	170.79
PT	Post ARD Week 10	11/24/2015	3	3	129	170.79
PT	Pre ARD Look-back Week	12/2/2015	2	3	78	170.79
PT	ARD Look-back Week	12/9/2015	5	3	252	\$170.79
None	Post ARD Week 1	12/16/2015	-	-	-	170.79
None	Post ARD Week 2	12/23/2015	-	-	-	193.36
None	Post ARD Week 3	12/30/2015	-	-	-	193.36
None	Post ARD Week 4	1/6/2016	-	-	-	193.36
None	Post ARD Week 5	1/13/2016	-	-	-	193.36
None	Post ARD Week 6	1/20/2016	-	-	-	193.36
None	Post ARD Week 7	1/27/2016	-	-	-	193.36
None	Post ARD Week 8	2/3/2016	-	-	-	193.36
None	Post ARD Week 9	2/10/2016	-	-	-	193.36

Source: Mission resident monthly record of treatment

Figure 2 displays a graphical representation of the dates, days, physician's orders, and RUG rates identified in Table 1. Information for five additional resident records examined during this audit are charted and graphed in Appendix D.

Figure 2: RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

Therapy Scheduling Application

Mission uses an information technology application to track and schedule therapy sessions. The therapy scheduling application's functionality includes automatically determining assessment reference dates and corresponding look-back periods. The application enables Mission to schedule and provide therapy in a manner that (a) generally adheres to physician's orders to provide three therapy days per week and (b) achieves the highest therapy RUG level available. In addition, the application tracks Medicare funding for Mission and exports therapy billing information to the billing application.

MDS Assessments Established Therapy RUG Levels Just Before Physician Orders for Therapy Expired and Therapy Was Discontinued

For all 30 of the selected resident files with a physician's order for therapy 3 days per week, at least one MDS assessment resulting in therapy RUG levels was performed 21 or fewer days before the physician's order for therapy was set to expire. In addition, for all 30 of the selected residents whose orders had expired, no therapy was scheduled until the next look-back period. Residents went without

therapy for an average of ten consecutive weeks. Finally, for all 30 of the selected residents, 5 days of therapy were clustered in the next look-back period to re-establish or sustain a therapy RUG level.

Mission continued to receive Medicaid payments based on the therapy RUG level established during the MDS assessment for as long as 11 weeks after the expiration of therapy orders. MDS assessments were not performed to indicate significant changes in patients' conditions, and resident records did not contain supporting documentation for the absence or re-ordering of therapy.

Table 2 presents another example of the therapy days and minutes scheduled before, during, and after the look-back period for Resident Y. In this example:

- The resident received therapy from March 4, 2015, through March 18, 2015, at a therapy RUG level of RAD, after which therapy services were discontinued. In the following ten weeks, the resident received no therapy, but the RUG rate continued at the same therapy RUG level of RAD.
- For the look-back period of June 3, 2015, the resident received 5 therapy days totaling 151 minutes at a therapy RUG level of RAD, after which therapy services continued through July 8, 2015, at the same RUG level.
- On July 8, 2015, therapy services were discontinued for the following nine weeks, but the RUG rate continued at the same therapy RUG level of RAD.

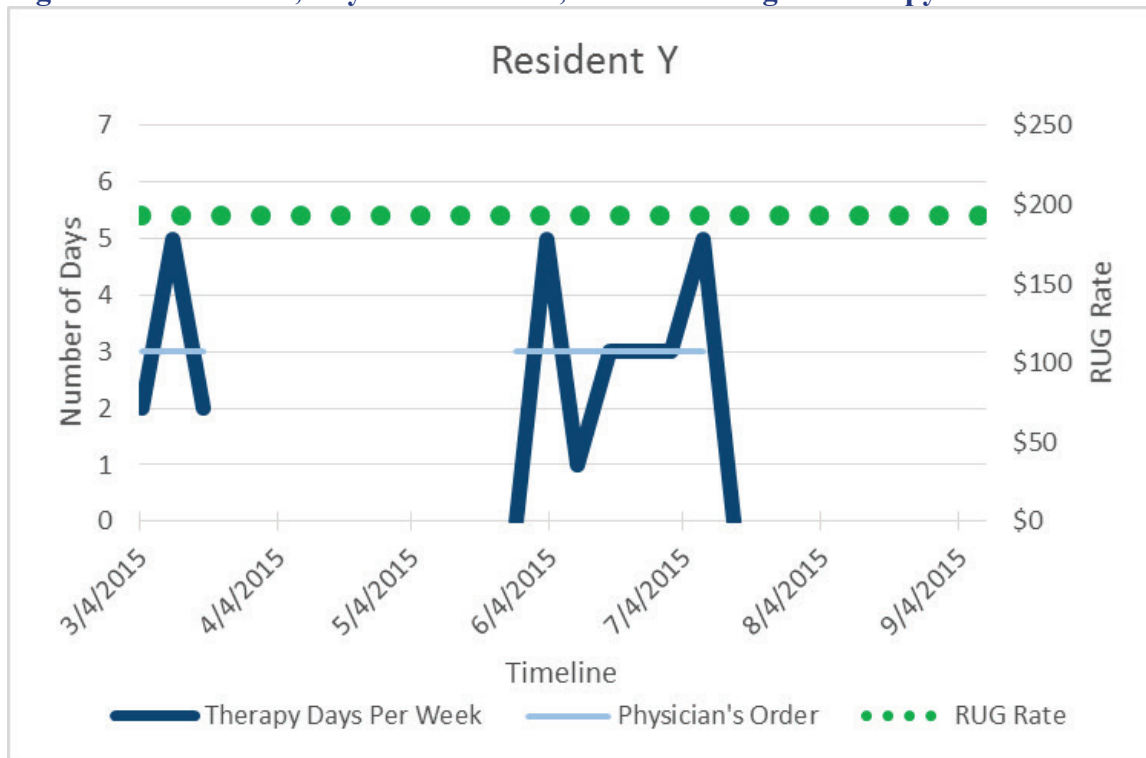
Table 2: Clustering Pattern of Therapy

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
OT	Pre ARD Look-back Week	3/4/2015	2	3	61	\$193.36
OT	ARD Look-back Week	3/11/2015	5	3	205	193.36
OT	Post ARD Week 1	3/18/2015	2	3	46	193.36
None	3/19/2015 through 5/20/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
PT	Pre ARD Look-back Week	5/27/2015	0	3	0	193.36
PT	ARD Look-back Week	6/3/2015	5	3	151	193.36
PT	Post ARD Week 1	6/10/2015	1	3	23	193.36
PT	Post ARD Week 2	6/17/2015	3	3	69	193.36
PT	Post ARD Week 3	6/24/2015	3	3	75	193.36
PT	Post ARD Week 4	7/1/2015	3	3	75	193.36
PT	Post ARD Week 5	7/8/2015	5	3	172	193.36
None	7/9/2015 through 9/9/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36

Source: Mission resident monthly record of treatment

Figure 3 displays a graphical representation of the dates, days, physician's orders, and RUG rates identified in Table 2. Mission continued to receive Medicaid payments based on the therapy RUG level of RAD established during the MDS assessment look-back periods after therapy services were discontinued (a) from March 18, 2015, through May 20, 2015, and (b) July 9, 2015, through September 9, 2015.

Figure 3: RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

Higher Medicaid Payments Resulting from Clustering Practice

Total RUG reimbursements to Mission for the 25-month audit period for 30 residents with clustering totaled \$1,907,581. The portion of this amount that resulted from clustering was \$692,952 (36 percent). Of the additional amount associated with clustering, a total of \$650,677¹² was paid through MCOs, and \$42,275 was paid as fee-for-service by HHSC. The practice of clustering of therapy services and Mission's subsequent billings for therapy RUG levels resulted in higher cost to the Medicaid program than would have been paid had the clustering not occurred and, consequently, in the inefficient use of Medicaid resources.

¹² Total paid through MCOs is adjusted for rounding.

Payments based on therapy RUG levels were paid to Mission for weeks when residents received no therapy. Of the \$692,952, a total of \$132,861 was reimbursed for therapy RUG levels that had been established by an MDS assessment that was performed just before therapy orders were set to expire. This amount represents \$130,452 paid through MCOs and \$2,409 paid as fee-for-service by HHSC.

The OIG Audit Division calculated the higher costs resulting from the clustering practice at Mission by identifying each resident's RUG level if the facility had reported on the MDS assessment an amount of therapy equal to what was prescribed per week by the physician.¹³ The OIG Audit Division recalculated RUG levels using MDS assessment software. The recalculated daily RUG level was then multiplied by the number of days during which the resident was assigned the original therapy RUG level as identified in MCO paid claims data and the daily census.¹⁴ The difference between the therapy RUG level payments and the recalculated RUG payment is the amount identified as excess cost.

The OIG Audit Division calculated the amount of the excess cost for residents who received no therapy after physician orders for therapy ended, and where Mission continued to receive payments based on a therapy RUG level. The number of days billed after therapy orders ended were multiplied by both the therapy RUG level and the recalculated RUG level without therapy. The difference represents the amount of the excess cost.

