

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DIALYSIS SERVICES PROVIDED
BY ATLANTIS HEALTH CARE
GROUP OF PUERTO RICO, INC.,
DID NOT COMPLY WITH
MEDICARE REQUIREMENTS
INTENDED TO ENSURE THE
QUALITY OF CARE PROVIDED TO
MEDICARE BENEFICIARIES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: December 2018

Report No. A-02-16-01009

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Medicare Part B covers dialysis services for beneficiaries with end-stage renal disease. Prior OIG reviews identified inappropriate Medicare payments made for dialysis services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements.

We selected Atlantis Health Care Group of Puerto Rico, Inc., for review because it ranked among the highest-paid providers of ESRD services in Puerto Rico.

Our objective was to determine whether dialysis services provided by Atlantis complied with Medicare requirements.

How OIG Did This Review

Our review covered 11,430 beneficiary-months for which Atlantis received Medicare reimbursement totaling \$20.3 million for dialysis services provided from January 2014 through October 2015. We reviewed a random sample of 100 beneficiary-months. A beneficiary-month was defined as all dialysis services provided to a beneficiary during 1 month. We evaluated the services for compliance with Medicare requirements and subjected them to medical review.

Dialysis Services Provided by Atlantis Health Care Group of Puerto Rico, Inc., Did Not Comply With Medicare Requirements Intended to Ensure the Quality of Care Provided to Medicare Beneficiaries

What OIG Found

Atlantis claimed reimbursement for dialysis services during all 100 sample beneficiary-months that did not comply with Medicare requirements. For example, Atlantis claimed reimbursement for dialysis services for which (1) beneficiaries' medical information was not adequately supported; (2) plans of care or comprehensive assessments did not comply with Medicare requirements, and (3) physicians' orders did not meet Medicare requirements.

These errors occurred because Atlantis' electronic health records system and related procedures were not adequate to ensure that certain ESRD measurements and comorbidities documented in beneficiaries' medical records were correctly reported on their associated Medicare claims. Additionally, while Atlantis had policies and procedures in place to ensure that dialysis services were properly ordered and adequately documented, and that plans of care and comprehensive assessments contained all required elements, these policies and procedures were not effective, not followed, or did not meet Medicare requirements.

We estimated that Atlantis received unallowable Medicare payments of at least \$403,000 for dialysis services that did not comply with Medicare requirements. Many of the deficiencies we identified did not affect Atlantis' Medicare reimbursement for the services since they were reimbursed on a bundled per-treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have a significant impact on the quality of care provided to Medicare beneficiaries and could result in the provision of inappropriate or unnecessary dialysis services.

What OIG Recommends and Atlantis Comments

We recommend that Atlantis refund an estimated \$403,000 to the Medicare program. We also made a series of recommendations to strengthen Atlantis' policies and procedures for ensuring that dialysis services comply with Medicare requirements.

In written comments on our draft report, Atlantis concurred with our findings and recommendations and described actions it has taken or planned to take to address them.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare Part B covers outpatient dialysis services for beneficiaries diagnosed with end-stage renal disease (ESRD). ESRD is a condition in which the kidneys no longer function at the level necessary for day-to-day life. The loss of kidney function in ESRD is usually irreversible and permanent and requires a regular course of dialysis or a kidney transplant. Most individuals with ESRD are eligible for Medicare benefits, regardless of age.

Prior Office of Inspector General (OIG) reviews identified inappropriate Medicare payments made for ESRD services (dialysis services) that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements.

We reviewed claims for dialysis services submitted for Medicare reimbursement by Atlantis Health Care Group of Puerto Rico (Atlantis) because it ranked among the highest-paid providers of ESRD services in Puerto Rico.

OBJECTIVE

Our objective was to determine whether dialysis services provided by Atlantis complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 or over, people with disabilities, and people with ESRD. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part B provides supplementary medical insurance for medical and other health services, including dialysis services. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Medicare Part B claims. First Coast Service Options is the MAC that processes and pays the Medicare claims submitted by Atlantis.

