DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

August 15, 2007

Report Number: A-06-06-00078

Mr. Michael Bovarnick
Physical Therapist
6642 NW 25th Court
Boca Raton, Florida 33496

Dear Mr. Bovarnick:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Florida Physical Therapist's Medicare Claims for Therapy Services Provided During 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me or Cheryl Blackmon, Audit Manager, at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. Please refer to report number A-06-06-00078 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Roger Perez
Regional Administrator, Region IV
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, GA 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FLORIDA PHYSICAL THERAPIST'S MEDICARE CLAIMS FOR THERAPY SERVICES PROVIDED DURING 2003

Daniel R. Levinson
Inspector General

August 2007
A-06-06-00078

Office of Inspector General

http://oig.hhs.gov

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Department of Health and Human Services

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at http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Physical therapy services are provided according to a physician-approved plan of care designed to improve or restore physical functioning following disease, injury, or loss of a body part. To aid in the treatment of a beneficiary, physical therapists use a variety of exercises, rehabilitative procedures, massages, and physical agents.

Medicare Part B covers outpatient physical therapy services provided by a qualified therapist in private practice when furnished in the therapist's office or the patient's home. Private practitioners are individuals who work in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice. Regardless of the business structure of the therapy practice, Medicare requires the practice to meet all State and local licensure laws.

Physical therapists must enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. To enroll in Medicare, a physical therapist must complete a form and be qualified to obtain a provider identification number that identifies him or her as the person who provided the service on the Medicare claim form. If a physical therapist plans to provide services as part of a group or organization, the group practice must enroll in Medicare. Each therapist who plans to reassign his or her benefits to a group or organization must complete and submit a separate form to its Medicare carrier.

Medicare carriers, under contract with the Centers for Medicare & Medicaid Services (CMS), process and pay Part B claims. First Coast Service Options, Inc., is the Medicare carrier responsible for paying Part B therapy claims in the state of Florida.

OBJECTIVE

Our objective was to determine whether therapy services provided by a Florida physical therapist during calendar year 2003 met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Of the 100 sampled claims, 96 did not meet Medicare's reimbursement requirements. In total, 494 of the 702 physical therapy services contained in the 100 sampled claims did not meet one or more of the Medicare reimbursement requirements because:

- the physical therapist inappropriately used his provider identification number to bill for services performed or supervised by someone else,
- the documentation for some therapy services did not meet Medicare requirements,
- some therapy services were miscoded, and

- a plan of care did not meet Medicare requirements.

The physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures in place to ensure that he billed Medicare only for services that met Medicare reimbursement requirements. As a result, the physical therapist improperly billed Medicare and received $10,781 for the 494 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $411,781 for calendar year 2003 services that did not meet Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that the physical therapist:

- refund to the Medicare program $411,781 in unallowable payments for therapy services provided in 2003 and

- develop quality control procedures to ensure that therapy services are provided and documented in accordance with Medicare reimbursement requirements.

AUDITEE'S COMMENTS

The physical therapist stated that he will address any issues concerning the audit through the Medicare appeals process.

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INTRODUCTION

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health insurance to people age 65 and over, the disabled, and people with end-stage renal disease. Administered by the Centers for Medicare & Medicaid Services (CMS), the Medicare program consists of four parts, including Part B, Supplementary Medical Insurance. Part B covers a multitude of medical and other health care services, including outpatient physical therapy.

Physical Therapy Services

Physical therapy services are provided according to a physician-approved plan of care designed to improve or restore physical functioning following disease, injury, or loss of a body part. To aid in the treatment of a beneficiary, physical therapists use a variety of exercises, rehabilitative procedures, massages, and physical agents.

Medicare's Coverage of Physical Therapy Services

Medicare Part B covers outpatient physical therapy services provided by a qualified therapist in private practice when furnished in the therapist's office or the patient's home. Private practitioners are individuals who work in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice. Regardless of the business structure of the therapy practice, Medicare requires the practice to meet all State and local licensure laws.