The calculations were not based on a statistical methodology and should not be applied or extrapolated across any population, such as other residents or time periods at Mission, or residents at other nursing facilities in Texas that provide therapy services. Appendix C contains a summary table of costs by resident, the calculation methodology used to identify the excess dollar amounts reported, and a list of all RUG levels paid by Medicaid dollars.

Recommendation 1

MCS should specify in policy or procedure that therapy RUG levels should not be based on (a) more therapy than the number of therapy days and the duration in minutes of each session as documented in a physician's written order or (b) an amount of therapy that would not qualify for a therapy RUG level if therapy decreases or ceases for a sustained period of time during a therapy RUG payment period.

¹³ When calculating Mission's non-therapy RUG payments, the IG used base RUG rate information that did not include additional payments or deductions that are facility or resident specific.

¹⁴ The daily census is a daily accounting of all residents in the facility. Mission also maintained in its daily census the RUG level for each resident.

Management Response

In 2008, Texas Medicaid replaced the state case-mix system for nursing facility provider payments, based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implemented Texas Health and Safety Code, §242.221, which required DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the Centers for Medicare and Medicaid Services (CMS). As a result, DADS replaced its Client Assessment, Review and Evaluation (CARE) form (also known as Form 3652) with the federal Minimum Data Set (MDS) assessment for making medical necessity determinations and calculating the RUG. The details of how this change has been operationalized can be found in 1 Texas Administrative Code (TAC) Chapter 355, Subchapter C (Reimbursement Methodology for Nursing Facilities).

As a result of a previous audit, MCS formed an internal workgroup to explore possibilities for addressing the Inspector General's findings regarding therapy RUG level processes. A change to a therapy RUG level policy may result in the need to change the entire assessment and payment system, which could result in costs and system changes. MCS will take under consideration the need to make any policy or procedural changes, and will consider the impact to legislative intent.

MCS recommends the Inspector General review the timing of new therapy orders in relation to the look-back period, as this may warrant additional attention. The Inspector General could check the medical record for documentation of a functional decline that would merit a new therapy evaluation and treatment order to ensure activity is not resulting in what would otherwise be an inappropriate increase in the RUG payment level.

Action Plan

MCS will follow the same steps being taken to address similar findings resulting from an investigation of another nursing facility. MCS will follow the leadership approved direction based on recommendations from the internal workgroup formed to address recommendation number one (1) in the Inspector General's report.

Responsible Manager

Deputy Associate Commissioner, Policy and Program

Target Implementation Date

- *Immediately utilize existing internal workgroup consisting of MCS policy and program, MCS quality monitoring, the State MDS RAI coordinator in MCS, regulatory services and rate analysis.*
- *Review nursing facility assessment policies and procedures: January 8, 2018 - March 31, 2018*
- *Develop policy or procedural change recommendations: April 2, 2018 - May 31, 2018*
- *Submit recommendations to the Deputy Executive Commissioner of Medical and Social Services: June 2018*
- *Submit final recommendations to the HHS Executive Commissioner: July 2018*

REVIEW OF MEDICAL RECORDS AND REQUIRED DOCUMENTATION

State rules and the HHSC nursing facility contract require nursing facilities to maintain accurate, complete, and readily accessible clinical notes in medical records, physician orders, plans of care, and MDS assessments.¹⁵ Mission is contractually obligated to keep medical records of adult residents for a minimum of five years after the medical services end and medical records of minor residents for a minimum of three years after the resident reaches legal age under Texas law.¹⁶

The OIG Audit Division reviewed and analyzed residents' medical records for required documentation supporting the evaluation, delivery, and billing for physical therapy, occupational therapy, and speech therapy services. Results indicated there were multiple instances of missing documentation and documents with no signatures.

Issue 2: Missing Documentation and Signatures

Resident medical records include physician orders, MDS assessments, and treatment plans that are required to be signed by qualified medical staff in accordance with their assigned authority and responsibilities. Resident evaluations that determine a need for therapy require a therapy plan of care. Plans of care must

¹⁵ 40 Tex. Admin. Code §§ 19.1910(a)(1) - (3) (May 1, 1995), 19.1911(b)(3), (4), (6), and (11) (Sept. 1, 2008), 19.1911(b)(3), (4), (7), (12), and (15) (Aug. 31, 2015), 19.1911(b)(4), (7), (12), and (15) (July 21, 2016), and 19.1912(d)(2) - (4) and (6) (May 1, 2002).

¹⁶ 40 Tex. Admin. Code § 19.1910(b)(1) and (2) (May 1, 1995).

be timely¹⁷ certified and signed¹⁸ by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as appropriate who has knowledge of the case.

Medical records for all 30 of the selected resident files were missing required documentation, such as signed and dated physician's orders, documentation for necessity of therapy, resident's certified plans of care, and recertified plans of care to support the evaluation and certification of the treatment plans for therapy services. Certification indicates that (a) the physician approves the plan of care for therapy and (b) the resident is under the care of a physician.

Mission, through its subcontracted therapy provider, delivered to the OIG Audit Division delayed certifications to compensate for the missing or unsigned plans of care. Delayed certifications were provided for all 30 residents in the audit scope, totaling 101 delayed certifications. The reason for issuing the delayed certifications was stated on the request for delayed certification as "Misplaced or lost in mail" or "Oversight: certification/recertification was not signed and dated for the certification/recertification period."

Of the 101 delayed certification forms for therapy services, 92 were prepared and signed by a physician during the onsite audit fieldwork. These certificates were produced after several months to more than a year and a half after therapy RUG reimbursements had been received by Mission. Therapy providers are required to provide a certification as soon as possible after the plan of care is established,¹⁹ but delayed certifications and recertifications are allowable when they include an explanation of the legitimate reason for the delay.²⁰

In addition, 9 of the 101 delayed certification forms did not include the physician signature. Three of the nine delayed certification forms that did not include a physician signature were also missing a specific type of therapy services ordered by the physician to be administered to the resident.

Medical records for all 30 of the selected resident files contained at least one plan of care that was not timely signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case. Record keeping was not well managed to ensure required documents were complete and included in the resident permanent file. Overall, the lack of appropriate documentation, including a certified plan of care by a physician or a qualified medical staff, creates a risk that residents may receive unnecessary or inappropriate treatment or do not receive needed treatment, potentially putting residents' health at risk.

¹⁷ 42 C.F.R. §§ 424.11(d)(3) (Oct. 1, 2014), 424.20(b) and (d) (Nov. 1, 2011, through Sept. 30, 2017), 424.24(c)(2) and (4)(i) (Jan. 1, 2008).

¹⁸ 42 C.F.R. §§ 424.20(e) (Nov. 1, 2011, through Sept. 30, 2017), 424.24(c)(3) and (4)(iii) (Jan. 1, 2008).

¹⁹ 42 C.F.R. § 424.24(c)(2) (Jan. 1, 2008).

²⁰ 42 C.F.R. § 424.11(d)(3) (Oct. 1, 2014).

Referral of Documentation Issue

Since the documentation issues at Mission may create risk to the CMS-administered Medicare program, which reimburses Mission for the cost of therapy services supported by this documentation, the OIG Audit Division referred the documentation issues to CMS.

CONCLUSION

The OIG Audit Division completed an audit of assessment and evaluation practices for Medicaid residents at Mission, a long-term care nursing facility.

Audit results indicated that patterns existed to substantiate that therapy services were scheduled more often during MDS assessment look-back periods than for other weeks outside of the look-back period. The practice resulted in Mission being reimbursed at a higher RUG level than would have been provided had clustering not occurred. Specifically, the OIG Audit Division concluded:

- Many MDS assessments indicated therapy was scheduled on more days and for more minutes during the look-back period than for other therapy weeks, resulting in a pattern referred to as clustering.
- Certification of the plan of care for therapy was missing from medical records, and other documents, such as documentation for necessity of therapy and physician orders, were missing signatures by qualified medical staff.

The OIG Audit Division offered recommendations to HHSC which, if implemented, will result in policy changes and associated procedures designed to disallow higher therapy RUG level payments associated with clustering, resulting in cost savings for the Texas Medicaid program.

Additionally, the OIG Audit Division referred the documentation issues to CMS, since the Medicare program reimburses Mission for the cost of therapy services supported by this documentation.

The OIG Audit Division thanks management and staff at MCS, Senior Care Centers, Mission, and Senior Rehab Solutions for their cooperation and assistance during this audit.

Appendix A: Objective, Scope, and Methodology

Objectives

The objectives of this audit were to (a) assess the accuracy of therapy related payments and reimbursements, and completeness of supporting documentation, and (b) determine whether therapy services were provided consistent with physician orders, in accordance with resident assessments and evaluations, and in compliance with applicable federal and state requirements.

Scope

The scope of this audit included Mission's practices for assessing, evaluating, and billing for therapy services during the period from March 1, 2015, through March 31, 2017, and selected IT general controls through the end of fieldwork in October 2017.