OIG believes that this audit report constitutes credible information of potential overpayments. Providers that receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).¹

¹ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

Medicare Dialysis Services

Medicare Part B covers dialysis services, items, supplies, and equipment provided in approved facilities to beneficiaries with ESRD.² Medicare pays dialysis facilities on a bundled per-treatment basis through CMS's ESRD Prospective Payment System. The bundled payment covers all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis, drugs, biologicals, laboratory tests, training, and support services.³ CMS adjusts the bundled payment to account for patient age, height and weight, and comorbidities.⁴

To qualify for Medicare payments, dialysis facilities must meet the conditions for coverage (CfC) described in 42 CFR part 494.⁵ The CfCs include, but are not limited to, providing each dialysis patient with an individualized comprehensive assessment of his or her needs and developing a written plan of care that specifies the services necessary to address the needs identified in the comprehensive assessment.⁶

Payment for dialysis services will only be made if a physician certifies services are or were medically required.⁷ Dialysis facilities must maintain complete, accurate, and accessible records on all patients and must furnish such information, as appropriate, to determine whether payment is due and the amount of payment.⁸

Atlantis Health Care Group of Puerto Rico, Inc.

Atlantis was founded in 2000 to provide dialysis services to Medicare beneficiaries in Puerto Rico. During the period January 1, 2014, through October 31, 2015 (audit period), Atlantis operated 17 dialysis centers throughout the Commonwealth, making it the second largest dialysis provider in Puerto Rico. Atlantis provides two types of treatment: in-center

² The Act, §§ 1832(a), 1861(s)(2)(f), and 1881(a).

³ The Act, § 1881(b)(14)(B).

⁴ Comorbidities are patient-specific conditions that are secondary to the patient's principal diagnosis that necessitates dialysis, yet have a direct affect on dialysis.

⁵ These standards focus on the patient and the care provided and are the foundation for ensuring quality care is provided and the health and safety of Medicare beneficiaries is protected. Dialysis facilities that do not comply with CfCs could be subject to enforcement remedies and corrective actions (42 CFR § 494.1(a)(2) and the Act, § 1861(e)(9)).

⁶ 42 CFR §§ 494.80 and 494.90.

⁷ The Act, §§ 1835(a)(2)(B), 1861(s)(2)(f), and 1881(b)(14)(B).

⁸ 42 CFR §§ 424.5(a)(6) and 494.170.

hemodialysis and home therapy.⁹ Atlantis also contracted with 12 hospitals in Puerto Rico to provide acute dialysis services.¹⁰ During the audit period, Atlantis' staff consisted of a multidisciplinary team of nurses, physicians, biomed technicians,¹¹ social workers, and dietitians.

HOW WE CONDUCTED THIS REVIEW

Our review covered 11,430 beneficiary-months¹² for which Atlantis received Medicare reimbursement totaling \$20,280,080 for dialysis services provided during the audit period. We reviewed a random sample of 100 beneficiary-months. We obtained medical records for each sample item to determine whether services complied with Medicare requirements. We also provided these medical records to an independent medical review contractor who determined whether services were medically reasonable and necessary and met Medicare requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Atlantis claimed dialysis services that did not comply with Medicare requirements during all 100 sample beneficiary-months. Specifically,

- During 99 beneficiary-months, Atlantis reported hematocrits, height and weight (ESRD measurements) and comorbidities that were not adequately supported.
- During 85 beneficiary-months, the associated beneficiary's height and/or weight were not measured in accordance with Medicare requirements.

⁹ In-center hemodialysis services are those furnished in a Medicare-certified ESRD facility on an outpatient basis. Home therapy modalities include both continuous ambulatory peritoneal dialysis and continuous cycler peritoneal dialysis.

¹⁰ Acute dialysis services are provided to individuals who are not ESRD patients but who require dialysis because of temporary kidney failure due to sudden trauma.

¹¹ Biomed technicians are responsible for ensuring that medical equipment is well-maintained, properly configured, and safely functional.

¹² A beneficiary-month was defined as all dialysis services provided to a Medicare beneficiary by Atlantis during 1 calendar month.

- During 78 beneficiary-months, plans of care and/or comprehensive assessments did not meet Medicare requirements.
- During 57 beneficiary-months, Atlantis provided dialysis services that were not properly ordered.
- During 15 beneficiary-months, dialysis treatments were not completed.
- During three beneficiary-months, there was no documentation to support some of the home dialysis services Atlantis billed to Medicare.

