Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A FLORIDA PHYSICAL THERAPY PRACTICE CLAIMED UNALLOWABLE MEDICARE PART B REIMBURSEMENT FOR SOME OUTPATIENT THERAPY SERVICES

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

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Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

A Florida physical therapy practice improperly claimed at least $55,000 in Medicare reimbursement for physical therapy services for calendar years 2012 and 2013.

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about $1.9 billion in calendar year 2014. Previous Office of Inspector General reviews have identified claims for outpatient physical therapy services that were unreasonable, medically unnecessary, improperly documented, and were vulnerable to fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including this therapy practice located in the State of Florida. Our analysis indicated that this selected therapy practice was among the highest Medicare therapy billers in the State of Florida.

Our objective was to determine whether claims for outpatient physical therapy services provided by a Florida physical therapy practice (the Therapy Practice) complied with Medicare requirements.

BACKGROUND

Federal regulations provide coverage of Medicare Part B outpatient physical therapy services. For these therapy services to be covered, they must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified therapist, periodically reviewed by a physician, and certified by a physician. Medicare Part B also covers outpatient physical therapy services performed by or under the personal supervision of a therapist in private practice. Federal law precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

HOW WE CONDUCTED THIS REVIEW

Our review covered 9,211 Medicare beneficiary claim days for outpatient physical therapy services totaling $898,169, provided by the Therapy Practice from January 1, 2012, through December 31, 2013. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the Therapy Practice received a payment from Medicare. We reviewed a random sample of 100 of those beneficiary claim days.

WHAT WE FOUND

The Therapy Practice claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our sample, the Therapy Practice properly claimed Medicare reimbursement on 87

beneficiary claim days. However, the Therapy Practice improperly claimed Medicare reimbursement on the remaining 13 beneficiary claim days.

These deficiencies occurred because the Therapy Practice did not have adequate policies and procedures in place to ensure that it billed for services that complied with Medicare requirements.

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least $55,189 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that the Therapy Practice:

- refund $55,189 to the Federal Government and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

THE THERAPY PRACTICE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Therapy Practice disagreed with most of our findings and recommendations. Of the 19 beneficiary claim days that we identified in our draft report as not meeting Medicare reimbursement requirements, the Therapy Practice disagreed with 18 beneficiary claim days. To support its disagreement, the Therapy Practice provided rebuttals for each of the 19 beneficiary claim days. For nine beneficiary claim days, the Therapy Practice also provided us with additional medical documentation not previously provided to the independent medical review contractor.

We forwarded to the Medicare administrative contractor (MAC) the Therapy Practice rebuttals and additional medical documentation, along with the independent medical reviewer's determinations for nine beneficiary claim days. After completing its review, the MAC's medical review staff determined that 6 of 19 beneficiary claim days met Medicare requirements. On the basis of the MAC's medical review of the Therapy Practice rebuttals, independent medical reviewer's determinations, and additional documentation; we revised our findings to disallow 13 instead of 19 beneficiary claim days. Thus, we maintain that our findings and recommendations related to the 13 sampled beneficiary claim days are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about $1.9 billion in calendar year 2014. Previous Office of Inspector General reviews have identified claims for outpatient physical therapy services that were unreasonable, medically unnecessary, not improperly documented, and were vulnerable to fraud, waste, and abuse.[1] As part of a nationwide effort, we selected multiple physical therapists for review, including this therapy practice located in the State of Florida. Our analysis indicated that this selected therapy practice was among the highest Medicare therapy billers in the State of Florida.

OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by a Florida physical therapy practice (the Therapy Practice) 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 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B covers services considered medically necessary to treat a disease or condition, including outpatient therapy services. CMS contracts with Medicare contractors to process and pay Part B claims.

Medicare Outpatient Physical Therapy Services

Medicare Part B provides coverage for outpatient physical therapy services.[2] Physical therapists evaluate and treat disorders of the musculoskeletal system. The goal of physical therapy is to restore maximal functional independence to each individual patient by providing services that aim to restore function, improve mobility, and relieve pain. Therapists use modalities such as exercise, heat, cold, electricity, and massage. These services are provided in a number of

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[1] *AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-13-01031), issued June 15, 2015; *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August, 20, 2014; *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 10, 2013; *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), issued December 21, 2010.

