

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SOUTH FLORIDA MEDICARE
COMPREHENSIVE OUTPATIENT
REHABILITATION FACILITIES**



Daniel R. Levinson
Inspector General

November 2011
OEI-05-10-00090



OBJECTIVES

1. To determine whether Comprehensive Outpatient Rehabilitation Facilities (CORF) in South Florida were operational (i.e., at the location on file with the Centers for Medicare & Medicaid Services (CMS) and open during business hours).
2. To describe CMS actions against CORFs that were not operational.

BACKGROUND

CORFs provide multidisciplinary outpatient rehabilitation services at a single location. Medicare allowed approximately \$70 million for almost 40,000 beneficiaries nationwide who received CORF services in 2010. Of this amount, more than \$22 million was for claims by South Florida CORFs. In 2010, more than 25 percent of all CORFs were in South Florida.

Previous work has demonstrated that CORFs in South Florida may be vulnerable to fraud, waste, and abuse. For example, the Office of Inspector General estimated that in 2003, three South Florida CORFs received between \$720,000 and \$1.6 million each in inappropriate payments for services. A 2004 report by the Government Accountability Office found that per-beneficiary payments to CORFs in South Florida were two to three times higher than per-beneficiary payments to other outpatient therapy providers.

To determine whether CORFs in South Florida were at the location on file with CMS and were open during business hours, we conducted unannounced site visits to all South Florida CORFs. We also determined the amount that Medicare allowed for claims from nonoperational CORFs and reviewed documentation about CMS actions against nonoperational CORFs.

FINDINGS

Eighteen of the one hundred one South Florida CORFs were not operational. Ten CORFs were not at the location on file with CMS. Eight CORFs were not open during business hours. Medicare allowed \$2.2 million for services provided by these CORFs in 2010.

CMS took action against most of the nonoperational CORFs based on a special enrollment project and routine oversight. CMS took action against 16 of the 18 nonoperational CORFs in the months after we completed our site visits. A special enrollment project resulted in 10 actions against nonoperational CORFs, and routine oversight resulted in 6 such actions.

RECOMMENDATIONS

Periodically conduct unannounced site visits to CORFs. Continuing to periodically conduct nationwide unannounced site visits would enable CMS to identify and remove nonoperational CORFs from the program and potentially reduce erroneous Medicare payments. CMS could focus unannounced site visits in high-risk areas or base them on fraud-risk assessments.

Use additional program safeguards for CORFs. CMS should use other program safeguards to prevent potentially nonoperational CORFs from enrolling in the Medicare program and to monitor existing CORFs. Other safeguards may include a moratorium on the enrollment of new CORFs and payment suspensions.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. CMS stated that it currently conducts unannounced enrollment and revalidation site visits to CORFs and that it plans to increase the frequency of unannounced, out-of-cycle site visits to CORFs. CMS also stated that it will continue to take administrative actions, as appropriate. CMS stated that these actions may include, but are not limited to, prepayment review, auto-deny edits, payment suspensions, and revocations. We did not make any changes to the report based on CMS's comments.



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BACKGROUND

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CORFs are disproportionately concentrated in South Florida. Over one-fourth of the 303 CORFs that billed Medicare in 2010 were located in South Florida.

Vulnerabilities with CORFs in South Florida

Previous work has demonstrated that CORFs in South Florida may be vulnerable to fraud, waste, and abuse. The Office of Inspector General (OIG) estimated that in 2003, three South Florida CORFs received between \$720,000 and \$1.6 million each in inappropriate payments for services.^{1, 2, 3} A 2004 report by the Government Accountability Office (GAO) identified aberrant billing patterns among South Florida CORFs. GAO found that per-beneficiary payments to CORFs in South Florida were two to three times higher than per-beneficiary payments to other outpatient therapy providers.⁴

In May 2009, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative was launched in Miami to increase efforts to reduce Medicare fraud. A collaboration between officials from

¹ OIG, *Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Ultimate Rehabilitation Agency, Inc.*, A-04-05-02009, September 2008.

² OIG, *Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Action Rehabilitation Center, Inc.*, A-04-05-02010, November 2008.

³ OIG, *Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Care Alliance of America, Inc.*, A-04-05-02011, November 2009.

⁴ GAO, *Comprehensive Outpatient Rehabilitation Facilities: High Medicare Payments in Florida Raise Program Concerns*, August 2004.

the Department of Health and Human Services and the Department of Justice, the HEAT initiative builds upon existing programs that combat fraud and identifies new methods to prevent fraud.