Physical therapists must enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. To enroll in Medicare, a physical therapist must complete a form and be qualified to obtain a provider identification number that identifies him or her as the person who provided the service on the Medicare claim form. If a physical therapist plans to provide services as part of a group or organization, the group practice must enroll in Medicare. Each individual therapist who plans to reassign his or her benefits to a group or organization must complete and submit a separate form to its Medicare carrier.

Medicare carriers contract with CMS to process and pay Part B claims. First Coast Service Options, Inc., is the Medicare carrier responsible for paying Part B therapy claims in the State of Florida.

The Selected Therapist

The selected physical therapist operated five clinics that were leased and subleased in Florida during 2003. Nine physical therapists, including the selected physical therapist, and 10 physical therapy assistants worked in these clinics during this period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether therapy services provided by a Florida physical therapist during calendar year 2003 met Medicare reimbursement requirements.

Scope

Our review covered claims paid by Medicare for physical therapy services provided during calendar year 2003. For this period, Medicare paid the physical therapist $883,310 for 6,924 claims.

We did not assess the physical therapist's overall internal control structure. We limited our internal control review to obtaining an understanding of the policies and procedures the physical therapist used to obtain physician-certified plans of care, document physical therapy services, and bill Medicare for them.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- discussed relevant Medicare regulations and guidance with Electronic Data Systems (EDS) and CMS officials;
- identified all of the Medicare paid claims for services performed during calendar year 2003;
- selected a stratified random sample (Appendix A) of 100 claims for medical review; and
- obtained copies of the physical therapist's medical records for each claim in our sample.

We contracted with EDS, a CMS program safeguard contractor located in Hingham, Massachusetts, to conduct a medical review of the documentation for the sample claims.[1] We discussed the medical review results with the physical therapist and his healthcare consultant.

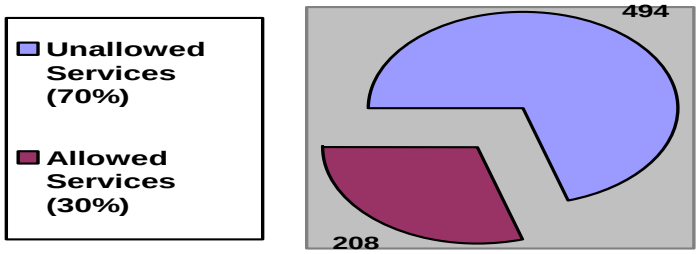
We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the 100 sampled claims, 96 did not meet Medicare's reimbursement requirements. In total, 494 of the 702 physical therapy services documented in the 100 sampled claims did not meet one or more of the Medicare reimbursement requirements because:

- the physical therapist inappropriately used his provider identification number to bill for services performed or supervised by someone else,
- the documentation for some therapy services did not meet Medicare requirements,
- some therapy services were miscoded, and
- a plan of care did not meet Medicare requirements.

Number of Physical Therapy Services Allowed and Unallowed on 100 Sampled Claims Billed By a Florida Therapist



The physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures in place to ensure that he billed Medicare only for services that met Medicare reimbursement requirements. As a result, the physical therapist

[1]The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program and authorized CMS to contract with entities, such as program safeguard contractors, to perform certain program safeguard activities, including medical review, cost report audits, data analysis, provider education, and fraud detection and prevention. We relied on the medical review determinations of EDS, which was under contract with CMS to promote the integrity of the Medicare program.

improperly billed Medicare and received $10,781 for the 494 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $411,781 for calendar year 2003 physical therapy services that did not meet Medicare reimbursement requirements.

Some physical therapy services were denied for more than one reason. Therefore, although the number of unallowable services on the 100 claims EDS reviewed totaled 494, the number of reasons the services were unallowable was 803. Appendix B shows the number of errors, by claim, that were unallowable for one or more reasons.

MEDICARE REIMBURSEMENT REQUIREMENTS NOT MET

Inappropriate Use of Provider Identification Number to Bill Medicare

The physical therapist inappropriately used his provider identification number to bill Medicare for 413 services he did not provide or supervise. Physical therapy assistants performed services billed under the physical therapist's provider identification number, and the medical records contained no evidence that he supervised the assistants. Most of these services were provided in patients' homes and in separate clinics as many as 51 miles away. Other physical therapists provided some services, but they did not have Medicare-issued provider identification numbers and, therefore, were not identified on the claims.