[2] Section 1832(a)(2)(C) of the Act.

different settings; however, the majority of Medicare payments for outpatient therapy services are made to physical therapists practicing in an office setting.

For Medicare Part B to cover outpatient physical therapy services, they must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified therapist, periodically reviewed by a physician, and certified by a physician.[3] Further, Medicare Part B pays for outpatient physical therapy services billed using standardized codes.[4] Services furnished by physical therapists in private practice must be performed by or under the direct supervision of a qualified physical therapist.[5] Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.[6] These requirements are further described in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. 100-04).

Florida Physical Therapy Practice

The selected physical therapy practice provides Medicare outpatient physical therapy services at its office in Boca Raton, Florida. From January 2012 through December 2013, the Therapy Practice's professional staff consisted of two physical therapists, one occupational therapist, one licensed massage therapist, one certified trainer, and two physical therapist assistants.

First Coast Service Options, Inc., serves as the Part B Medicare Administrative Contractor for providers in Jurisdiction N (formerly Jurisdiction 9), which includes Florida.

HOW WE CONDUCTED THIS REVIEW

Our review covered the Therapy Practice's claims for Medicare Part B outpatient physical therapy services provided from January 1, 2012, through December 31, 2013 (the audit period). Our sampling frame consisted of 9,211 beneficiary claim days[7] of outpatient physical therapy services, totaling $898,169, of which we reviewed a random sample of 100 beneficiary claim days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary claim days were provided in accordance with 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

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[3] Sections 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) of the Act.

[4] Standardized codes used by providers are called Healthcare Common Procedure Coding System (HCPCS) codes to report units of service.

[5] 42 CFR § 410.60(c).

[6] Section 1833(e) of the Act.

[7] A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the Therapy Practice received a Medicare payment.

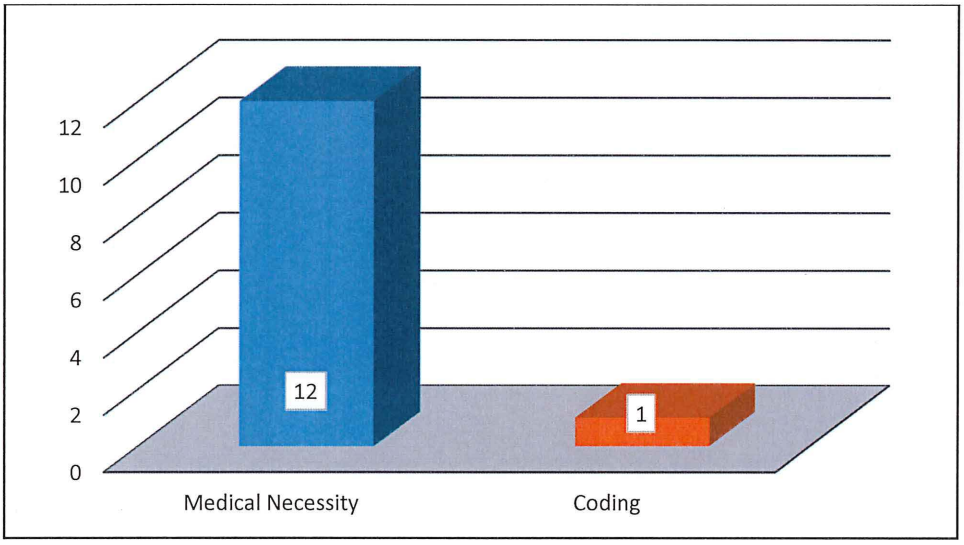
based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

The Therapy Practice claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our random sample, the Therapy Practice properly claimed Medicare reimbursement on 87 beneficiary claim days. However, the Therapy Practice improperly claimed Medicare reimbursement on the remaining 13 beneficiary claim days[8] as shown in Figure 1.

Figure 1: Beneficiary Claim Days by Type of Error



As illustrated in Figure 1:

- 12 beneficiary claim days had therapy services that were not medically necessary and
- 1 beneficiary claim day did not meet Medicare coding requirements.