CORF Services

CORFs are required to offer the following core services: CORF physician services, physical therapy services, and social and/or psychological services. CORF physician services are administrative and include such tasks as consultation with, and medical supervision of, CORF staff and review of patient treatment plans, as appropriate.⁵

In addition to offering core services, CORFs may elect to offer occupational therapy, speech-language pathology, respiratory therapy, prosthetic and orthotic devices, supplies and durable medical equipment, and nursing as well as other services.

A CORF must maintain a physical location that provides safe and sufficient space for the scope of services offered.⁶ Except for a single home environment evaluation visit and except for physical therapy, occupational therapy, and speech-language pathology services, all CORF services must be provided on CORF premises.⁷ The majority of physical therapy, occupational therapy, and speech-language pathology services must also be provided on CORF premises for all CORF patients.⁸

CORF Enrollments

To enroll in Medicare, a CORF must submit an application that collects a variety of information, including the address at which the CORF will provide services (i.e., the practice location).⁹

Before approving a CORF's enrollment, CMS arranges for an initial site visit. This visit is part of a process called "survey and certification," in which CMS contracts with State survey agencies to assess the prospective CORF's compliance with certain Federal regulations. The survey and certification process culminates in a recommendation by the

⁵ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 12 § 20.1. Accessed at <http://www.cms.hhs.gov> on May 19, 2011.

⁶ 42 CFR § 485.62(a)(7).

⁷ 42 CFR § 485(e).

⁸ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 12 § 30(A). Accessed at <http://www.cms.hhs.gov> on May 19, 2011.

⁹ Form CMS-855A. Accessed at <http://www.cms.hhs.gov> on May 19, 2011.

State survey agency to CMS as to whether the CORF should be accepted into the Medicare program.

After being accepted, each CORF must continue to meet the initial enrollment requirements. Each CORF is required to be periodically resurveyed by its State survey agency to ensure continued compliance with all requirements.¹⁰ CMS also requires CORFs to report enrollment application changes, including changes in practice location, within 90 days of the changes.¹¹

Postenrollment Site Visits

After a CORF is enrolled in the Medicare program, CMS may conduct unannounced site visits.¹² CMS cites the use of unannounced postenrollment site visits as a successful way to determine whether providers are operational and are at the location on file with CMS.¹³

The *Medicare Program Integrity Manual* provides guidelines regarding unannounced site visits. When conducting a site visit to verify that a provider is operational, CMS should attempt to make its determination using only an external review of the facility. CMS requires that reviewers document visits using written observations of the facilities and photographs, as appropriate.¹⁴ Unannounced site visits should take place during posted business hours, or between 9 a.m. and 5 p.m. if no business hours are posted.¹⁵

CMS Administrative Actions

CMS may take the following administrative actions against nonoperational providers, including CORFs:

- *Investigation.* CMS investigations may include site visits and interviews with CORF staff and Medicare beneficiaries, as well as analysis of claims data.

¹⁰ 42 CFR § 488.20(b)(1).

¹¹ 42 CFR § 424.516(e)(2). A change in ownership or control must be reported within 30 days. 42 CFR § 424.516(e)(1).

¹² CMS, *Medicare Program Integrity Manual* Pub. No. 100-08, ch. 15, § 15.20. Accessed at <http://www.cms.hhs.gov> on May 19, 2011.

¹³ Preamble to final rule implementing sections of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. 76 Fed. Reg. 5862, 5869 (Feb. 2, 2011).

¹⁴ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.20.1. Accessed at <http://www.cms.hhs.gov> on February 22, 2011.

¹⁵ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.20.1. Accessed at <http://www.cms.hhs.gov> on May 19, 2011.

- *Prepayment review.* CMS reviews documentation from providers before deciding whether to pay claims.
- *Payment suspension.* CMS temporarily stops some or all payments to a provider. CMS may suspend payments to a provider if there is a credible allegation of fraud against that provider.¹⁶
- *Revocation.* CMS may revoke Medicare billing privileges for a CORF that is no longer operational.¹⁷
- *Deactivation.* CMS may deactivate a provider's billing privileges when a CORF has not submitted claims for 12 consecutive months.¹⁸ This reduces the risk that the provider's billing privileges will be used for fraudulent purposes.

