DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

November 18, 2009

Report Number: A-04-05-02011

Ms. Maxine Hochhauser
Care Alliance of America, Inc
2500 Quantum Lakes Drive, Suite 108
Boynton Beach, Florida 33426

Dear Ms. Hochhauser:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Care Alliance of America, Inc." 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 the 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (404) 562-7750, or contact Andrew Funtal, Audit Manager, at (404) 562-7762 or through email at Andrew.Funtal@oig.hhs.gov. Please refer to the report number A-04-05-02011 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY THERAPY SERVICES PROVIDED BY CARE ALLIANCE OF AMERICA, INC.

Daniel R. Levinson
Inspector General

November 2009
A-04-05-02011

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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.

EXECUTIVE SUMMARY

BACKGROUND

Comprehensive outpatient rehabilitation facilities (CORF) provide outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons. Sections 4523(d) and 4541 of the Balanced Budget Act of 1997 amended the Social Security Act to require that payment for hospital outpatient services, including CORF services, be made under a prospective payment system.

Care Alliance of America, Inc. (Care Alliance), is a CORF headquartered in Pompano Beach, Florida. Care Alliance received $2,038,991 for 6,927 claims for physical therapy, speech language pathology, and occupational therapy services provided during calendar year (CY) 2003. With the assistance of a program safeguard contractor, we reviewed a random sample of 100 of these claims. Each claim included multiple services.

OBJECTIVE

Our objective was to determine whether payments to Care Alliance for physical therapy, speech language pathology, and occupational therapy services provided during CY 2003 were in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

From our sample of 100 claims for 1,394 services, medical reviewers identified 97 claims for 1,186 services totaling $27,219 that did not meet Medicare reimbursement requirements, including:

- 812 services totaling $18,781 that did not meet requirements for reporting service units,
- 240 services totaling $5,441 that did not meet documentation requirements,
- 104 services totaling $2,331 that did not comply with the written plan of treatment, and
- 30 services totaling $666 that were not medically necessary.

Based on our sample results, we estimated that for CY 2003, Care Alliance received $1,664,635 for therapy services that did not meet Medicare reimbursement requirements.

Care Alliance did not always follow Medicare requirements or its own policies and procedures for reporting service units, ensuring that therapy services were adequately documented and complied with the written plan of treatment, or determining medical necessity.

RECOMMENDATIONS

We recommend that Care Alliance:

- refund to the Medicare program the estimated $1,664,635 in unallowable payments for CY 2003;

- follow its policies and procedures for reporting therapy service units, ensuring that therapy services are adequately documented and comply with the written plan of treatment, and determining medical necessity in accordance with Medicare requirements; and

- review services provided after our audit period and submit adjusted claims for any services that do not meet Medicare reimbursement requirements.

CARE ALLIANCE COMMENTS

In its written comments on our draft report, Care Alliance generally disagreed with our findings. Specifically, Care Alliance disagreed with the medical review disallowances of 866 services totaling $19,961 that did not meet Medicare requirements for reporting of service units and requested that we withdraw the disallowances of these therapy services.

In addition, Care Alliance disagreed with 254 therapy services disallowed by the medical reviewers for not meeting Medicare documentation requirements. Care Alliance provided medical records related to 87 of these 254 therapy services. Further, Care Alliance asked that we consider the impact of a Therapy Cap that was in effect for part of our audit period.

Care Alliance commented on neither the 104 services disallowed because they were not provided under a plan of treatment nor the 30 services disallowed because they were not considered medically necessary.

OFFICE OF INSPECTOR GENERAL RESPONSE

Service Units Reported

Based on Care Alliance's response, we accepted 54 previously disallowed services, but still consider 812 of the 866 services to be unallowable. We have revised both our estimates and the report accordingly.

Documentation

Along with its comments on our draft report, Care Alliance provided medical records for 87 of the 254 therapy services previously disallowed for lack of documentation. The additional documentation in 14 of the records caused us to accept 14 therapy services that we had previously disallowed and to revise both our estimates and the report accordingly. We are continuing to disallow 240 of the 254 therapy services previously disallowed for lack of documentation.

Effect of the Therapy Cap

The therapy cap was an annual dollar limitation placed on Medicare beneficiaries' utilization of outpatient therapy services and had no effect on our sample or on our findings.

The complete text of Care Alliance's comments is included as Appendix C. We did not include the additional medical documentation that Care Alliance provided because it contains Personally Identifiable Information and is too voluminous.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Comprehensive Outpatient Rehabilitation Facilities

Comprehensive outpatient rehabilitation facilities (CORF) provide outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons. Pursuant to section 1861(cc)(2)(B) of the Social Security Act (the Act), Medicare-certified CORFs must provide physician services, physical therapy, and social or psychological services. Medicare also covers occupational and speech-language pathology services provided by CORFs (section 1861(cc)(1)(B) of the Act).