The total exceeds 100 because each of the 100 beneficiary-months contained more than one error.

These errors occurred because Atlantis' electronic health records (EHR) system¹³ and related procedures were not adequate to ensure that certain ESRD measurements documented in beneficiaries' medical records were correctly reported on their associated Medicare claims. Additionally, while Atlantis had policies and procedures in place to ensure that dialysis services were properly ordered and adequately documented, and that plans of care and comprehensive assessments contained all required elements, these policies and procedures were not effective, not followed, or did not meet Medicare requirements.

Many of the errors we identified did not affect the Medicare reimbursement Atlantis received because Medicare pays for dialysis on a bundled per-treatment basis or because the findings relate to Medicare CfCs. These findings, however, could have a significant effect on the quality of care Atlantis provided to Medicare beneficiaries and may have resulted in inappropriate or unnecessary treatments.

On the basis of our sample results, we estimated, for errors that affected reimbursement, Atlantis received unallowable Medicare payments of at least \$403,525 during the audit period.¹⁴ As of the publication of this report, this unallowable amount includes claims outside the 4-year Medicare claims reopening period.¹⁵

¹³ In 2007, Atlantis implemented an EHR and billing program designed to manage beneficiary information.

¹⁴ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

¹⁵ 42 CFR § 405.980(b)(2) (reopening for good cause).

END-STAGE RENAL DISEASE MEASUREMENTS AND COMORBIDITIES NOT SUPPORTED

During 99 beneficiary-months, Atlantis reported ESRD measurements and comorbidities that were not supported by the associated beneficiary's medical records, as detailed below.¹⁶

Hematocrit Levels Not Supported

Dialysis facilities are required to report hematocrit levels on all dialysis claims. These readings should reflect the most recent reading that was taken before the start of the billing period.¹⁷

During 99 beneficiary-months, Atlantis reported hematocrit levels on Medicare claims that did not reflect the most recent reading noted in the associated beneficiary's medical record. Hematocrit levels must be accurate in order to ensure a dialysis patient is receiving the correct dosage of necessary medications.

According to Atlantis officials, hematocrit levels noted in a beneficiary's EHR should have been used to populate Medicare claims associated with the beneficiary. However, Atlantis' system for submitting claims to Medicare for reimbursement did not pull these measurements. Rather, the system reported three times the beneficiary's hemoglobin reading as the hematocrit level. This is not a clinically acceptable measurement of the hematocrit level because the calculation reflects an estimate, not an exact measurement. While reporting an inaccurate hematocrit level on the claim does not impact Medicare reimbursement, an inaccurate level may result in a dialysis patient not receiving the necessary medication.

Height and Weight Measurements Not Supported

The ESRD bundled payment includes a payment adjustment based on a case-mix that may take into account patient weight, body mass index, body surface area, length of time on dialysis, age, race ethnicity, and other factors.¹⁸ Medicare computes body mass index and body surface area using height and weight data reported on dialysis facilities' claims. These measures are closely associated with the duration and intensity of dialysis services needed to achieve a therapeutic target for ESRD patients.¹⁹ Accordingly, inaccurate height or weight measurements could potentially result in a beneficiary receiving inappropriate dialysis treatments.

¹⁶ The errors for each category under this finding total more than 99 because 5 beneficiary-months contained more than 1 deficiency.

¹⁷ *Medicare Claims Processing Manual*, chapter 8, § 60.4.2.

¹⁸ The Act, § 1881(b)(14)(D)(i) and *Medicare Claims Processing Manual*, chapter 8, § 20.1.

¹⁹ *Medicare Benefit Policy Manual*, chapter 11, § 60.A.3.

During three beneficiary-months, the height or weight that Atlantis reported on a Medicare claim was not the height or weight documented in the associated beneficiary's medical record.²⁰ As a result, Atlantis improperly claimed Medicare reimbursement for these three beneficiary-months and may have provided inappropriate dialysis treatments to the associated beneficiaries.

These errors occurred because Atlantis' procedures were not adequate to ensure that height and weight measurements documented in the medical record were correctly reported on Medicare claims. Specifically, Atlantis attributed height errors to its staff not updating beneficiaries' EHRs to reflect changes in height noted during the comprehensive assessment. Additionally, Atlantis mistakenly reported the beneficiary's change in weight instead of the post-treatment weight.