Temporary Moratoria

CMS may also reduce the potential for fraud, waste, or abuse among CORFs by imposing a moratorium on CORF enrollment. CMS's authority to impose moratoria on specific provider types, specific geographic areas, or both was established by the Patient Protection and Affordable Care Act and implemented in 2011.¹⁹

South Florida High Risk Enrollment Project

Concurrent to our review, CMS conducted a special enrollment project—the South Florida High Risk Provider Enrollment Project—that targeted fraud among specific provider types that are vulnerable to abuse. As part of the project, CMS conducted site visits to all CORFs in South Florida to verify their existence.

CMS used the results of these site visits, along with other information, to create a fraud-risk score for each CORF. CORFs with high fraud-risk scores could be subject to a variety of administrative actions. In some

¹⁶ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.1.1. Accessed at <http://www.cms.hhs.gov> on August 16, 2011. See also 42 CFR §§ 405.371(a)(2) and 405.372(a)(4).

¹⁷ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2(A). Accessed at <http://www.cms.hhs.gov> on January 31, 2011. See also 42 CFR § 424.535(a)(5).

¹⁸ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.1. Accessed at <http://www.cms.hhs.gov> on January 31, 2011. See also 42 CFR § 424.540(a).

¹⁹ The Patient Protection and Affordable Care Act, P.L. 111-148, § 6401(a)(3) (adding section 1866(j)(6) of the Social Security Act, which was redesignated as section 1866(j)(7) by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, § 1304). Implementing regulations for moratoria on newly enrolling Medicare providers and suppliers are located at 42 CFR § 424.570.

cases, CMS used evidence from the site visits to take action against CORFs that were not operational.

METHODOLOGY

We performed unannounced site visits to all CORFs with a practice location in one of three Core Based Statistical Areas (CBSA) in Florida: the Miami–Miami Beach–Kendall CBSA, the Fort Lauderdale–Pompano Beach–Deerfield Beach CBSA, and the West Palm Beach–Boca Raton–Boynton Beach CBSA. We refer to these CBSAs collectively as South Florida. We determined whether these CORFs were operational (i.e., were at the location on file with CMS and were open during business hours). We also reviewed documentation about CMS actions against CORFs that were not operational at the time of our site visits. See Appendix A for a detailed description of our methodology.

Scope

We focused our review on whether CORFs were operational—that is, whether they were at the locations on file with CMS and were open during business hours. We focused on these criteria to limit our interaction with CORF staff and reduce the risk of alerting staff at potentially fraudulent CORFs to our presence.

Data Sources and Data Collection

Identifying CORF locations. To identify CORF locations for our South Florida site visits, we first used the 2009 Outpatient National Claims History (NCH) file to identify CORFs that submitted claims in 2009 for a practice location in South Florida. We then located addresses for all 132 CORFs through the Provider Enrollment, Chain, and Ownership System (PECOS) and a data request to CMS.

Site visits to CORFs. We conducted unannounced site visits to determine whether these CORFs maintained a physical facility at the location on file with CMS and were open during business hours. We recorded all observations using a standard form. We conducted all site visits in May 2010.

Updates after site visits. To account for changes in our information between the time we identified our study population and the dates of our site visits, we requested address updates and changes in enrollment status from CMS for all CORFs that we found to be nonoperational.

CMS actions against nonoperational CORFs. To describe CMS actions against nonoperational CORFs following our site visits, we requested the results of the special enrollment project through April 2011. Along with the results of the special enrollment project, we also received data about routine actions that CMS took through April 2011 for these nonoperational CORFs.

Payments to nonoperational CORFs. We used the 2010 Outpatient NCH file to determine how much Medicare allowed for services reportedly provided by nonoperational CORFs.

Analysis

Before analyzing our results, we removed 31 CORFs from our analysis. Twenty-nine were no longer enrolled in the Medicare program at the time of our site visits. We removed one CORF because we were unable to complete the full site visit protocol. We removed another CORF because it was closed for remodeling during the time of our visits. We performed our analysis on the remaining 101 CORFs.

We defined “operational” as at the location on file with CMS and open during business hours. We determined whether a CORF met these criteria in the following manner:

- We determined that a CORF was at the location on file with CMS if it maintained a physical facility with its name clearly marked somewhere other than a building directory (e.g., a sign on or near the primary entrance to the CORF).
- We determined that a CORF was open if it was accessible to CMS and beneficiaries during regular business hours (i.e., the door was unlocked) during either of two visits on separate days.

CORFs that did not meet at least one criterion were considered nonoperational for the purposes of this report.