Federal regulations (42 CFR § 410.60) state that Medicare Part B pays for therapy services performed by or under the personal supervision of a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

During our audit period, the "Medicare Benefits Policy Manual," chapter 15, section 230.1C, stated, "The owner must be physically present when services are rendered by an employee." Additionally, if a provider is a member of a group practice, the "Medicare Claims Processing Manual," chapter 26, section 10.4, requires the claims to include the provider identification number of the individual who performed the services.

Pursuant to the Medicare Federal Health Care Provider/Supplier Enrollment Application (form CMS 855I), physical therapists must enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. To enroll in Medicare, a physical therapist must complete form CMS855I and be qualified to obtain a provider identification number that identifies him or her as the person who provided the service on the Medicare claim form.

Documentation Did Not Meet Medicare Requirements

For 329 therapy services, the physical therapist did not document the therapy services billed, or the documentation was not adequate to support the services billed. For example, the physical

therapists documented 6 minutes of service time in the medical records that did not adequately support the two 15-minute units of billed therapeutic exercises.

Federal regulations (42 CFR § 486.161(b)) require physical therapists' clinical records to contain sufficient information to clearly identify the patient, justify the treatment, and accurately document the results. The clinical records should include the care and services provided. Further, the "Medicare Claims Processing Manual," chapter 5, section 20.2, states that providers should record in a patient's medical records either the beginning and ending times or total time of the treatment and a note describing the treatment. If the duration of a single 15-minute procedure is greater than or equal to 23 minutes to less than 38 minutes, the two units should be billed.

Miscoded Therapy Services

The physical therapist miscoded 58 therapy services he billed to Medicare. For some services, the therapist incorrectly billed the manual (attended) electrical stimulation procedure code, 97032. However, based on the diagnosis and treatment notes, he should have billed for these services using an unattended electrical stimulation procedure code (either 97014 before April 1, 2003, or G0283 on or after April 1, 2003). For other services, the physical therapist incorrectly billed therapeutic exercises (97110), rather than either gait training (97116) or therapeutic activities (97530) as documented in the medical records.

These codes, with the exception of code G0283, are defined in the "Physician's Current Procedural Terminology." On June 27, 2003, CMS issued Program Memorandum AB-03-093 instructing providers to use procedure code G0283 when reporting unattended electrical stimulation on or after April 1, 2003.

Plan of Care Did Not Meet Medicare Requirements

The physical therapist billed for three services related to one plan of care that did not meet Medicare requirements. This is because the plan of care was not signed or dated by the physician when it was initially established.

Pursuant to the "Medicare Carriers Manual," part 3, chapter II, section 2210, for Medicare to pay for physical therapy services, the services must relate directly and specifically to an active, written plan of care. Either the physician, after any needed consultation with the qualified therapist, or the therapist providing such services may establish the plan of care.

Pursuant to 42 CFR §§ 410.61(a), (c) and (e), the written plan of care must be dated and signed by the physician who reviews it as often as the individual's condition requires, but at least every 30 days.

Physical Therapist Lacked Understanding of Medicare Requirements and Effective Policies and Procedures

These services were improperly billed because the physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures in place to ensure that he billed Medicare only for services that met Medicare reimbursement requirements.

Effect of Improperly Billed Physical Therapy Services

As a result, the physical therapist improperly billed Medicare and received $10,781 for the 494 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $411,781 for calendar year 2003 physical therapy services that did not meet Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that the physical therapist:

- refund to the Medicare program $411,781 in unallowable payments for therapy services provided in 2003 and

- develop quality control procedures to ensure that therapy services are provided and documented in accordance with Medicare reimbursement requirements.

AUDITEE'S COMMENTS

The physical therapist stated that he will address any issues concerning the audit through the Medicare appeals process.

Appendixes

SAMPLE METHODOLOGY AND RESULTS

METHODOLOGY

Population

The population consisted of all physical therapy claims of $25 or greater paid to the physical therapist, with service dates from January 1 through December 31, 2003.