Sections 4523(d) and 4541 of the Balanced Budget Act (BBA) of 1997 required the Centers for Medicare & Medicaid Services (CMS) to implement a prospective payment system for hospital outpatient services, including CORF services. Accordingly, CMS implemented a prospective payment system for CORF services furnished on or after January 1, 1999. The BBA also added section 1834(k) to the Act, requiring all CORF services to be paid at 80 percent of the lesser of the actual charge for the service or the applicable fee schedule amount. Section 1834(k)(3) of the Act defines the applicable fee schedule amount as ". . . the amount determined under the fee schedule established under section 1848 [i.e., the physician fee schedule]. . . ."

Fiscal Intermediaries

CORFs generally receive payments for covered services furnished to Medicare beneficiaries through fiscal intermediaries under contract with CMS. Federal regulations specify that the intermediaries' functions include processing claims, assisting in the application of safeguards against unnecessary utilization of services, conducting provider audits, resolving provider disputes, and reconsidering payment denial determinations (42 CFR § 421.100).

Program Safeguard Contractors

CMS contracts with program safeguard contractors (PSC) to perform medical review functions, including analyzing data, writing local coverage determinations, reviewing claims, and educating providers.

Care Alliance of America, Inc.

Care Alliance of America, Inc. (Care Alliance), headquartered in Pompano Beach, Florida, became a Medicare-certified CORF in August 1998. The fiscal intermediary for Care Alliance is First Coast Service Options, Inc., located in Jacksonville, Florida.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether payments to Care Alliance for physical therapy, speech language pathology, and occupational therapy services provided during calendar year (CY) 2003 were in accordance with Medicare reimbursement requirements.

Scope

Our review covered physical therapy, speech language pathology, and occupational therapy services provided in CY 2003, for which Care Alliance received Medicare payments of $2,038,991 for 6,927 claims.

Although we did not perform detailed tests of internal controls, we reviewed Care Alliance's written policies and procedures relating to the documentation and submission of claims for CORF therapy services.

We contracted with the PSC, Electronic Data Systems, to perform medical reviews. The purpose of the medical reviews was to determine whether the CORF services that Care Alliance claimed were reasonable, medically necessary, supported by adequate documentation, and correctly coded and reimbursed. In addition, the PSC was to determine and explain the reason for any inappropriately paid claims.

We conducted fieldwork at a Care Alliance facility in Miami Lakes, Florida.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and Medicare guidance for CORF therapy services;

- used CMS's Data Extract System user interface to retrieve all Care Alliance claim information related to physical therapy, speech language pathology, and occupational therapy services for the audit period;

- selected a random sample of 100 paid claims containing 1,394 services totaling $32,359 (Appendix A);

- contracted with the PSC to review all medical and billing records for the sampled claims to determine whether Care Alliance's CORF services met Medicare reimbursement requirements;

- worked with PSC staff to develop a payment error matrix that defined all the error codes;

- obtained supporting medical and billing records from Care Alliance for each sampled claim;

- reviewed Care Alliance's policies and procedures manual to determine whether policies existed to prevent the errors that the medical reviewers identified;

- reviewed the PSC's medical review determinations;

- estimated overpayments to Care Alliance (Appendix B); and

- provided Care Alliance management with the results of our review.

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 objective.

FINDINGS AND RECOMMENDATIONS

From our sample of 100 claims for 1,394 services, medical reviewers identified 97 claims for 1,186 services totaling $27,219 that did not meet Medicare reimbursement requirements, including:

- 812 services totaling $18,781 that did not meet requirements for reporting service units,

- 240 services totaling $5,441 that did not meet documentation requirements,

- 104 services totaling $2,331 that did not comply with the written plan of treatment, and

- 30 services totaling $666 that were not medically necessary.

Based on our sample results, we estimated that for CY 2003, Care Alliance received $1,664,635 for therapy services that did not meet Medicare reimbursement requirements.

Care Alliance did not always follow Medicare requirements or its own policies and procedures for reporting service units, ensuring that therapy services were adequately documented and complied with the written plan of treatment, or determining medical necessity.

SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS

Medicare requirements specify that CORF services must meet requirements for reporting service units, be adequately documented, be furnished under a written plan of treatment, and be medically necessary. Medical reviewers determined that 97 claims for 1,186 physical, speech, and occupational therapy services totaling $27,219 did not meet Medicare requirements.

Service Units Reported

Section 1833(e) of the Act precludes payments to any service provider unless the provider has furnished information necessary to determine the amounts due such provider. Pursuant to Federal requirements, providers must report therapy services using the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes and the appropriate number of units of service.[1] Providers must determine the appropriate number of units based on the total treatment time and CMS-designated treatment intervals. Specifically, Medicare guidance provides that:

> For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed . . . .
>
> The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, should be recorded. (The length of the treatment to the minute could be recorded instead.) ["Medicare Intermediary Manual," Pub. No. 13, part 3, section 3653(I)].