We aggregated the results of our site visits to determine the number of CORFs that (1) maintained a physical facility at the location on file with CMS and (2) were open during business hours. We also categorized site reviewers’ observations about what they found (e.g., a sign with a different business name) at the location on file with CMS.

Payments to nonoperational CORFs. We calculated the total amount that Medicare allowed for 2010 for CORFs that were not at the location on file with CMS and for CORFs that were not open. For each CORF, we also calculated the amount Medicare allowed in 2010 following our

I N T R O D U C T I O N

site visits (i.e., from the date of our last site visit through December 2010).

Review of CMS actions against nonoperational CORFs. We reviewed CMS actions against the nonoperational CORFs identified by our site visits. We determined for how many CORFs CMS took each type of action (e.g., prepayment review) and whether the actions resulted from the special enrollment project or from routine oversight. We aggregated these results to determine the number of nonoperational CORFs that CMS took action against after our site visits, as well as the nonoperational CORFs that had been subject to each type of action.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Eighteen of the one hundred one South Florida CORFs were not operational

Eighteen of the one hundred one CORFs in South Florida were not at the location on file with CMS or

were not open during business hours. Medicare allowed \$2.2 million for services provided by these CORFs in 2010, \$450,000 of which was allowed after our site visits. An additional five CORFs were open only during the second visit made to their locations. We considered these CORFs open for the purposes of this review.

Ten CORFs were not at the location on file with CMS

After taking into account the CORFs that submitted address updates to CMS, 10 of the CORFs that we visited did not maintain a facility at the location on file with CMS. Medicare allowed \$1.4 million for these 10 CORFs in 2010.

As Table 1 shows, when site reviewers visited the location on file with CMS, they found different businesses, unmarked office suites, and a private residence with no indication that a CORF was located there. In one case, site reviewers found an eviction notice posted on the door of an empty CORF facility. See Photo 1 for an example of an empty storefront that reviewers found at the location CMS had on file for one CORF.

TABLE 1
Description of the location on file with CMS for 10 nonoperational CORFs.

What OIG Found at Location on File	
Description	Count
Sign with a different business name	4
No sign indicating a business name	4
Private residence with no sign indicating a CORF	1
Eviction notice	1
Total	10

Source: OIG unannounced site visits to CORFs, May 2010.

FINDINGS

PHOTO 1
There was no indication that a CORF was operational at this location.



Source: OIG unannounced site visits to CORFs, May 2010.

Eight CORFs were not open during business hours

Eight CORFs maintained a visible sign at the location on file with CMS but were locked during business hours on 2 separate days. Site reviewers visited seven of the eight CORFs during their posted business hours. The remaining CORF did not have posted business hours and was visited during reasonable business hours (9 a.m. to 5 p.m.). Medicare allowed \$800,000 for these eight CORFs in 2010.

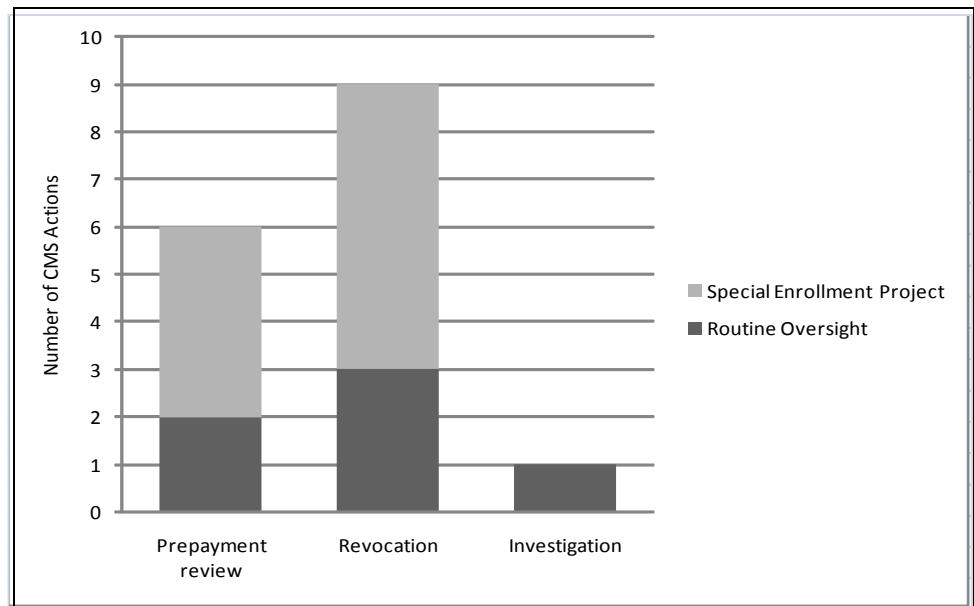
Five additional CORFs were locked during business hours on the first date we visited and open on the second day. These CORFs were considered open for the purposes of this report because they were open on our second visit. However, these CORFs may have been open on our second visit because they became aware of our review.