These deficiencies occurred because the Therapy Practice did not have adequate policies and procedures in place to ensure that it billed for services that complied with Medicare requirements. On the basis of our sample results, we estimated that the Therapy Practice

[8] On the basis of the MAC's review of the rebuttals and additional medical documentation for 9 claims that the Therapy Practice provided in response to our draft report, the claims that did not meet Medicare requirements decreased from 19 to 13.

improperly received $55,189 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

SERVICES WERE NOT MEDICALLY NECESSARY

For services to be payable, a beneficiary must need the physical therapy services (*Medicare Benefit Policy Manual*, chapter 15 § 220.1). For a service to be covered, the service must be reasonable and necessary (section 1862(a)(1)(A) of the Act and *Medicare Benefit Policy Manual*, chapter 15 § 220.1).

Services are reasonable and necessary if it is determined that services were safe and effective, of appropriate duration and frequency within accepted standards of medical practice for the particular diagnosis or treatment, and met the patient's medical needs (*Medicare Program Integrity Manual*, chapter 3 § 3.6.2.2).

For 12 beneficiary claim days, the Therapy Practice received Medicare reimbursement for services that the beneficiaries' medical records did not support as being medically necessary. The results of the medical review contractor indicated that these services did not meet Medicare requirements. Specifically, the amount, frequency, and duration of services were not reasonable.

For example, the Therapy Practice received payment for physical therapy services provided to a 54-year-old Medicare beneficiary. The medical review contractor determined that the therapy service did not meet Medicare coverage requirements. Specifically, the medical records failed to support that the functional ability of the beneficiary after having reached a plateau in which some physical goals were met. However, the beneficiary had shown no improvement on others physical goals which required further additional therapy beyond the implementation of a home exercise program.

CODING DID NOT MEET MEDICARE REQUIREMENTS

Outpatient therapy services are payable when the medical record and information on the provider's claim form consistently and accurately report covered services (*Medicare Benefit Policy Manual,* chapter 15, § 220.3A). Providers must include the National Provider Identifier[9] (NPI) on claims for the rendering therapist providing the services (*Medicare Claims Processing Manual*, chapter 26 § 10.4). In addition, providers must also report the number of units for outpatient rehabilitation services based on the procedures or services provided. For timed procedures, units are reported in 15-minute intervals. For untimed procedures, units are reported based on the number of times the procedure is performed (*Medicare Claims Processing Manual,* chapter 5 § 20.2).

For one beneficiary claim day, the Therapy Practice received Medicare reimbursement for which the timed units billed on the claim did not match the treatment notes.

The Therapy Practice received payment for physical therapy provided under HCPCS code 97110 to a 77-year-old Medicare beneficiary. The therapist provided treatment notes stating that the

[9] A National Provider Identifier is a unique identification number for health care providers.

"therapeutic exercise applied to: Therapeutic Exercises – Therapeutic Procedure 1+ Area (14 minutes)." Therefore, only 1 unit (14 minutes) should have been billed for this service rather than the 2 units (28 minutes) that were billed. As a result, the Therapy Practice received an overpayment for HCPCS code 97110.

CONCLUSION

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least $55,189 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

We recommend that the Therapy Practice:

- refund $55,189 to the Federal Government and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

THE THERAPY PRACTICE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Therapy Practice Comments

In written comments on our draft report, the Therapy Practice disagreed with most of our findings and recommendations. Of the 19 beneficiary claim days that we identified in our draft report as not meeting Medicare reimbursement requirements, the Therapy Practice disagreed with 18 beneficiary claim days. To support its disagreement, the Therapy Practice provided rebuttals for each of the 19 beneficiary claim days. For nine beneficiary claim days, the Therapy Practice also provided us with additional medical documentation not previously provided to the independent medical review contractor.

The Therapy Practice comments are included as Appendix D.

Office of Inspector General Response

We forwarded to the Medicare administrative contractor (MAC) the Therapy Practice rebuttals and additional medical documentation, along with the independent medical reviewer's determinations for nine beneficiary claim days. After completing its review, the MAC's medical review staff determined that 6 of 19 beneficiary claim days met Medicare requirements. On the basis of the MAC's medical review of the Therapy Practice rebuttals, independent medical reviewer's determinations, and additional documentation; we revised our findings to disallow 13 instead of 19 beneficiary claim days. Thus, we maintain that our findings and recommendations related to the 13 sampled beneficiary claim days are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the Therapy Practice's claims for Medicare outpatient physical therapy services provided from January 1, 2012, through December 31, 2013 (the audit period). Our sampling frame consisted of 9,211 beneficiary claim days of outpatient physical therapy services, totaling $898,169, of which we reviewed a sample of 100 beneficiary claim days. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the Therapy Practice received a payment from Medicare. These claims were extracted from CMS's National Claims History (NCH) file.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the Therapy Practice's policies and procedures for documenting and billing Medicare for outpatient therapy services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data, but we did not assess the completeness of the file.