Comorbidity Not Supported

The ESRD bundled payment may include a payment adjustment (i.e., add-on payment) based on a case-mix that takes into account patient comorbidities (i.e., patient-specific conditions that affect dialysis treatment). The comorbidity adjustment recognizes the increased costs associated with comorbidities by providing additional payments for certain conditions that occur concurrently with the need for dialysis. Dialysis facilities are responsible for obtaining documentation of the presence of the comorbidity and maintaining that documentation in the beneficiary's medical record.²¹

During two beneficiary-months, Atlantis received a comorbidity payment adjustment; however, the associated beneficiaries' medical records did not support the comorbidity. Specifically, for these two beneficiary-months, the physicians noted the wrong comorbidity on the associated beneficiary's comprehensive assessment. Atlantis relied strictly on what was noted on the comprehensive assessment to claim these payment adjustments but did not verify whether other documentation in the medical record supported that comorbidity. As a result, Atlantis received improper Medicare reimbursement for these two beneficiary-months.

HEIGHT AND WEIGHT MEASUREMENTS DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Height and weight are measurements needed to calculate a dialysis patient's body size, which is closely associated with the duration and intensity of dialysis services. Although height and weight are taken at intervals throughout any given month of dialysis treatment, a dialysis patient's weight must be taken immediately following the last dialysis session of the month and their height must be measured no less frequently than once per year.²²

²⁰ During two beneficiary-months, only the height was incorrectly reported on Medicare claims. During one beneficiary-month, only the weight was incorrectly reported.

²¹ *Medicare Benefit Policy Manual*, chapter 11, § 60.A.5.

²² *Medicare Benefit Policy Manual*, chapter 11 § 60.A.3 and *Medicare Claims Processing Manual*, chapter 8, § 50.3.

During 85 beneficiary-months, Atlantis submitted claims for dialysis services for which height and/or weight measurements did not comply with Medicare requirements. Specifically, during 80 beneficiary-months, more than 1 year had passed since Atlantis had measured the associated beneficiary's height.²³ In addition, during seven beneficiary-months, a beneficiary had not been weighed immediately following the last home dialysis session of the month.^{24, 25}

Contrary to Medicare requirements, Atlantis' procedures required a beneficiary's height to be measured only during their admission to its facility—not on an annual basis afterward. Additionally, Atlantis' procedures required the weight for a home dialysis beneficiary to be taken during a monthly visit to the facility which was not always the last dialysis session of the month.

We could not determine whether any of these errors had an impact on the Medicare reimbursement that Atlantis received because the height and weight measurements needed to determine the correct amount of Medicare reimbursement were not available. However, height and weight measurements are clinical parameters that are critical to establishing the ideal treatment for a dialysis patient. Accordingly, inaccurate height or weight measurements could potentially result in a beneficiary receiving inappropriate dialysis treatments.

PLANS OF CARE AND COMPREHENSIVE ASSESSMENTS DID NOT MEET MEDICARE REQUIREMENTS

An interdisciplinary team is responsible for providing dialysis patients with individualized, comprehensive assessments of their needs.²⁶ The comprehensive assessment must be used to develop the patient's plan of care.²⁷ The interdisciplinary team must also develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the beneficiary's needs identified in the comprehensive assessment. The plan of care must reflect the evaluations conducted as part of the comprehensive assessment

²³ Height measurements were taken between 13 days and nearly 7 years after the 1-year requirement.

²⁴ Home dialysis patients are given a scale so that they can weigh themselves before and after each dialysis treatment. The patient is then responsible for noting their weight on a flowsheet that is provided to Atlantis for inclusion in the medical record.

²⁵ Total exceeds 85 because 2 beneficiary-months contained both of these deficiencies.

²⁶ The comprehensive assessment must include the patient's current health status and medical conditions, as well as an evaluation of the appropriateness of the dialysis prescription. Additionally, the assessment should evaluate the patient's nutritional and psychological status, current physical activity level, family support system, suitability for a transplant, the type of dialysis access, and factors associated with anemia and any applicable treatment plans (42 CFR § 494.80).