Sampling Frame

The sampling frame consisted of a list of 6,084 physical therapy claims of $25 or greater totaling $868,312 paid to the physical therapist, with service dates from January 1 through December 31, 2003. The list was extracted from Medicare Part B claims using Clementine software.

Sample Unit

The sample unit was a paid Medicare claim for physical therapy services.

Sample Design

We used a stratified random sample.

Estimation Methodology

We used the Office of Inspector General, Office of Audit Services (OAS) RAT-STATS variable appraisal for stratified samples to estimate the amount of unallowable program payments. We reported the estimate of unallowable program payments at the lower limit of the 90-percent two-sided confidence interval in accordance with OAS policy.

RESULTS AND PROJECTION

	Population	Sample	Errors
Stratum 1			
Items	6,077	93	89
Payments	$864,650.64	$12,113.55	$7,229.89
Stratum 2			
Items	7	7	7
Payments	$3,661.33	$3,661.33	$3,551.43

Projection of Sample Results
(at the 90-percent confidence level)

Point estimate	$475,982
Lower limit	$411,781
Upper limit	$540,183
Precision percent	13.49%

Summary of Medical Review Determinations

Of the 100 sampled claims, 96 did not meet Medicare reimbursement requirements. In total, 494 of the 702 physical therapy services were denied for one or more reasons. Therefore, although the number of unallowable services on the 100 claims Electronic Data Systems reviewed totaled 494, the number of reasons the services were unallowable was far higher.

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE			
CLAIM NUMBER	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	INAPPROPRIATE USE OF PROVIDER IDENTIFICATION NUMBER	DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS	MISCODED THERAPY SERVICES	PLANS OF CARE DID NOT MEET MEDICARE REQUIREMENTS
1	9	$115.96			9	$115.96	9			
2	8	160.42			8	160.42	8	5	2	
3	1	56.56			1	56.56	1			
4	6	126.21			6	126.21	6	3		
5	5	108.21	3	$101.87	2	6.34		2	2	
6	9	182.96	8	180.36	1	2.60			1	
7	10	216.42	6	220.22	4	(3.80)		4	4	
8	4	78.18			4	78.18	4	4		
9	2	37.63			2	37.63	2	2		
10	2	34.21			2	34.21	2		1	
11	6	112.39			6	112.39	6	4	2	
12	8	158.07			8	158.07	8	6	1	
13	7	142.42			7	142.42	7	6	1	
14	6	163.43			6	163.43	6	2	1	
15	6	113.74			6	113.74	6	4	2	
16	6	174.09	5	152.29	1	21.80		1		
17	4	119.83			4	119.83	4	2	1	
18	9	206.88			9	206.88	9	6		
19	4	78.26	3	55.03	1	23.23		1		
20	4	93.28			4	93.28	4	3		
21	2	43.60			2	43.60	2	2		
22	10	217.66	5	101.51	5	116.15		5		
23	5	81.57	3	76.27	2	5.30			2	
24	5	143.07	1	93.96	4	49.11		3	1	
25	10	229.46	8	183.00	2	46.46		2		
26	2	35.07			2	35.07	2	1	1	
27	7	138.40			7	138.40	7	4	2	
28	9	206.88			9	206.88	9	6		
29	5	131.67			5	131.67	5		2	
30	9	206.88			9	206.88	9	6		
31	5	95.15	3	89.85	2	5.30			2	
32	3	68.26			3	68.26	3	2		
33	6	137.53			6	137.53	6	2		