We conducted our fieldwork at the Therapy Practice's office in Boca Raton, Florida, in February 2015 and September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- extracted from CMS's NCH file a sampling frame of 9,211 outpatient therapy service beneficiary claim days, totaling $898,169, for the audit period;
- selected a random sample of 100 outpatient therapy service beneficiary claim days from the sampling frame (Appendixes B and C);
- obtained medical records documentation from the Therapy Practice for the 100 sampled beneficiary claim days and provided them to an independent medical review contractor, to determine whether each service was allowable in accordance with Medicare requirements;
- used the results of the sample review to calculate the estimated unallowable Medicare reimbursement paid to the Therapy Practice (Appendix C); and
- discussed the results of our review with the auditee.

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

POPULATION

The population consisted of all Medicare Part B outpatient therapy service claims paid to the Therapy Practice during the audit period.

SAMPLING FRAME

The sampling frame was an Access database containing 9,211 outpatient therapy service beneficiary claim days, totaling $898,169, provided by the Therapy Practice during the audit period. We extracted the claims data from CMS's NCH file.

SAMPLE UNIT

The sample unit was an outpatient therapy service beneficiary claim day. A beneficiary claim day consisted of all payments made for a beneficiary on the same dates of service. The beneficiary claim days were limited to payment amounts greater than or equal to $50.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 outpatient therapy service beneficiary claim days.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items. We then created a list of the 100 sampled items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the total amount of inappropriate Medicare payments for unallowable outpatient therapy services made to the Therapy Practice at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Beneficiary Claim Days in Frame	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Beneficiary Claim Days	Value of Unallowable Beneficiary Claim Days
9,211	$898,169	100	$9,915	13	$1,072

ESTIMATES

Table 2: Estimated Value of Unallowable Beneficiary Claim Days
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$98,769
Lower Limit	55,189
Upper Limit	142,348

APPENDIX D: THE THERAPY PRACTICE'S COMMENTS

[redacted]
Physical Therapy and Hand Rehabilitation

January 16, 2016

Mrs Lori S. Pilcher

Regional Inspector General for Audit Services

61 Forsyth Street, SW, st 3141

Atlanta, GA 30303

RE: response to Draft Report case number: A-04-15-07054

Dear Ms Pilcher;

The Draft Report in reference to the audit performed by [redacted] at our clinic located at [redacted], indicates 2 types of deficiencies. The evaluation indicated that 81 samples out of 100 passed Medicare guidelines related to policies and procedures for providing skilled outpatient physical therapy.

Unfortunately, 18 samples selected for review had comments about "excessive treatment visits". One sample was selected for procedure coding error.

After completing a thorough chart review, I disagree with the determination of "excessive treatment visits" on the 18 samples. I completed narrative medical rebuttals detailing this information for each sample, in conjunction with CMS form 20027. My medical rebuttals are based on medical information collected from Patient history, patient evaluations, daily soap notes and progress notes, monthly reevaluations and discharge summaries provided to your officers with the data collection of March and September 2015. In addition, I consulted with a local Physical Therapy specialist and looked at signed Letters of Medical Necessity and Plan of Care attests by attending and referring Physicians of said samples. My chart review also noted that in 2 samples, i.e. 09 and 11, the evaluators overstated the utilization and number of treatment visits by mistake.

In addition, there is sample 76 reviewed for billing errors. Here I am not argueing the fact that a technical coding error occurred, documenting in the daily note 14 minutes of 97110, 14 minutes

1

[redacted]

of 97530, 14 minutes each of 97140 and 97112 and 10 minutes of ES. Mistakenly 2 units of 97110 were billed in addition to the 97112 (x1) and 97140 (x1) for a total treatment time of 72 minutes. Corrective action should be taken to rebill said date of service corrected as above. We have reviewed our internal office policy and procedures to avoid future such mistakes.

I understand that these comments will be forwarded to First Coast reviewers for further testing. If I can provide any additional information at this time to assist in the process, please do not hesitate to contact me directly at [redacted]

Respectfully,

[redacted]

Attachment enclosed : 19 rebuttals organized by sample number as provided.