Eli's Rehab Report

Therapy Claims: Review Your PT Claims' Records To Eliminate These Deficiencies

Only 38 percent of claims were billed properly by this practice.

If you think clear, detailed documentation is a drag, think again. Lack of it can actually cause numerous billing errors and denials or paybacks or worse fraud charges. The **HHS Office of the Inspector General** (OIG) recently released its findings in its audit "AgeWell Physical Therapy & Wellness, PC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services."

The OIG reviewed claims by **AgeWell Physical Therapy & Wellness** because it was a top outpatient physical therapy (PT) provider in New York State. Out of 100 claims that the OIG reviewed, only 38 were billed properly. Even worse, of the 62 claims with errors, 29 of them included more than one deficiency, the OIG report noted.

"These deficiencies occurred because AgeWell did not have a thorough understanding of Medicare requirements related to claiming outpatient therapy services and did not have adequate policies and procedures to ensure that it billed for services in accordance with Medicare requirements," the OIG said. Based on the errors, the agency estimated that AgeWell collected nearly $1.4 million that it was not entitled to collect from Medicare.

Get to Know These Frequent Errors

The majority of issues that the OIG found involved treatment notes that failed to meet Medicare requirements. In some cases, the treatment notes didn't support the number of units that the therapists billed, while in other scenarios the treatment note was missing the providing or supervising therapist's signature.

The next most common error occurred when the treatment plan was missing or did not meet Medicare requirements. In some cases, therapists provided services that were not included in the plan, while in others the plans were missing or weren't dated.

In additional cases, outpatient therapy services did not meet Medicare's physician certification rules, meaning there was either no dated practitioner signature on the plan or the claims were not certified within 30 days of the first treatment.

Rounding out the errors, the OIG also saw several claims for services that were not medically necessary, and two claims in which the therapist did not actually perform or supervise the service.

Keep in mind: Your plan of care must include the patient's diagnoses, the long-term treatment goals and the type, amount, duration and frequency of therapy services.

The certification must be signed by the physician (or NPP) within 30 days of the initial therapy treatment, according to the CMS document, "Physical, Occupational and Speech Therapy Services."

Resource: To read the complete OIG report, visit http://oig.hhs.gov/oas/reports/region2/21301031.pdf.