CMS took action against most of the nonoperational CORFs based on a special enrollment project and routine oversight

CMS took action against 16 of the 18 nonoperational CORFs in the months after we completed our site visits. These actions included investigation, prepayment review, and revocation. More than half of these actions were because of CMS's special enrollment project. The rest were because of routine oversight activities that apply to all Medicare providers. See Chart 1 for the actions that CMS took against nonoperational CORFs that we identified in our site visits.

FINDINGS

CHART 1
CMS actions
against
nonoperational
CORFs.



Source: OIG unannounced site visits to CORFs and CMS actions against CORFs, May 2010.

The special enrollment project resulted in actions against 10 nonoperational CORFs

Based on the results of the special enrollment project, CMS revoked the billing privileges of six nonoperational CORFs and monitored four others with prepayment review. During the special enrollment project, CMS conducted site visits to Medicare providers in South Florida, including CORFs. As a result of this project, CMS took action against 10 nonoperational CORFs that may not have been identified through routine oversight.

Actions based on the special enrollment project were not always timely. For one CORF, CMS took 9 months to take action. After finding this CORF to be nonoperational on two separate visits, CMS made a third visit 6 months later. Another 3 months elapsed before CMS put the provider on prepayment review. Similarly, CMS took almost 7 months to revoke another CORF's billing privileges. CMS found this CORF to be nonoperational on two separate visits. Five months elapsed before CMS returned for a third site visit and found "for rent" signs posted at the location. Another 2 months elapsed before CMS finalized the revocation of this CORF's billing privileges.

F I N D I N G S

Routine CMS oversight resulted in actions against six nonoperational CORFs

CMS revoked the billing privileges of three CORFs, monitored two others with prepayment review, and investigated another as a result of routine oversight. CMS revoked the billing privileges of three CORFs because they were found to be nonoperational during site visits that were not related to the special enrollment project.

CMS took no action against two nonoperational CORFs

After the OIG site visits, CMS visited these two CORFs as part of the special enrollment project and found them to be operational. Almost a year later, CMS reported that prepayment review actions were pending for these CORFs. These actions were based on fraud indicators unrelated to the site visits.



R E C O M M E N D A T I O N S

Eighteen of the one hundred one CORFs in South Florida were not operational. Ten of these CORFs were not found at the location on file with CMS, and eight were not open during business hours.

CMS also identified nonoperational CORFs in South Florida and was able to remove or monitor most of them. CMS actions included revocation of billing privileges, prepayment review, and investigation. By using a special enrollment project, CMS was able to identify and take action against more CORFs than it would have using routine oversight alone. However, in some cases, CMS took several months to take action against CORFs after identifying them as nonoperational. Further, CMS was unable to prevent these CORFs from initially enrolling in the Medicare program.

Given the number of CORFs that OIG and CMS found to be nonoperational, CMS should continue its attempts to protect the integrity of the Medicare program and beneficiaries from potentially fraudulent CORFs. Therefore, we recommend that CMS:

Periodically conduct unannounced site visits to CORFs

CMS advocates the use of unannounced postenrollment site visits to determine whether providers are operational. Notably, CMS used unannounced site visits as a key component of its special enrollment project. Continuing to periodically conduct nationwide unannounced site visits to CORFs would enable CMS to identify and remove nonoperational CORFs from the program and potentially reduce erroneous Medicare payments. CMS could focus unannounced site visits in high-risk areas or base them on fraud-risk assessments.