Methodology

To accomplish its objectives, the OIG Audit Division collected information for this audit through observations and discussions with responsible staff at Mission, and:

- Reviewed federal and state rules, regulations, policies, and procedures.
- Assessed medical records for 30 out of 138 residents who had the highest number of MDS assessment forms with a therapy RUG level, and with assessments that were administered between March 1, 2015, and March 31, 2017.
- Reviewed supporting documentation for therapy services and related Medicaid billings for the 30 residents whose records were reviewed.
- Analyzed and charted therapy information.
- Examined authorizations for computer user access and group permissions for the MDS assessment application at Mission, and computer user access authorization and group permissions for the application of its subcontractor of therapy services. This examination was not extended to general or application controls related to HHSC SAS because the system does not affect Mission's practices for assessing, evaluating, and billing for therapy services, and the data in HHSC SAS was not relied upon by the auditors to support their audit findings and conclusions.

The OIG Audit Division issued an engagement letter on July 28, 2017, to Mission providing information about the upcoming audit, and conducted fieldwork at

Mission's facility in Mission, Texas, from August 21, 2017, through August 24, 2017. While on site, the OIG Audit Division interviewed responsible personnel, evaluated resident information, and reviewed relevant documents related to physical therapy, occupational therapy, and speech therapy services.

Criteria

The OIG Audit Division used the following criteria to evaluate the information provided:

- 42 C.F.R. §§ 424.11 (2014), 424.20 (2011 through 2017), 424.24 (2008), and 483.20 (2012 through 2016)
- Tex. Gov. Code § 531.1011 (2013)
- 1 Tex. Admin. Code § 371.1 (2014 through 2017)
- 40 Tex. Admin. Code §§ 19.101 (2013 through 2017), 19.1202 (1995), 19.1301 (1995), 19.1306 (2008), 19.1910 (1995), 19.1911 (2008 through 2016), 19.1912 (2002), 19.2403 (2008), 19.2413 (2008), 19.801 (2006 through 2015), and 19.802 (2006)
- Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v. 1.12 (2014) and v. 1.13 (2015)
- Centers for Medicare and Medicaid Services Medicare Benefit Policy Manual, Chapter 15, §§ 220.1.3 (2008) and 220.3 (2008 through 2015)
- Contract for Mission SCC LLC d/b/a Mission Nursing & Rehabilitation Center, Contract No. 001018970 (2013)

Auditing Standards

GAGAS

The OIG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

ISACA

The OIG Audit Division performs work in accordance with the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals published by ISACA.

Appendix B: Data Analysis and Sampling Methodology

The OIG Audit Division obtained and compiled in a Microsoft Excel spreadsheet the detailed MDS assessments obtained from OIG Data and Technology for the audit scope of March 1, 2015, through March 31, 2017.

A pivot table was created in Excel from the detailed MDS assessments to derive a population of 138 individuals who resided at Mission during the scope period. Of these, 138 residents were assigned to a Medicaid therapy RUG level.

From the 138 residents with Medicaid therapy RUG levels, the OIG Audit Division selected a judgmental sample²¹ of 30 residents for audit fieldwork based on the highest number of MDS assessment forms billed for a Medicaid therapy RUG level. Residents with MDS assessment forms that included Medicaid therapy RUG levels and a single therapy discipline were in the audit scope and were selected for testing. The selected 30 residents' charts included a minimum of 5 MDS forms with therapy assessments to a maximum of 10 MDS forms with therapy assessments.

²¹ Judgmental sampling is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

Appendix C: Methodology for Calculating Higher Medicaid Payments

The clustering practices for therapy days resulted in higher-paying RUG levels than would have been paid if the facility had reported on the MDS assessment form an amount of therapy equal to what was prescribed per week by the physician. For the 30 selected residents who received therapy services from Mission 5 times per week during the look-back period, and for whom physician orders were for therapy services to be provided 3 times per week, the OIG Audit Division calculated the difference between payment under the original RUG level and payment that would have been made under the recalculated RUG level. Based on Mission's RUG levels data for the 30 selected residents, the total RUG reimbursed to Mission and the calculated portion of reimbursement caused by clustering are listed in Table 3.

Figure 4 provides an example of the methodology used for the calculation of excess costs. From July 29, 2015, through January 13, 2016, Resident 3 was assigned therapy RUG level RAD based on five therapy days provided to Resident 3 during that resident's look-back period. Mission billed and was reimbursed at RUG level RAD, which is \$193.36 per day, for a total of 186 days. Had Mission reported three therapy days during the look-back period, Mission would not have qualified for a therapy RUG level and would have been reimbursed at rehabilitative RUG level PE1, which is \$113.06 per day, for 186 days.

From March 23, 2016, through July 12, 2016, Resident 3 was assigned therapy RUG level RAC based on five therapy days provided to Resident 3 during that resident's look-back period. Mission billed and was reimbursed at RUG level RAC, which is \$170.79 per day, for a total of 131 days. Had Mission reported three therapy days during the look-back period, Mission would not have qualified for a therapy RUG level and would have been reimbursed at the following rehabilitative RUG levels:

- PD1, which is \$107.90 per day, for 45 days
- PE1, which is \$113.06 per day, for the following 86 days

Figure 4 represents the calculation of the RUG level used to determine the increased Medicaid cost if RUG level PE1 had been billed for 186 days, instead of billing RUG level RAD for 186 days. The calculation of the RUG level used to determine the increased Medicaid cost if RUG level PD1 had been billed for 45 days followed by PE1 for 86 days, instead of billing RUG level RAC for 131 days.

Figure 4: Calculation Methodology Example

Resident 3: Example of Calculation Methodology					
RUG Level	RUG Description	RUG Level Per Diem	No. of Days	Total Amount	Excess Costs
RAD Therapy RUG Level	Therapy Rehab/All Levels / 17-18 ADLs	\$193.36	186	\$35,964.96	
PE1 Non-Therapy RUG Level	Physical Function/ 16-18 ADLs	\$113.06	186	\$21,029.16	
RAC Therapy RUG Level	Therapy Rehab/All Levels / 14-16 ADLs	\$170.79	131	\$22,373.49	
PD1 Non-Therapy RUG Level	Physical Function/ 11-15 ADLs	\$107.90	45	\$ 4,855.50	
PE1 Non-Therapy RUG Level	Physical Function/ 16-18 ADLs	\$113.06	86	\$ 9,723.16	
Difference Between Therapy RUGs (RAD and RAC) and Non-Therapy RUGs (PD1 and PE1): $(\$35,964.96 + \$22,373.49) - (\$21,029.16 + \$4,855.50 + \$9,723.16) = \$22,730.63$					\$22,730.63

Source: HHSC Rate Analysis and Mission Resident MDS Assessments

Table 3: Higher Medicaid Costs²²

Based on Mission's RUG Levels Data		
Therapy Resident	Total RUG Reimbursed	Portion of Reimbursement Caused by Clustering
Resident 1	\$ 71,827.15	\$ 26,629.41
Resident 2	103,640.96	39,361.56
Resident 3	58,338.45	22,730.63
Resident 4	93,974.63	37,218.51
Resident 5	54,191.32	19,921.55
Resident 6	93,435.30	36,120.88
Resident 7	86,186.00	34,630.64
Resident 8	87,012.00	30,662.91
Resident 9	70,963.12	23,748.57
Resident 10	60,521.68	20,350.77
Resident 11	83,918.24	34,850.20
Resident 12	62,167.56	18,309.74
Resident 13	90,685.84	36,132.88
Resident 14	32,245.30	3,899.60
Resident 15	52,400.56	21,761.30
Resident 16	62,672.20	19,929.89
Resident 17	66,129.11	27,462.60
Resident 18	53,534.44	20,108.11
Resident 19	66,322.48	26,498.37
Resident 20	20,195.21	0.00 ²³
Resident 21	42,925.92	15,928.00
Resident 22	51,920.16	18,045.28
Resident 23	74,732.62	29,847.80
Resident 24	28,663.52	9,542.74
Resident 25	63,228.72	21,160.17
Resident 26	52,698.10	19,929.86
Resident 27	37,831.84	13,583.88
Resident 28	58,057.84	18,620.02
Resident 29	79,857.68	28,736.34
Resident 30	47,303.45	17,229.49
Totals:	\$1,907,581.40	\$ 692,951.70

Source: HHSC Rate Analysis and Mission Resident MDS Assessments

²² Table totals adjusted for rounding.

²³ For Resident 20, there was clustering of therapy due to the difference between the doctor's order and the number of days of therapy reported during the look-back period on the MDS form. At the same time, the resident's medical needs required resources of extensive services at the higher non-therapy RUG level of SE2.