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE			
CLAIM NUMBER	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	INAPPROPRIATE USE OF PROVIDER IDENTIFICATION NUMBER	DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS	MISCODED THERAPY SERVICES	PLANS OF CARE DID NOT MEET MEDICARE REQUIREMENTS
34	6	133.92			6	133.92	6	3		
35	7	186.66			7	186.66	7	4	1	
36	8	160.20			8	160.20	8	6	2	
37	6	123.29	5	100.06	1	23.23		1		
38	6	161.59	5	138.36	1	23.23		1		
39	6	133.92			6	133.92	6	3		
40	4	119.83	2	93.95	2	25.88		1	1	
41	5	101.84	4	78.61	1	23.23		1		
42	5	113.60			5	113.60	5	3		
43	5	113.60			5	113.60	5	3		
44	7	159.75	7	159.75						
45	5	140.20	3	77.45	2	62.75	1		1	
46	6	163.43	2	92.52	4	70.91		3	1	
47	7	151.57	6	148.92	1	2.65			1	
48	2	35.07			2	35.07	2	1	1	
49	2	31.80	1	10.00	1	21.80		1		
50	3	69.70	2	46.47	1	23.23		1		
51	6	133.92			6	133.92	6	3		
52	6	140.08	6	140.08						
53	3	58.30			3	58.30	3		1	
54	5	94.80			5	94.80	5		2	
55	6	135.09			6	135.09	6			
56	9	206.88			9	206.88	9	6		
57	4	118.40			4	118.40	4		1	
58	6	122.17			6	122.17	6	2	1	
59	4	90.02	3	69.70	1	20.32	1			
60	11	256.26	11	256.26						
61	9	206.88			9	206.88	9	6		
62	9	201.84	7	155.38	2	46.46		2		
63	9	206.88	5	113.96	4	92.92		4		
64	3	70.04			3	70.04	3	2		
65	3	70.04			3	70.04				3
66	9	193.39	8	190.74	1	2.65			1	
67	5	128.40	4	118.40	1	10.00		1		
68	7	160.41			7	160.41	7	3		
69	7	141.26			7	141.26	7	4	2	
70	8	186.54	8	186.54						
71	5	103.33	4	100.68	1	2.65			1	
72	3	105.13	2	45.03	1	60.10	1			

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE			
CLAIM NUMBER	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	INAPPROPRIATE USE OF PROVIDER IDENTIFICATION NUMBER	DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS	MISCODED THERAPY SERVICES	PLANS OF CARE DID NOT MEET MEDICARE REQUIREMENTS
73	5	112.77	4	89.54	1	23.23		1		
74	7	159.76	5	113.30	2	46.46		2		
75	5	141.63			5	141.63	5		1	
76	5	141.63			5	141.63	5		1	
77	5	111.03			5	111.03	5			
78	10	226.60	8	180.14	2	46.46		2		
79	4	70.14	2	64.84	2	5.30			2	
80	5	113.60	4	90.37	1	23.23		1		
81	5	113.60	4	90.37	1	23.23		1		
82	8	185.47			8	185.47	8			
83	5	65.76	3	27.48	2	38.28		2		
84	2	40.54			2	40.54	2	2		
85	8	170.81			8	170.81	8	6		
86	4	93.28			4	93.28	4	4		
87	7	138.40	5	133.10	2	5.30			2	
88	8	212.76	3	117.19	5	95.57		4	1	
89	4	128.36	1	60.10	3	68.26		3		
90	4	66.87			4	66.87	4	2	1	
91	6	101.08	4	94.44	2	6.64			2	
92	6	112.39	3	85.48	3	26.91		1	2	
93	8	162.69	7	160.09	1	2.60			1	
94	25	580.80			25	580.80	25	25		
95	20	464.64			20	464.64	20	20		
96	25	580.80			25	580.80	25	25		
97	20	464.99			20	464.99	20	20		
98	25	580.80			25	580.80	25	25		
99	20	439.70	15	109.90	5	329.80		5		
100	25	549.60			25	549.60	25	25		
Total	**702**	**$15,774.88**	**208**	**$4,993.56**	**494**	**$10,781.32**	**413**	**329**	**58**	**3**

APPENDIX C

Michael Bovarnick, PT
6642 NW 25th Ct
Boca Raton, FL 33496

07-31-07

Michele Louviere
HHS/OIG/OAS
9100 Bluebonnet Centre Blvd.
STE 504
Baton Rouge, LA 70809

Dear Ms. Louviere:

In regards to audit report, number A-06-06-00078, I will address any issues concerning the audit, through the Medicare appeals process.

Thank you,

Michael Bovarnick, PT