Use additional program safeguards for CORFs

CMS should use other program safeguards to prevent potentially nonoperational CORFs from enrolling in the Medicare program and to monitor existing CORFs. Such safeguards may include payment suspensions and a moratorium on the enrollment of new CORFs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. In response to our first recommendation, CMS stated that it currently conducts unannounced enrollment and revalidation site visits to CORFs and that it plans to increase the frequency of unannounced, out-of-cycle site visits to

R E C O M M E N D A T I O N S

CORFs. CMS also plans to compare CORF enrollment information with public records to identify potential changes to enrollment information that would warrant further investigation. In response to our second recommendation, CMS stated that it will continue to take administrative actions, as appropriate. CMS stated that these actions may include, but are not limited to, prepayment review, auto-deny edits, payment suspensions, and revocations. CMS also stated that it had referred certain providers to OIG for investigation. We did not make any changes to the report based on CMS's comments. For the full text of CMS's comments, see Appendix B.



Detailed Methodology

We conducted unannounced site visits to all Comprehensive Outpatient Rehabilitation Facilities (CORF) in three Core Based Statistical Areas (CBSA) in Florida: the Miami–Miami Beach–Kendall CBSA, the Fort Lauderdale–Pompano Beach–Deerfield Beach CBSA, and the West Palm Beach–Boca Raton–Boynton Beach CBSA. We refer to these CBSAs collectively as South Florida. We determined whether each CORF was at the location on file with the Centers for Medicare & Medicaid Services (CMS) and was open during business hours. We then reviewed documentation about actions that CMS took against the noncompliant CORFs and determined how much money Medicare allowed for services reportedly provided by these CORFs in 2010.

Scope

To concentrate our visits on CORFs with recent activity in the Medicare program, we focused our review on CORFs that submitted claims for Medicare payment in 2009. At the time we developed our study population, data on claims from 2009 were the most recent available.

Data Sources and Data Collection

Identifying CORF locations. We identified CORFs that submitted claims in 2009 using the bill type and provider identification numbers (provider ID) fields in the 2009 Outpatient National Claims History (NCH) file. We counted each provider ID that had claims with bill type 75 as a CORF.²⁰ We then used the State code from the NCH file to identify all CORFs in Florida.

Using two sources, we located an address for each CORF in Florida. Our primary source for CORF addresses was the practice location field from the Provider Enrollment, Chain, and Ownership System (PECOS).²¹ Most CORFs have enrollment information, such as practice locations, stored in PECOS.²² When a CORF did not have an address available in PECOS, we requested this information from CMS.

²⁰ Bill type is a variable used to describe the type of Medicare facility that delivered the services billed.

²¹ PECOS is the system of record for Medicare provider enrollment information. PECOS is populated based on the initial provider enrollment application and updated any time a provider submits an updated application to CMS.

²² A CORF that enrolled before 2004 and has not submitted an updated application may not have an enrollment record in PECOS.

Finally, we matched the ZIP Code from each address to the ZIP Codes corresponding to each CBSA to determine whether the address was located in one of the three South Florida CBSAs. This process resulted in 132 CORFs with addresses in South Florida.

Site visits to CORFs. We conducted unannounced site visits to these 132 CORFs to determine whether they were at the location on file with CMS and were open during business hours. We recorded all observations using a standard form. We conducted all site visits from May 17 through May 28, 2010.

We designed our site visit protocol to ensure that we gave providers the benefit of the doubt when determining whether they were operational. For example:

- All visits to CORFs were made during posted business hours if hours were posted or during reasonable business hours (9 a.m. to 5 p.m.) if none were posted.
- If a CORF was locked, we conducted a second visit to that location on a different day. We considered CORFs to be open if they were open on either the first visit or (if applicable) the second visit.
- When the building at a CORF location on file with CMS was a multisuite office building, site reviewers searched for the CORF by name as well as by suite number. We considered the CORF to be at the location on file with CMS if site reviewers could find it in any suite or office space in the building.
- If a CORF had a sign posted indicating that visitors should ring a buzzer or doorbell to enter the facility, site reviewers did so. If the door was opened (e.g., someone came to the door or the lock was released), we considered the CORF to be open.
- If a CORF had a sign posted indicating that it was available by appointment only, a site reviewer attempted to make an appointment for services with that CORF (i.e., called the phone number listed on the sign). If the site reviewer was able to make an appointment, we considered the CORF to be open.
- If we found a different business name at the CORF location on file with CMS, we attempted to determine if the CORF we were looking for was operating under the name we found. First, we requested from CMS all names for CORFs that we did not find

and reviewed this information to ensure that we captured all possible aliases. Second, as a final check, we reviewed public Web sites, including the National Provider Identifier registry, to determine whether the CORF we were looking for could be operating under the name we found. If we were able to connect the two names, we categorized the CORF as being at the location on file with CMS.