Table 4: Texas Medicaid RUG Levels and RUG Category Label

RUG Level	RUG Category Label
SE3	Extensive Services / 7+ ADLs / 4 or 5 Extensive services
SE2	Extensive Services / 7+ ADLs / 2 or 3 Extensive services
SE1	Extensive Services / 7+ ADLs / 1 Extensive service
RAD	Rehab / All Levels / 17 - 18 ADLs
RAC	Rehab / All Levels / 14 - 16 ADLs
RAB	Rehab / All Levels / 9 - 13 ADLs
RAA	Rehab / All Levels / 4 - 8 ADLs
SSC	Special Care / 17 - 18 ADLs
SSB	Special Care / 15 - 16 ADLs
SSA	Special Care / 7 - 14 ADLs
CC2	Clinically Complex / 17 - 18 ADLs / Depression
CC1	Clinically Complex / 17 - 18 ADLs
CB2	Clinically Complex / 12 - 16 ADLs / Depression
CB1	Clinically Complex / 12 - 16 ADLs
CA2	Clinically Complex / 4 - 11 ADLs / Depression
CA1	Clinically Complex / 4 - 11 ADLs
IB2	Impaired Cognition / 6 - 10 ADLs / Nursing Rehab
IB1	Impaired Cognition / 6 - 10 ADLs
IA2	Impaired Cognition / 4 - 5 ADLs / Nursing Rehab
IA1	Impaired Cognition / 4 - 5 ADLs
BB2	Behavior Only / 6 - 10 ADLs / Nursing Rehab
BB1	Behavior Only / 6 - 10 ADLs
BA2	Behavior Only / 4 - 5 ADLs / Nursing Rehab
BA1	Behavior Only / 4 - 5 ADLs
PE2	Physical Function / 16 - 18 ADLs / Nursing Rehab
PE1	Physical Function / 16 - 18 ADLs
PD2	Physical Function / 11 - 15 ADLs / Nursing Rehab
PD1	Physical Function / 11 - 15 ADLs
PC2	Physical Function / 9 - 10 ADLs / Nursing Rehab
PC1	Physical Function / 9 - 10 ADLs
PB2	Physical Function / 6 - 8 ADLs / Nursing Rehab
PB1	Physical Function / 6 - 8 ADLs
PA2	Physical Function / 4 - 5 ADLs / Nursing Rehab
PA1	Physical Function / 4 - 5 ADLs
BC1/PCE	Default, if missing key data

Source: Department of Health and Hospitals, RUG III Classification Model, Version 5.20, 34 Group

Appendix D: Clustering of Therapy Days Pattern

Resident 3

Costs Due to Clustering: \$22,730.63

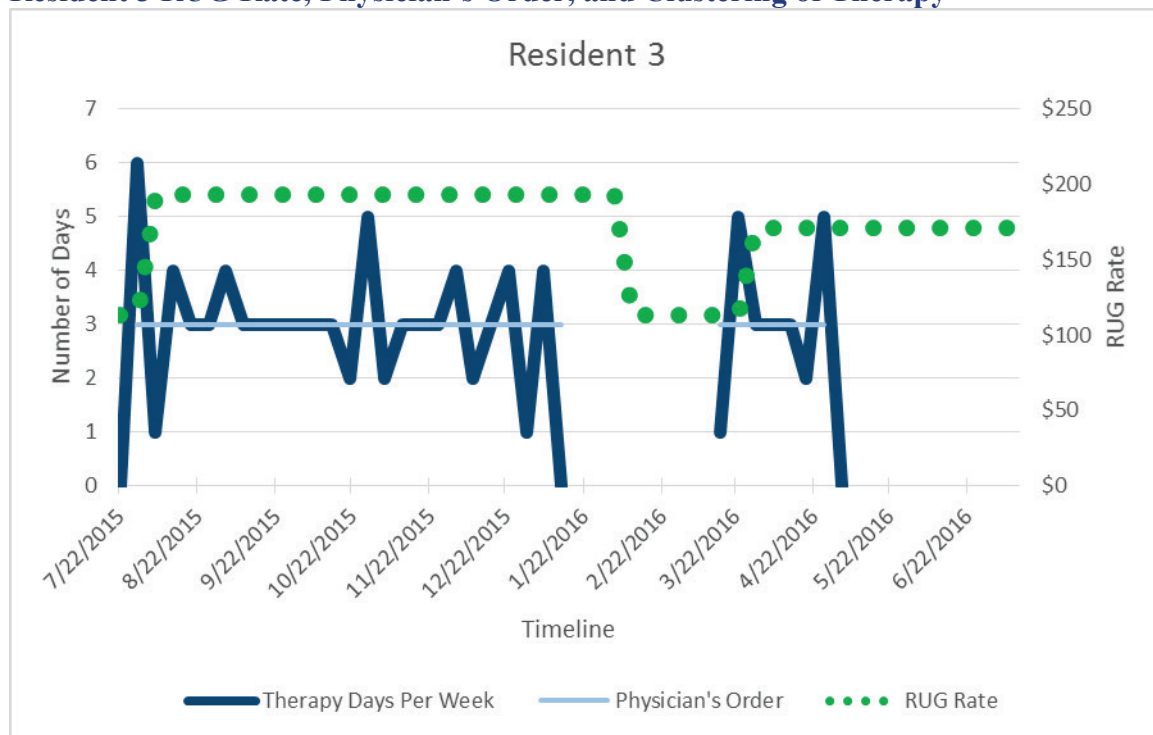
Resident 3 Clustering Pattern of Therapy

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
None	Pre ARD Look-back Week	7/22/2015	-	-	-	\$113.06
OT	ARD look-back Week	7/29/2015	6	3	317	113.06
OT	Post ARD Week 1	8/5/2015	1	3	68	193.36
OT	Post ARD Week 2	8/12/2015	4	3	197	193.36
OT	Post ARD Week 3	8/19/2015	3	3	144	193.36
OT	Post ARD Week 4	8/26/2015	3	3	144	193.36
OT	Post ARD Week 5	9/2/2015	4	3	197	193.36
OT	Post ARD Week 6	9/9/2015	3	3	144	193.36
OT	Post ARD Week 7	9/16/2015	3	3	129	193.36
OT	Post ARD Week 8	9/23/2015	3	3	159	193.36
OT	Post ARD Week 9	9/30/2015	3	3	159	193.36
OT	Post ARD Week 10	10/7/2015	3	3	166	193.36
OT	Post ARD Week 11	10/14/2015	3	3	161	193.36
OT	Pre ARD Look-Back Week	10/21/2015	2	3	106	193.36
OT	ARD Look-back Week	10/28/2015	5	3	265	193.36
OT	Post ARD Week 1	11/4/2015	2	3	113	193.36
OT	Post ARD Week 2	11/11/2015	3	3	159	193.36
OT	Post ARD Week 3	11/18/2015	3	3	173	193.36
OT	Post ARD Week 4	11/25/2015	3	3	159	193.36
OT	Post ARD Week 5	12/2/2015	4	3	219	193.36
OT	Post ARD Week 6	12/9/2015	2	3	106	193.36
OT	Post ARD Week 7	12/16/2015	3	3	159	193.36
OT	Post ARD Week 8	12/23/2015	4	3	219	193.36
OT	Post ARD Week 9	12/30/2015	1	3	60	193.36
OT	Post ARD Week 10	1/6/2016	4	3	219	193.36
OT	Post ARD Week 11	1/13/2016	0	3	0	193.36
None	Pre ARD Look-back Week	1/20/2016	-	-	-	193.36
	ARD Look-back Week	1/27/2016	-	-	-	193.36
	Post ARD Week 1	2/3/2016	-	-	-	193.36
	Post ARD Week 2	2/10/2016	-	-	-	113.06
	Post ARD Week 3	2/17/2016	-	-	-	113.06
	Post ARD Week 4	2/24/2016	-	-	-	113.06
	Post ARD Week 5	3/2/2016	-	-	-	113.06
	Post ARD Week 6	3/9/2016	-	-	-	113.06
PT	Pre ARD Look-back Week	3/16/2016	1	3	75	\$113.06

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
PT	ARD Look-back Week	3/23/2016	5	3	279	113.06
PT	Post ARD Week 1	3/30/2016	3	3	170	170.79
PT	Post ARD Week 2	4/6/2016	3	3	110	170.79
PT	Post ARD Week 3	4/13/2016	3	3	150	170.79
PT	Pre ARD Look-Back Week	4/19/2016	2	3	95	170.79
PT	ARD Look-back Week	4/26/2016	5	3	275	170.79
None	4/27/2016 through 7/12/2016 - Continued reimbursement at RUG level RAC. No documentation of physician's order, therapy days, and therapy minutes.				-	170.79