²⁷ 42 CFR § 494.80.

and be signed by all members of the interdisciplinary team and Medicare beneficiary.²⁸ Comprehensive reassessments and revisions to the plan of care are required to be conducted at least annually for stable patients and at least monthly for unstable patients.²⁹

During 78 beneficiary-months, Atlantis claimed Medicare reimbursement for dialysis services for which the plan of care (57 beneficiary-months) or comprehensive assessment (54 beneficiary-months) did not comply with certain Medicare requirements.³⁰ Instances of noncompliance included plans of care that: (1) were not signed by all members of the interdisciplinary team (46 beneficiary-months), (2) did not contain all required elements (26 beneficiary-months), (3) were not updated timely³¹ (2 beneficiary-months), and (4) were unrelated to the type of dialysis services the beneficiary was receiving (1 beneficiary-month).³² In addition, comprehensive assessments did not contain all required elements (48 beneficiary-months) or were not updated timely³³ (17 beneficiary-months).³⁴ The exhibit lists some of the required elements that were missing.

Exhibit: Missing Required Elements

Missing required elements for plans of care included the beneficiary's dialysis dosage, psychosocial status, patient education and training plans, and certain medical information.

Missing required elements for comprehensive assessments included information related to the beneficiary's medical history, health status, suitability for transplant surgery, and patient preferences and goals.

These errors occurred because Atlantis' policies and procedures were not effective to ensure that plans of care and comprehensive assessments complied with Medicare requirements. Specifically, Atlantis staff reviewed all medical records on a monthly basis to ensure that plans of care and comprehensive assessments are signed by all members of the interdisciplinary team, contain all the required elements, and are updated timely. Atlantis staff is then supposed to follow up with the interdisciplinary teams to ensure the deficiencies noted are corrected. Atlantis acknowledged that these reviews did not always identify or correct the deficiencies we identified but it could not explain which of their procedures failed.

²⁸ If the beneficiary chooses not to sign, that choice must be documented in the plan of care with the reason the signature was not provided (42 CFR § 494.90).

²⁹ 42 CFR § 494.80.

³⁰ Total exceeds 78 because both the plans of care and comprehensive assessments associated with 33 beneficiary-months were deficient.

³¹ The plans of care were for two unstable patients and were updated 9 to 229 days late.

³² Total exceeds 57 because 18 beneficiary-months contained more than 1 of these deficiencies.

³³ Comprehensive assessments were for 11 stable patients and 6 unstable patients and were updated 9 to 505 days late.

³⁴ The total exceeds 54 because 11 beneficiary-months contained both of these errors.

Atlantis' failure to ensure plans of care and comprehensive assessments complied with Medicare requirements did not result in improper Medicare payments, however, it could result in inadequate treatment planning and could preclude beneficiaries from receiving needed services.

NO PHYSICIANS' ORDERS OR ORDERS DID NOT MEET MEDICARE REQUIREMENTS

According to Medicare requirements, payment for dialysis services furnished to beneficiaries must be supported by a physician's order certifying that such services are or were medically required.³⁵

During 57 beneficiary-months, Atlantis claimed reimbursement for dialysis services, including laboratory services and drugs, for which physicians' orders were not provided or orders did not meet Medicare requirements. Specifically, Atlantis claimed reimbursement for laboratory services (50 beneficiary-months) or drugs (1 beneficiary-month) for which it did not provide a physician's order. In addition, Atlantis claimed reimbursement for dialysis services or drugs for which physicians' orders were not signed by a physician (5 beneficiary-months) or the physician's order had expired (2 beneficiary-months). Atlantis also claimed reimbursement for drugs in excess of the frequency prescribed in the physician's order (1 beneficiary-month).³⁶

While Atlantis had policies and procedures in place to ensure that dialysis services were ordered properly, the policies and procedures did not ensure that physicians' orders complied with Medicare requirements. Specifically, Atlantis staff reviewed beneficiaries' medical records on a monthly basis to ensure that dialysis services had been ordered properly. If staff identified issues with physicians' orders, Atlantis contacted the associated physicians and instructed them to make necessary corrections. However, physicians did not always make these corrections and Atlantis did not follow up with them. As a result, Atlantis improperly claimed Medicare reimbursement for some dialysis services for which physicians' orders were not provided or the orders did not meet Medicare requirements.³⁷ Additionally, physicians may not have been adequately involved in the care provided to their patients, resulting in the provision of medically unnecessary services or drugs.