CMS actions against nonoperational CORFs. Data received from the South Florida High Risk Enrollment Project (special enrollment project) through December 2010 included:

- administrative actions taken against nonoperational CORFs,
- the source of these administrative actions (i.e., special enrollment project activity or routine oversight),
- the effective dates of these actions,
- the dates that CMS finalized these actions, and
- the dates and results of all of CMS's site visits and in-depth investigations related to the special enrollment project.

Analysis

Updates after site visits. CMS indicated that it deactivated the billing privileges of 26 CORFs and revoked the billing privileges of 3 others before the dates of our site visits. We removed these 29 CORFs from our analysis.

► A P P E N D I X ~ B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 12 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. */SI/*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities" (OEI-05-10-00090)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled, "South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities." The purpose of this report is two-fold. First, it seeks to determine whether Comprehensive Outpatient Rehabilitation Facilities (CORFs) in South Florida were operational (i.e., at the location on file with CMS and open during business hours). Secondly, it describes CMS actions against CORFs that were not operational.

CORFs provide multidisciplinary rehabilitation services at a single location. According to OIG's report, Medicare allowed approximately \$70 million for CORF services for almost 40,000 beneficiaries in 2010. Of this, more than \$22 million was for claims by CORFs in South Florida.

The Affordable Care Act provides important new tools for CMS to use to strengthen the integrity of the Medicare, Medicaid, and CHIP programs, including enhanced provider and supplier screening requirements, the authority to suspend payments to providers/suppliers pending investigations of credible allegations of fraud, and the authority to impose enrollment moratoria on new providers and suppliers when necessary to combat fraud and abuse.

CORF services have historically been vulnerable to abuse. To combat this abuse, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group, using the authorities granted under the Affordable Care Act. This includes continuing to conduct unannounced site visits to CORFs and exploring options to use payment suspensions in conjunction with revocation actions for providers/suppliers determined to be non-operational.

According to the OIG report, CMS took action against most of the non-operational CORFs based on a special enrollment project and routine oversight. CMS believes it took the appropriate action on all non-operational CORFs identified by OIG in this study. CMS' definition of taking action includes, but is not limited to, conducting its own unannounced site visit and taking the

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appropriate administrative action. Administrative actions may include, but are not limited to, prepayment review, auto-deny edits, payment suspensions and revocations. CMS has also referred certain CORFs to OIG for investigation.

We appreciate OIG's efforts in working with CMS to ensure that CORFs are not vulnerable to abuse. Our response to each of the OIG recommendations follows.

OIG Recommendation

The CMS should periodically conduct unannounced site visits to CORFs.

CMS Response

The CMS concurs with this recommendation. CMS and its contractors currently conduct unannounced site visits to CORFs during the initial enrollment and revalidation process. These screenings will continue under new screening provisions promulgated as part of CMS 6028-FC¹, which authorizes CMS to conduct unscheduled pre- and/or post-enrollment site visits for providers that CMS designates as "moderate risk." CMS has designated CORFs as a "moderate-risk" provider/supplier type.

The CMS plans to increase the frequency of unannounced, out-of-cycle site visits of CORFs. Historically, these types of site visits were focused on projects confined to certain small geographical areas. Although not specifically required by CMS-6028-FC, CMS will soon begin to systematically screen enrollment data with public source data on a quarterly basis to identify potential changes to enrollment information that would warrant further investigation. CMS anticipates that this automated screening may indicate whether a site visit is warranted to determine if the CORF remains operational. To assist in this effort, CMS is currently soliciting a contractor to conduct site verifications (other than for suppliers of durable medical equipment, prosthetics, orthotics, and supplies) on a national scope.

The CMS believes that OIG should note in the report that CMS has and will continue to perform unannounced site visits for CORFs.

OIG Recommendation

The CMS should use additional program safeguards for CORFs.

CMS Response

The CMS concurs with this recommendation. CMS has and will continue to take administrative actions as appropriate. Administrative actions may include, but are not limited to, prepayment review, auto-deny edits, payment suspensions and revocations. CMS has also referred certain

¹ CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

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CORFs to OIG for investigation. CMS believes that OIG should note in the report that CMS has and will continue to take administrative actions, as appropriate, for CORFs.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas Komaniecki, Deputy Regional Inspector General.

Laura Kordish served as the team leader for this study, and Lisa Minich and Mara Werner served as lead analysts.

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