Source: Mission resident monthly record of treatment

Resident 3 RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

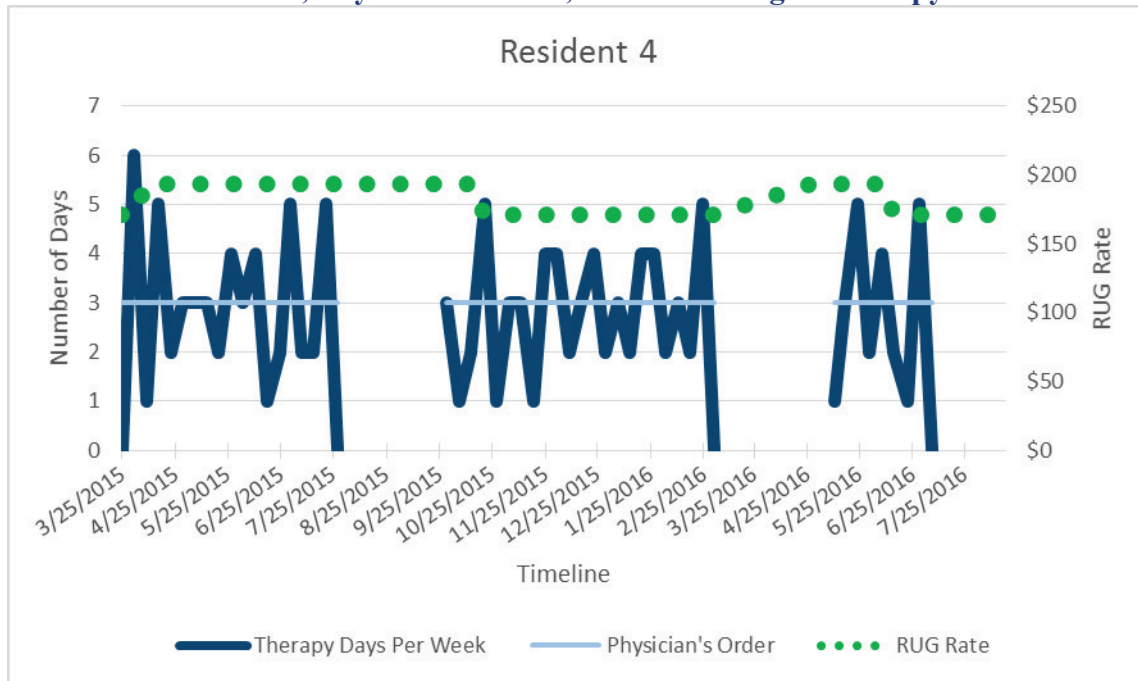
Resident 4**Costs Due to Clustering: \$37,218.51****Resident 4 Clustering Pattern of Therapy**

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
PT	Pre ARD Look-back Week	3/25/2015	0	3	0	\$170.79
PT	ARD Look-back Week	4/1/2015	6	3	258	170.79
PT	Post ARD Week 1	4/8/2015	1	3	53	193.36
PT	Post ARD Week 2	4/15/2015	5	3	235	193.36
PT	Post ARD Week 3	4/22/2015	2	3	106	193.36
PT	Post ARD Week 4	4/29/2015	3	3	116	193.36
PT	Post ARD Week 5	5/6/2015	3	3	129	193.36
PT	Post ARD Week 6	5/13/2015	3	3	159	193.36
PT	Post ARD Week 7	5/20/2015	2	3	61	193.36
PT	Post ARD Week 8	5/27/2015	4	3	197	193.36
PT	Post ARD Week 9	6/3/2015	3	3	159	193.36
PT	Post ARD Week 10	6/10/2015	4	3	233	193.36
PT	Post ARD Week 11	6/17/2015	1	3	38	193.36
PT	Pre ARD Look-back Week	6/24/2015	2	3	80	193.36
OT	ARD Look-back Week	6/30/2015	5	3	205	193.36
OT	Post ARD Week 1	7/7/2015	2	3	106	193.36
OT	Post ARD Week 2	7/14/2015	2	3	61	193.36
OT	Post ARD Week 3	7/21/2015	5	3	265	193.36
OT	Post ARD Week 4	7/28/2015	0	3	0	193.36
None	7/29/2015 through 9/22/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
PT	Pre ARD Look-back Week	9/22/2015	-	-	-	193.36
PT	ARD Look-back Week	9/29/2015	3	3	181	193.36
PT	Post ARD Week 1	10/6/2015	1	3	53	193.36
PT	Pre ARD Look-back Week	10/13/2015	2	3	91	193.36
PT	ARD Look-back Week	10/21/2015	5	3	264	170.79
PT	Post ARD Week 1	10/28/2015	1	3	53	170.79
PT	Post ARD Week 2	11/4/2015	3	3	144	170.79
PT	Post ARD Week 3	11/11/2015	3	3	159	170.79
OT	Post ARD Week 4	11/18/2015	1	3	60	170.79
OT	Post ARD Week 5	11/25/2015	4	3	219	170.79
OT	Post ARD Week 6	12/2/2015	4	3	219	170.79
OT	Post ARD Week 7	12/9/2015	2	3	120	170.79
OT	Post ARD Week 8	12/16/2015	3	3	173	170.79
OT	Post ARD Week 9	12/23/2015	4	3	231	170.79
OT	Post ARD Week 10	12/30/2015	2	3	106	170.79
OT	Post ARD Week 11	1/6/2016	3	3	173	170.79

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
OT	Post ARD Week 12	1/13/2016	2	3	106	\$170.79
OT	Post ARD Week 13	1/20/2016	4	3	240	170.79
OT	Post ARD Week 14	1/27/2016	4	3	233	170.79
OT	Post ARD Week 15	2/3/2016	2	3	120	170.79
OT	Post ARD Week 16	2/10/2016	3	3	180	170.79
OT	Pre ARD Look-back Week	2/17/2016	2	3	106	170.79
OT	ARD Look-back Week	2/24/2016	5	3	235	170.79
OT	Post ARD Week 1	3/2/2016	0	3	0	170.79
None	3/3/2016 through 5/4/2016 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
ST	Post ARD Week 11	5/11/2016	1	3	60	193.36
ST	Pre ARD Look-back Week	5/17/2016	3	3	120	193.36
ST	ARD Look-back Week	5/24/2016	5	3	180	193.36
ST	Post ARD Week 1	5/31/2016	2	3	90	193.36
ST	Post ARD Week 2	6/7/2016	4	3	120	193.36
ST	Post ARD Week 3	6/14/2016	2	3	90	170.79
ST	Pre ARD Look-back Week	6/22/2016	1	3	60	170.79
ST	ARD Look-back Week	6/29/2016	5	3	195	170.79
ST	Post ARD Week 1	7/6/2016	0	3	0	170.79
None	7/7/2016 through 8/17/2016 - Continued reimbursement at RUG level RAC. No documentation of physician's order, therapy days, and therapy minutes.				-	170.79

Source: Mission resident monthly record of treatment

Resident 4 RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

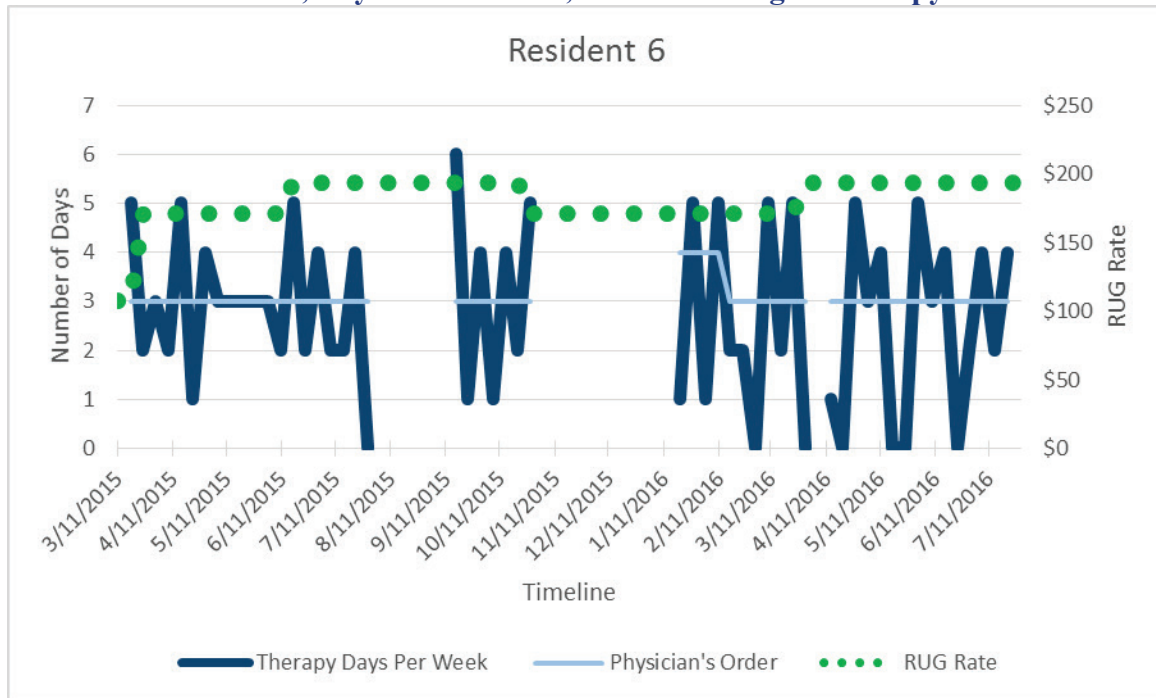
Resident 6**Costs Due to Clustering: \$36,120.88****Resident 6 Clustering Pattern of Therapy**