³⁵ The Act, §§ 1835(a)(2)(B), 1861(s)(2)(F), and 1881(b)(14)(B), and 42 CFR §§ 410.12(a)(3), 410.32, and 424.10.

³⁶ Total exceeds 57 because 2 beneficiary-months contained more than 1 of these deficiencies.

³⁷ Because ESRD services are paid on a bundled per-treatment basis, only 5 of the 57 beneficiary-months resulted in improper Medicare reimbursement. The remaining beneficiary-months involved bundled services for which the impact of the errors on Medicare reimbursement cannot be calculated.

DIALYSIS TREATMENTS NOT COMPLETED

Medicare does not reimburse dialysis providers for incomplete dialysis treatments.³⁸ If a dialysis treatment is started but not completed for some unforeseen reason, and a valid medical reason is documented in the medical record, the provider is paid based on CMS's base rate for ESRD services. This is a rare occurrence and must be medically justified.

During 15 beneficiary-months, Atlantis claimed Medicare reimbursement for 19 dialysis treatments that were not completed and for which the beneficiary's medical record did not document a valid medical reason for discontinuing treatment or the beneficiary's refusal of treatment.

While Atlantis had policies and procedures in place for documenting the medical reason for discontinuing treatment or a beneficiary's refusal of treatment in their medical record, it did not always follow those procedures. Atlantis stated that, for the treatments we identified, the associated beneficiaries requested that their treatment be stopped and that Atlantis staff should have noted these requests in the beneficiaries' medical records but failed to do so. As a result, Atlantis improperly claimed Medicare reimbursement for these dialysis treatments. In addition, failure to complete dialysis treatments could result in a beneficiary not receiving needed treatments and could be detrimental to the beneficiary's health.

HOME DIALYSIS SERVICES NOT DOCUMENTED

No payment shall be made to any provider of Medicare services unless there has been furnished such information as may be necessary in order to determine the amounts due such provider.³⁹ In this respect, dialysis facilities must maintain complete, accurate, and accessible records on all patients and as appropriate, must furnish such information to determine whether payment is due and the amount of such payment.⁴⁰

Dialysis facilities that have been certified to provide dialysis services in patients' homes must ensure that the services are equivalent to services provided within a dialysis facility.⁴¹ The facilities must retrieve and review patients' self-monitoring data and other information, and maintain it in the patients' medical records.⁴²

³⁸ *Medicare Claims Processing Manual*, chapter 8, §§ 10.1 and 10.2, and *Medicare Benefit Policy Manual*, chapter 11, § 50.A.6.

³⁹ The Act, §1833(e).

⁴⁰ 42 CFR §§ 424.5(a)(6) and 494.170.

⁴¹ 42 CFR § 494.100.

⁴² 42 CFR §§ 494.100(b)(2) and (3).

During three beneficiary-months, Atlantis received Medicare reimbursement for home dialysis services for which it did not provide documentation to support some services. Specifically, Atlantis did not provide treatment notes for 53 home dialysis sessions claimed during the 3 beneficiary-months. This occurred because Atlantis did not follow its procedures for ensuring that self-monitoring data for home dialysis patients was complete and documented in the medical record.

CONCLUSION

On the basis of our sample results, we estimated that Atlantis received unallowable Medicare payments of at least \$403,525 for our audit period. We note that, while these identified payments are not significant when compared to Atlantis' total Medicare reimbursements for the period, the errors we identified could have a significant impact on the quality of services that Atlantis is providing to Medicare beneficiaries.

RECOMMENDATIONS

We recommend that Atlantis:

- refund to the Federal Government the portion of the estimated \$403,525 in improper payments for claim incorrectly billed to the Medicare program that are within the reopening period;⁴³
- for the remaining portion of the estimated \$403,525 in improper payments for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify any additional similar improper payments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;
- develop or modify procedures to ensure that ESRD measurements and comorbidities noted in beneficiaries' electronic health records are accurately recorded on Medicare claims for services and comply with Medicare requirements;
- strengthen its policies and procedures for documenting home dialysis services and the discontinuance of dialysis treatments; and

⁴³ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a MAC, will determine whether a potential overpayment exists and will recoup any improper payments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904 (a)(2)). The Medicare Part A/B appeals process have five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An improper payment based on extrapolation is re-estimated depending on the result of the appeal.