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
None	Pre ARD Look-back Week	3/11/2015	-	-	-	\$107.90
OT	ARD Look-back Week	3/18/2015	5	3	227	107.90
OT	Post ARD Week 1	3/25/2015	2	3	76	170.79
OT	Post ARD Week 2	4/1/2015	3	3	99	170.79
OT	Post ARD Week 3	4/8/2015	2	3	76	170.79
OT	Post ARD Week 4	4/15/2015	5	3	193	170.79
OT	Post ARD Week 5	4/22/2015	1	3	53	170.79
OT	Post ARD Week 6	4/29/2015	4	3	174	170.79
OT	Post ARD Week 7	5/6/2015	3	3	159	170.79
OT	Post ARD Week 8	5/13/2015	3	3	114	170.79
OT	Post ARD Week 9	5/20/2015	3	3	151	170.79
OT	Post ARD Week 10	5/27/2015	3	3	164	170.79
OT	Post ARD Week 11	6/3/2015	3	3	159	170.79
OT	Pre ARD Look-back Week	6/10/2015	2	3	121	170.79
OT	ARD Look-back Week	6/17/2015	5	3	265	193.36
OT	Post ARD Week 1	6/24/2015	2	3	106	193.36
OT	Post ARD Week 2	7/1/2015	4	3	204	193.36
OT	Post ARD Week 3	7/8/2015	2	3	91	193.36
OT	Post ARD Week 4	7/15/2015	2	3	76	193.36
OT	Post ARD Week 5	7/22/2015	4	3	204	193.36
OT	Post ARD Week 6	7/29/2015	0	3	0	193.36
None	7/30/2015 through 9/9/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
PT	Post ARD Week 13	9/16/2015	6	3	310	193.36
PT	Post ARD Week 14	9/23/2015	1	3	53	193.36
PT	Post ARD Week 15	9/30/2015	4	3	197	193.36
PT	Post ARD Week 16	10/7/2015	1	3	53	193.36
PT	Post ARD Week 17	10/14/2015	4	3	219	193.36
PT	Pre ARD Look-back Week	10/21/2015	2	3	106	193.36
PT	ARD Look-back Week	10/28/2015	5	3	250	170.79
None	10/29/2015 through 1/13/2016 - Continued reimbursement at RUG level RAC. No documentation of physician's order, therapy days, and therapy minutes.				-	170.79
OT	Pre ARD Look-back Week	1/20/2016	1	4	45	170.79
OT	ARD Look-back Week	1/27/2016	5	4	248	170.79
OT	Post ARD Week 1	2/3/2016	1	4	60	170.79
OT	Post ARD Week 2	2/10/2016	5	4	229	170.79

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
OT	Post ARD Week 3	2/17/2016	2	3	106	\$170.79
OT	Post ARD Week 4	2/24/2016	2	3	107	170.79
OT	Post ARD Week 5	3/2/2016	0	3	0	170.79
OT	Post ARD Week 6	3/9/2016	5	3	244	170.79
OT	Pre ARD Look-back Week	3/16/2016	2	3	113	170.79
OT	ARD Look-back Week	3/23/2016	5	3	308	170.79
OT	Post ARD Week 1	3/30/2016	0	3	0	193.36
None	Post ARD Week 2	4/6/2016	-	-	-	193.36
PT	Post ARD Week 3	4/13/2016	1	3	75	193.36
PT	Post ARD Week 4	4/20/2016	0	3	0	193.36
PT	Post ARD Week 5	4/27/2016	5	3	280	193.36
PT	Post ARD Week 6	5/4/2016	3	3	170	193.36
PT	Post ARD Week 7	5/11/2016	4	3	220	193.36
PT	Post ARD Week 8	5/18/2016	0	3	0	193.36
PT	Post ARD Week 9	5/25/2016	0	3	0	193.36
PT	Post ARD Week 10	6/1/2016	5	3	288	193.36
PT	Pre ARD Look-back Week	6/9/2016	3	3	173	193.36
PT	ARD Look-back Week	6/16/2016	4	3	218	193.36
PT	Post ARD Week 1	6/23/2016	0	3	0	193.36
PT	Post ARD Week 2	6/30/2016	2	3	91	193.36
PT	Post ARD Week 3	7/7/2016	4	3	214	193.36
PT	Post ARD Week 4	7/14/2016	2	3	106	193.36
PT	Post ARD Week 5	7/21/2016	4	3	197	193.36
None	Post ARD Week 6	7/28/2016	-	-	-	193.36

Source: Mission resident monthly record of treatment

Resident 6 RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

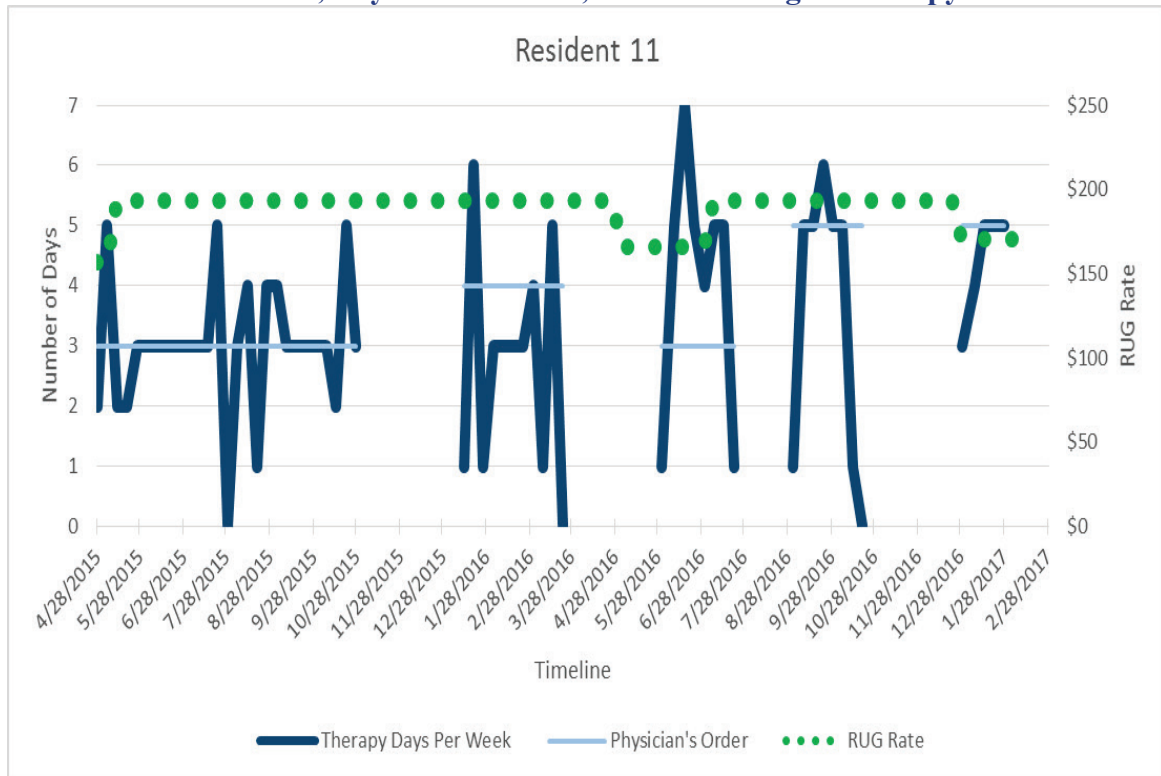
Resident 11**Costs Due to Clustering: \$34,850.20****Resident 11 Clustering Pattern of Therapy**

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
PT	Pre ARD Look-back Week	4/28/2015	2	3	115	\$156.83
PT	ARD Look-back Week	5/5/2015	5	3	265	156.83
PT	Post ARD Week 1	5/12/2015	2	3	98	193.36
PT	Post ARD Week 2	5/19/2015	2	3	91	193.36
PT	Post ARD Week 3	5/26/2015	3	3	159	193.36
PT	Post ARD Week 4	6/2/2015	3	3	144	193.36
PT	Post ARD Week 5	6/9/2015	3	3	144	193.36
PT	Post ARD Week 6	6/16/2015	3	3	144	193.36
PT	Post ARD Week 7	6/23/2015	3	3	93	193.36
PT	Post ARD Week 8	6/30/2015	3	3	144	193.36
PT	Post ARD Week 9	7/7/2015	3	3	129	193.36
PT	Pre ARD Look-back Week	7/15/2015	3	3	121	193.36
OT	ARD Look-back Week	7/22/2015	5	3	204	193.36
OT	Post ARD Week 1	7/29/2015	0	3	0	193.36
OT	Post ARD Week 2	8/5/2015	3	3	151	193.36
OT	Post ARD Week 3	8/12/2015	4	3	212	193.36
OT	Post ARD Week 4	8/19/2015	1	3	53	193.36
OT	Post ARD Week 5	8/26/2015	4	3	182	193.36
OT	Post ARD Week 6	9/2/2015	4	3	172	193.36
OT	Post ARD Week 7	9/9/2015	3	3	151	193.36
OT	Post ARD Week 8	9/16/2015	3	3	131	193.36
OT	Post ARD Week 9	9/23/2015	3	3	144	193.36
OT	Post ARD Week 10	9/30/2015	3	3	144	193.36
OT	Post ARD Week 11	10/7/2015	3	3	173	193.36
OT	Pre ARD Look-Back Week	10/14/2015	2	3	106	193.36
OT	ARD Look-back Week	10/21/2015	5	3	235	193.36
OT	Post ARD Week 1	10/28/2015	3	3	151	193.36
None	10/29/2015 through 1/5/2016 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
OT	Pre ARD Look-back Week	1/12/2016	1	4	75	193.36
OT	ARD Look-back Week	1/19/2016	6	4	293	193.36
OT	Post ARD Week 1	1/26/2016	1	4	53	193.36
OT	Post ARD Week 2	2/2/2016	3	4	166	193.36
OT	Post ARD Week 3	2/9/2016	3	4	144	193.36
OT	Post ARD Week 4	2/16/2016	3	4	166	193.36
OT	Post ARD Week 5	2/23/2016	3	4	144	193.36
OT	Post ARD Week 6	3/1/2016	4	4	226	193.36

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
OT	Post ARD Week 7	3/8/2016	1	4	60	\$193.36
OT	Post ARD Week 8	3/15/2016	5	4	293	193.36
OT	Post ARD Week 9	3/22/2016	0	4	0	193.36
None	3/23/2016 through 4/26/2016 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
None	Pre ARD Look-back Week	4/12/2016	-	-	-	193.36
None	ARD Look-back Week	4/19/2016	-	-	-	193.36
None	Post ARD Week 1	4/26/2016	-	-	-	193.36
None	Post ARD Week 2	5/3/2016	-	-	-	166.27
None	Post ARD Week 3	5/10/2016	-	-	-	166.27
None	Post ARD Week 4	5/17/2016	-	-	-	166.27
None	Post ARD Week 5	5/24/2016	-	-	-	166.27
PT	Post ARD Week 6	5/31/2016	1	3	75	166.27
PT	Pre ARD Look-back Week	6/9/2016	5	3	243	166.27
PT	ARD Look-back Week	6/16/2016	7	3	330	166.27
PT	Post ARD Week 1	6/23/2016	5	3	283	166.27
PT	Post ARD Week 2	6/30/2016	4	3	182	166.27
PT	Post ARD Week 3	7/7/2016	5	3	249	193.36
PT	Post ARD Week 4	7/14/2016	5	3	251	193.36
PT	Post ARD Week 5	7/21/2016	1	3	38	193.36
None	7/22/2016 through 8/25/2016 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
OT	Post ARD Week 11	9/1/2016	1	5	30	193.36
OT	Pre ARD Look-back Week	9/8/2016	5	5	227	193.36
OT	ARD Look-back Week	9/15/2016	5	5	265	193.36
OT	Post ARD Week 1	9/22/2016	6	5	280	193.36
OT	Post ARD Week 2	9/29/2016	5	5	268	193.36
OT	Post ARD Week 3	10/6/2016	5	5	227	193.36
OT	Post ARD Week 4	10/13/2016	1	5	53	193.36
OT	Post ARD Week 5	10/20/2016	0	5	0	193.36
None	10/21/2016 through 12/22/2016 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
PT	Post ARD Week 15	12/29/2016	3	5	151	170.79
PT	Pre ARD Look-back Week	1/7/2017	4	5	197	170.79
PT	ARD Look-back Week	1/14/2017	5	5	265	170.79
PT	Post ARD Week 1	1/21/2017	5	5	257	\$170.79
PT	Post ARD Week 2	1/28/2017	5	5	265	170.79
None	Post ARD Week 3	2/4/2017	-	-	-	170.79
None	Post ARD Week 4	2/11/2017	-	-	-	170.79

Source: Mission resident monthly record of treatment

Resident 11 RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

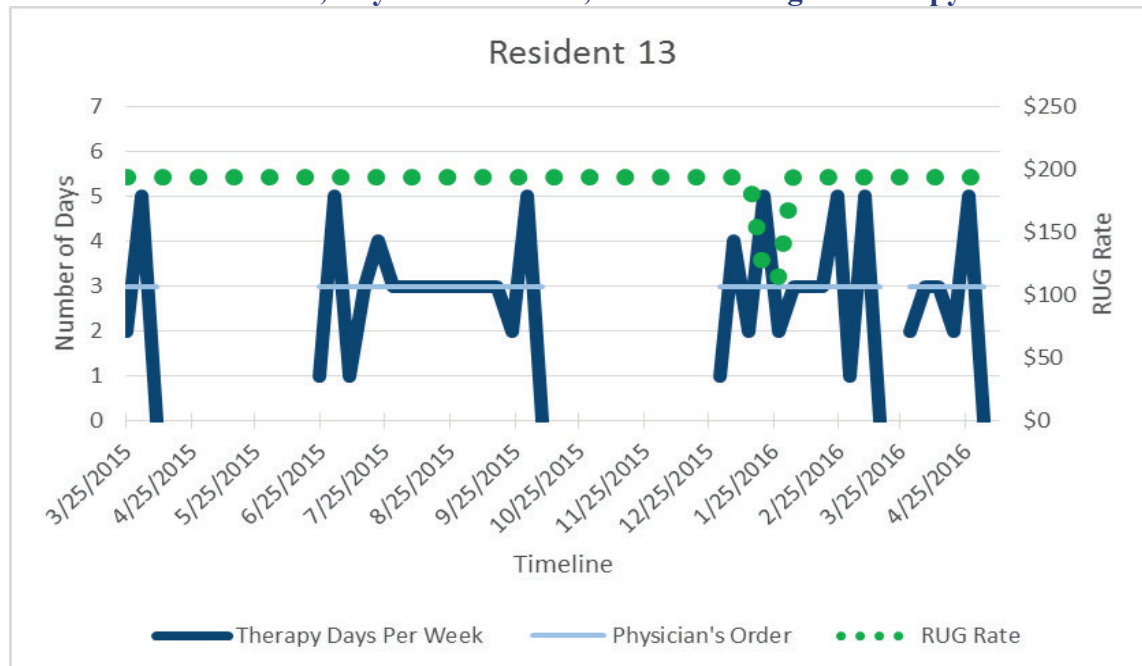
Resident 13**Costs Due to Clustering: \$36,132.88****Resident 13 Clustering Pattern of Therapy**

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
PT	Pre ARD Look-back Week	3/25/2015	2	3	95	\$193.36
PT	ARD Look-back Week	4/1/2015	5	3	226	193.36
PT	Post ARD Week 1	4/8/2015	0	3	0	193.36
None	4/9/2015 through 6/17/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
OT	Pre ARD Look-back Week	6/24/2015	1	3	45	193.36
OT	ARD Look-back Week	7/1/2015	5	3	227	193.36
OT	Post ARD Week 1	7/8/2015	1	3	53	193.36
OT	Post ARD Week 2	7/15/2015	3	3	129	193.36
OT	Post ARD Week 3	7/22/2015	4	3	197	193.36
OT	Post ARD Week 4	7/29/2015	3	3	144	193.36
OT	Post ARD Week 5	8/5/2015	3	3	144	193.36
OT	Post ARD Week 6	8/12/2015	3	3	159	193.36
OT	Post ARD Week 7	8/19/2015	3	3	129	193.36
OT	Post ARD Week 8	8/26/2015	3	3	144	193.36
OT	Post ARD Week 9	9/2/2015	3	3	144	193.36
OT	Post ARD Week 10	9/9/2015	3	3	166	193.36
OT	Post ARD Week 11	9/16/2015	3	3	159	193.36
OT	Pre ARD Look-back Week	9/23/2015	2	3	106	193.36
OT	ARD Look-back Week	9/30/2015	5	3	235	193.36
OT	Post ARD Week 1	10/7/2015	0	3	0	193.36
None	10/8/2015 through 12/23/2015 - Continued reimbursement at RUG level RAD. No documentation of physician's order, therapy days, and therapy minutes.				-	193.36
PT	ARD Look-back Week	12/30/2015	1	3	60	193.36
PT	Post ARD Week 1	1/6/2016	4	3	212	193.36
PT	Pre ARD Look-back Week	1/13/2016	2	3	113	193.36
PT	ARD Look-back Week	1/20/2016	5	3	295	113.06
PT	Post ARD Week 1	1/27/2016	2	3	106	113.06
PT	Post ARD Week 2	2/3/2016	3	3	173	193.36
PT	Post ARD Week 3	2/10/2016	3	3	174	193.36
PT	Post ARD Week 4	2/17/2016	3	3	91	193.36
PT	Post ARD Week 5	2/24/2016	5	3	272	193.36
PT	Pre ARD Look-back Week	3/1/2016	1	3	60	193.36
PT	ARD Look-back Week	3/8/2016	5	3	293	193.36
PT	Post ARD Week 1	3/15/2016	0	3	0	193.36
None	Post ARD Week 2	3/22/2016	-	-	-	193.36

Therapy Type	ARD Week	ARD Week Last Day	Therapy Days Per Week	Physician's Order	Therapy Minutes	RUG Rate
OT	Post ARD Week 3	3/29/2016	2	3	100	\$193.36
OT	Post ARD Week 4	4/5/2016	3	3	155	193.36
OT	Post ARD Week 5	4/12/2016	3	3	135	193.36
OT	Pre ARD Look-back Week	4/19/2016	2	3	110	193.36
OT	ARD Look-back Week	4/26/2016	5	3	280	193.36
OT	Post ARD Week 1	5/3/2016	0	3	0	193.36
None	Post ARD Week 2	5/10/2016	-	-	-	193.36