- strengthen its policies and procedures to ensure that:
 - plans of care are signed by all members of the interdisciplinary team, contain all required elements, are updated timely, and are related to the type of dialysis services provided;
 - comprehensive assessments contain all required elements and are updated timely; and
 - physicians' orders for dialysis services are completed and comply with Medicare requirements.

ATLANTIS HEALTH CARE GROUP OF PUERTO RICO, INC., COMMENTS

In written comments on our draft report, Atlantis concurred with our findings and recommendations and described actions it has taken or planned to take to address them. Atlantis' comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 11,430 beneficiary-months for which Atlantis received Medicare reimbursement totaling \$20,280,080 for dialysis services provided during our audit period. A beneficiary-month was defined as all dialysis services provided to a beneficiary by Atlantis during 1 calendar month. Claims for these services were extracted from CMS's National Claims History (NCH) file.

We did not review the overall internal control structure of Atlantis. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of Atlantis' policies and procedures for documenting and billing Medicare for dialysis services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data from the NCH file, but we did not assess the completeness of the file.

We performed fieldwork at Atlantis' offices in Trujillo Alto, Puerto Rico.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations and guidance;
- interviewed officials from First Coast Service Options (the MAC that processed and paid the Medicare claims submitted by Atlantis during our audit period) to obtain an understanding of the Medicare requirements related to dialysis services;
- interviewed Atlantis officials to gain an understanding of Atlantis' policies and procedures for providing dialysis services, maintaining documentation for services provided and billing Medicare for such services;
- obtained from CMS's NCH file a sampling frame of 11,430 beneficiary-months totaling \$20,280,080 for our audit period;
- selected a random sample of 100 beneficiary-months from the sampling frame;
- reviewed data from CMS's Common Working File to determine whether claims associated with the sampled beneficiary-months had been cancelled or adjusted;
- obtained medical records and other documentation from Atlantis for the 100 sampled beneficiary-months;

- reviewed the medical records and other documentation provided by Atlantis to support the sampled beneficiary-months;
- provided the medical records and other documentation to an independent medical review contractor, who determined whether services were medically reasonable and necessary and met Medicare requirements;
- reviewed the medical review contractor’s results and summarized the reason(s) a beneficiary-month did not comply with Medicare requirements;
- used the results of the sample to estimate the amount of improper Medicare payments made to Atlantis for dialysis services; and
- discussed the results of our review with Atlantis officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of all Medicare Part B beneficiary-month claims for which Atlantis received Medicare reimbursement during the period of January 1, 2014, through October 31, 2015 (audit period). A beneficiary-month was defined as all ESRD services provided to a beneficiary by Atlantis during 1 calendar month.

SAMPLING FRAME

The sampling frame was an Access database containing 11,430 beneficiary-months (11,617 claims) with payments totaling \$20,280,080 for ESRD services provided during our audit period. The claims data were extracted from CMS's NCH file.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiary-months in the sampling frame from 1 to 11,430. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated the total amount of improper Medicare payments made to Atlantis at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	Number of Beneficiary-Months With Errors	Value of Unallowable Beneficiary-Months
11,430	\$20,280,080	100	\$171,881	100 ⁴⁴	\$9,122

**Estimated Value of Unallowable Beneficiary-Months
(Limits Calculated for a 90-Percent Confidence Interval)**

Point Estimate	\$1,042,685
Lower Limit	403,525
Upper Limit	1,681,845

⁴⁴ While all 100 beneficiary-months contained services with an error, services during only 27 of the 100 beneficiary-months impacted Atlantis' Medicare reimbursement.