Source: Mission resident monthly record of treatment

Resident 13 RUG Rate, Physician's Order, and Clustering of Therapy



Source: Mission resident monthly record of treatment

Appendix E: Mission Management Comment



Mission Nursing and Rehabilitation Center
1013 S. Bryan Rd.
Mission, TX. 78572

Date: 3/7/18
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Steve Sizemore, CIA, CISA, CGAP
Performance Audit Director
Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Sizemore:

Set forth below are the provider comments to address the issues identified in the draft, *Assessment and Evaluation Practices at Mission Nursing and Rehabilitation Center*, issued 2/21/18 (the "Assessment"). Our comments have been organized to address three issues, identified as:

- **Clustering**
 - Per reviewer findings, 135 of 194 MDS assessments, across 30 residents, demonstrated provision of services at 5x/week frequency during the look back period, resulting in a financial impact of \$692,000.00, 39% of the \$1.78 million billed charges reviewed. Such findings, from a reviewer perspective, contributed to clustering, and
 - RUG categories not representative of actual services delivered per a therapy week; and
 - RUG categories consisting of treatment not representative of physician orders
 - In response, the provider responds that:
 - There is a lack of a definition for a treatment week provided by CMS. The absence of this definition results in the utilization of a Sunday through Saturday calendar week, which may differ from the week defined by the MDS assessment reference date
 - The Provider has complied with the provision of therapy services under the ***RUG-III Version 5.12 Calculation Worksheet, 34 Group Model, 5/15/01***. This was confirmed by the OIG review team through the statement in the Assessment that "...this practice is not prohibited practice currently..."
 - The Provider has also complied with CMS Pub 100-02, Chapter 15, Section 220.1.2, which states in pertinent part that "... Changes to the frequency may be made based on the clinicians [sic] clinical judgment and ***do not*** require recertification of the plan..."
- **Scheduling of therapy sessions**

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- Per reviewer findings, scheduled sessions, in 70% of MDS assessments reviewed, therapy days/minutes provided during the look-back period were greater than those provided for most weeks outside the look-back period, indicating a pattern of clustering. Discussion addressed the therapy scheduling application utilized to track and schedule therapy sessions, stating the application enables the provider to schedule and provide therapy in a manner that (a) generally adheres to physician's orders to provide three therapy days per week and (b) achieves the highest therapy RUG level available.
- In response, the provider cites utilization of this application, Casamba, as a scheduling tool, by providers industry wide. The application's *Planner3 (Version 11.16)* is available for review and reference.

- **Documentation**

- Per reviewer findings, the documentation reviewed incorporated a large volume of delayed certifications, in excess of 100, with many signed during the onsite review visit
- In response, the provider cites,
 - The provider's established process for securing timely certification complies with the following:
 - **CMS Pub. 100-02, Chapter 15, 220.1.3 - Certification and Recertification of Need for Treatment and Therapy Plans of Care (Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08) Reference: 42CFR424.24(c)**

D. Delayed Certification References: §1835(a) of the Act 42CFR424.11(d)(3)

Certifications are required for each interval of treatment based on the patient's needs, not to exceed 90 calendar days from the initial therapy treatment. Certifications are timely when the initial certification (or certification of a significantly modified plan of care) is dated within 30 calendar days of the initial treatment under that plan. Recertification is timely when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less. Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.

Delayed certifications should include any evidence the provider or supplier considers necessary to justify the delay. For example, a certification may be delayed because the physician did not sign it, or the original was lost. In the case of a long delayed certification (over 6 months), the provider or supplier may choose to submit with the delayed certification some other documentation (e.g., an order, progress notes, telephone contact, requests for certification or signed statement of a physician/NPP) indicating need for care and that the patient was under the care of a physician at the time of the treatment. Such documentation

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may be requested by the contractor for delayed certifications if it is required for review.

It is not intended that needed therapy be stopped or denied when certification is delayed. The delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately).

EXAMPLE: Payment should be denied if there is a certification signed 2 years after treatment by a physician/NPP who has/had no knowledge of the patient when the medical record also shows e.g., no order, note, physician/NPP attended meeting, correspondence with a physician/NPP, documentation of discussion of the plan with a physician/NPP, documentation of sending the plan to any physician/NPP, or other indication that there was a physician/NPP involved in the case.

EXAMPLE: Payment should not be denied, even when certified 2 years after treatment, when there is evidence that a physician approved needed treatment, such as an order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, certifications for intervals before or after the service in question, or physician/NPP services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.

EXAMPLE: Subsequent certifications of plans for continued treatment for the same condition in the same patient may indicate physician certification of treatment that occurred between certification dates, even if the signature for one of the plans in the episode is delayed. If a certified plan of care ends March 30th and a new plan of care for continued treatment after March 30th is developed or signed by a therapist on April 15th and that plan is subsequently certified, that certification may be considered delayed and acceptable effective from the first treatment date after March 30th for the frequency and duration as described in the plan. Of course, documentation should continue to indicate that therapy during the delay is medically necessary, as it would for any treatment. The certification of the physician/NPP is interpreted as involvement and approval of the ongoing episode of treatment, including the treatment that preceded the date of the certification unless the physician/NPP indicates otherwise.

E. Denials Due to Certification

Denial for payment that is based on absence of certification is a technical denial, which means a statutory requirement has not been met. Certification is a statutory requirement in SSA 1835(a)(2)- ("periodic review" of the plan). For example, if a patient is treated and the provider/supplier cannot produce (on contractor request) a plan of care (timely or delayed) for the billed treatment

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dates certified by a physician/NPP, then that service might be denied for lack of the required certification. If an appropriate certification is later produced, the denial shall be overturned.

In the case of a service furnished under a provider agreement as described in 42CFR489.21, the provider is precluded from charging the beneficiary for services denied as a result of missing certification.

However, if the service is provided by a supplier (in the office of the physician/NPP, or therapist) a technical denial due to absence of a certification results in beneficiary liability. For that reason, it is recommended that the patient be made aware of the need for certification and the consequences of its absence.

A technical denial decision may be reopened by the contractor or reversed on appeal as appropriate, if delayed certification is later produced.

The provider would like consideration by the review committee, of probe results, issued 5/15/17, following review of 20 Part B claims by Novitas Solutions, Inc., the Medicare Administrative Contractor for the facility. The results, found that 19 of 20 claims for service dates 10/1/16 – 12/3/16, were approved for reimbursement, as billed, and only 1 of 20 claims was denied reimbursement. Upon appeal, of the one denial the denial was completely overturned. .

Mission Nursing and Rehabilitation Center continues to provide training and oversight to ensure compliant practices related to assessment and evaluation. Monthly documentation reviews are completed by Senior Rehab Solutions. Weekly interdisciplinary Medicaid meetings are scheduled to discuss resource utilization, identify upcoming assessment reference dates, and communicate regarding resident needs. A tracking log is maintained to record physician signatures for therapy documentation. Additionally, monitoring has been added to the monthly triple check process to ensure that appropriate signatures are present prior to the billing of claims.

Thank you,



Phil Whirley, LNFA
Interim Administrator
Senior Care of Mission
361.549.1240

Enclosures:

1. Centers for Medicare and Medicaid Services. (2017, July 11). Medicare Benefits Policy Manual, Chapter 15, Section 220.1.2 – 220.1.3, Retrieved October 17, 2017, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

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2. Casamba *SMART* Manual, Planner3 (Version 11.16)
3. Jordan, J. (2017, May 15). Notice of Medical Review results [Letter to Mission SCC LLC].
4. RUG-III Version 5.12 Grouper Package Files. (2013, April 11). 34 Group Model Calculation Worksheet Retrieved October 17, 2017, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDS20SWSpecs/RUGIIIVersion512GrouperPackageFiles.html>

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Appendix F: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Melissa Larson, CIA, CISA, CFE, HCISPP, Audit Manager
- Nejiba Kheribi, CPA, CITP, CISA, CGAP, Audit Project Manager
- Brian Baker, Staff Auditor
- Carolyn Cadena, CIGA, CRMA, Staff Auditor
- Scott Miller, Senior Audit Operations Analyst
- Kathryn Messina, Senior Audit Operations Analyst

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- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Victoria Ford, Chief Policy Officer
- David Kostroun, Deputy Executive Commissioner, Regulatory Services
- Karen Ray, Chief Counsel
- Karin Hill, Director of Internal Audit
- Enrique Marquez, Deputy Executive Commissioner, Medical and Social Services
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Michelle Erwin, Director of Policy and Program Development, Medicaid and CHIP Services
- Grace Windbigler, Director, Health Plan Management, Medicaid and CHIP Services

Mission Nursing and Rehabilitation Center

- Andrew Kerr, President, Chief Financial Officer, Senior Care Centers, LLC
- Phil Whirley, Administrator, Mission Nursing and Rehabilitation Center, Senior Care Centers, LLC

Appendix G: OIG Mission and Contact Information

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, Chief of Staff and Chief Counsel
- Olga Rodriguez, Chief of Strategy
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Roland Luna, Deputy IG for Investigations
- Brian Klozik, Deputy Inspector General for Medicaid Program Integrity
- Lizet Hinojosa, Deputy IG for General Investigations
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

To Contact the OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
Office of Inspector General
P.O. Box 85200
Austin, Texas 78708-5200
- Phone: 512-491-2000