APPENDIX D: ATLANTIS HEALTH CARE GROUP OF PUERTO RICO, INC., COMMENTS

Atlantis Health Care Group of Puerto Rico, Inc.
OIG Audit Response



December 17, 2018

Report Number: A-02-16-01009

Brenda M. Tierney
Regional Inspector General for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

SUBJECT: Atlantis Health Care Group Inc. Puerto Rico Response to OIG

Dear Ms. Tierney:

We are in receipt of the Office of Inspector (OIG) document dated December 6th, 2018, entitled "U.S. Department of Health and Human Services, Office of Inspector General (OIG), *Dialysis Services Provided by Atlantis Health Care Group of Puerto Rico, Inc., did Not Comply with Medicare Requirements Intended to Enhance the Quality of Care Provided to Medicare Beneficiaries*. The organization prides itself in striving to maintain a strong regulatory compliance culture across the organizational spectrum. Patient care is important. We are committed to provide quality care to our Medicare beneficiaries and their families and adhering to Medicare regulation. Our goal is to be compliant with all federal regulations and the providing of quality care and clinical performance measures established by the Centers for Medicare and Medicaid (CMS).

Atlantis Health Care Group (AHG) underwent ownership change in February of 2013. In December of that year, I succeeded as the new Chief Executive Officer (CEO). With the new changes in ownership, regulatory compliance and patient care has always been a priority.

Upon preliminary review of the above referenced OIG report, the organization concurs with the findings and recommendations. However, we also acknowledge that while the policies and procedures were present as thematically stated by the OIG, there is a need to modify and strengthen these procedures that incorporate proper checks and balances to ensure future billing and claims compliance and maintain quality care. The OIG has made four recommendations of which two are based on improper payments and payback, and a look back period to identify any similar or improper payments and return overpayments in accordance with Medicare Regulation. AHG has established the look back period from November 1st, 2015 to date. Please note, the established audit period is taking into consideration the change of ownership. Additionally, the

P.O. Box 1350 • St. Just Station, P.R. 00978 • Calle Aniceto Díaz, Int. 876, Trujillo Alto, P.R. 00976
Tel. 787.292.7979 • Fax: 787.292.7999

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organization has contacted the Medicare Administrative Contractor, First Coast Services Options to make an immediate payment for \$403,525.00. As of today's date, we are awaiting specific payment instructions from First Coast Services Options. Other recommendations are focused on the providing of dialysis services that meet the Medicare requirements for all elements underscoring documentation, plan of care and comprehensive assessments, accurate reporting of measurements and comorbidities, and physician orders.

The task force has already begun to review current policies and procedures to assess the effectiveness as well as deficiencies impacting claims and billing accuracies, and possible patient care. A number of interventional measures such as mandatory re-education and training for physicians, nursing, and staffing on proper documentation, physician ordering of dialysis services, and the implementation of new procedures to address electronic healthcare records (EHR) system failures due to poor and or lack of internet connection, faulty interface and downloading of data i.e. communication failures. Additional measures include the following:

1. Optimizing the current electronic healthcare record systems software.
2. Assessing the current PD equipment patient tools.
3. Implementing an integrated billing and clinical audit tool.
4. Companywide re-training and education on *Regulatory Compliance: Elements of Proper Documentation*.
5. Patient Engagement Education and Training on the *Harmful Effects of Missed Treatments and Incomplete Dialysis Treatments*.
6. Development of a stronger policy and procedure to ensure timely orders and physician signatures.
7. The establishment of a companywide education and training on *Creating a Culture of Regulatory Compliance*.
8. AHG has added six new positions to the organization to strengthen the checks and balance infrastructure:
 - Vice President of Administrative Operations
 - Assistant Vice President of Clinical Operations
 - Director of Peritoneal Dialysis Services
 - Two clinical nurse auditors
 - Physician Clinical Consultant

As part of the overall process, AHG has developed a user-friendly audit tool for both the OIG and the organization to better describe the Plan of Correction (POC) specifics and timeline. The document is open to further recommendation from the OIG and will be used as the operational foundation for both current, future, and ongoing compliance. The newly developed *OIG Corrective Action Plan Audit Tool* is subject to change based on the continued audit efforts, findings, and recommendations made by both the OIG and the internal task force.

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AHG appreciates your feedback and recommendations. These changes will lead to stronger company policies and procedures reflective of AHG's continued efforts to provide quality patient care to all Medicare beneficiaries, and the implementation of a systemic foundation underpinning a robust regulatory compliance culture that meets all required Medicare policies.

Respectfully,

Ruby Harford, RN, PhD
CEO/President
Atlantis Health Care Group, Inc. Puerto Rico