Care Alliance claimed $18,781 for 812 therapy services that did not comply with Medicare requirements for reporting service units. For 773 of these services, Care Alliance did not document the number of units billed by recording either the beginning and ending time or the length of time to the minute. In addition, for 39 services, Care Alliance billed for more units of direct contact therapy than were documented in the records. For example, in one case, Care Alliance billed for two units of service, which require a minimum of 23 minutes of direct contact. However, Care Alliance's records documented only 14 minutes of direct contact.

Documentation

Medicare requirements pertaining to documentation of CORF services include the following:

- Pursuant to Federal regulations (42 CFR § 485.60), documentation on each patient must be consolidated into one clinical record that must contain progress notes or other documentation that reflects the patient's reaction to treatment, tests, or injury, or the need to change the established plan of treatment. Medicare guidance states: "Progress notes are to be maintained in the patient's record . . . . Progress notes must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition" (Local Coverage Determination for Therapy Rehabilitation Services (L1125)).[2]

[1]Section 1834(k)(5) of the Social Security Act, 42 U.S.C. § 1395m(k)(5) (requiring all claims for outpatient rehabilitation therapy services and CORF services to be reported using a uniform coding system specified by the Secretary); Program Memorandum, HCFA Pub. 60A, Transmittal No. A-98-8, dated March 1, 1998 (specifying HCPCS/CPT codes as the uniform coding system). See also "Medicare Intermediary Manual," Pub. No. 13, part 3, section 3653(I).

[2]We used Medicare guidance that was current during CY 2003, our audit period.

- Pursuant to 42 CFR § 410.105(c)(1), services "must be furnished under a written plan of treatment that . . . [i]s established and signed by a physician before treatment is begun . . . ."

- Pursuant to 42 CFR § 424.11, the provider must obtain the required certification and recertification statements. Medicare guidance states: "No payment may be made for CORF services unless a physician certifies that . . . [a] plan for furnishing such services is or was established and periodically reviewed by a physician . . . . Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify the necessity for the services" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, chapter II, section 252(F)(1)).

Care Alliance claimed $5,441 for 240 therapy services that did not have supporting documentation. For 167 of these services, there were no progress notes, initial plans of treatment, or certifications. In addition, for 73 of these services, there was no documentation indicating that services were provided. For example, there was no documentation in the progress notes to indicate that therapy services were performed on the dates billed.

Written Plan of Treatment

Medicare requirements pertaining to the plan of treatment for CORF services include the following:

- Pursuant to 42 CFR § 410.105, services must be furnished under a written plan of treatment, and the plan must be reviewed at least once every 60 days by a facility physician.[3] Medicare guidance states: "The plan of treatment must contain the diagnosis, type, amount, frequency, and duration of services to be performed and the anticipated rehabilitation goals." Additionally: "The plan of treatment must be reviewed by the CORF physician at least once every 60 days" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, chapter II, section 252(E)).

- "The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established, must be recorded with the plan" (Local Coverage Determination for Therapy and Rehabilitation Services (L6196)).

- "Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 60 days) is required for the review of the plan. Recertifications are signed by the physician who reviews the plan of treatment" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, chapter II, section 252(F)(2)).

Care Alliance claimed $2,331 for 104 therapy services that did not comply with the written plan of treatment requirements. For 99 of these services, the plans of treatment and/or the certifications were not signed by a physician; were not dated; or did not include the amount,

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[3]CMS amended 42 CFR § 410.105 in 2007, effective January 1, 2008 (72 Fed. Reg. 66222, 66400 (Nov. 27, 2007)), requiring the plan of treatment for physical therapy, occupational therapy, and speech-language pathology services to be reviewed at least every 90 days. We used regulations that were in effect during CY 2003, our audit period, instead of the later version.

frequency, or duration of therapy services or the anticipated skilled rehabilitation goals. In addition, Care Alliance billed for five services that were not included in the plans of treatment.

Medical Necessity

Sections 1862(a)(1)(A) and 1833(e) of the Act provide that Medicare pays for services only if they are medically necessary and supported by documentation. Medicare guidance states:

- "When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends for that aspect of the plan of treatment" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, chapter II, section 252(E)).

- "CORF services are not covered if not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. Thus, there must be potential for restoration or improvement of lost or impaired functions. For example, services involving repetitive services that do not require the skilled services of nurses or therapists, e.g., maintenance programs, general conditioning, or ambulation, are not covered" ("Medicare Outpatient Physical Therapy/CORF Manual," Pub. No. 9, chapter II, section 251(B)).

Care Alliance claimed $666 for 30 therapy services that were not medically necessary because the patient did not meet the benefit requirements for CORF services:

- For 12 services, the therapy goals established were unreasonable. For example, medical records described a patient as a 100-year-old, confused, and disoriented female living in a secure unit of an assisted living facility. This patient had potential for wandering because of poor memory and sequencing abilities. Medical records further documented that the patient required 24-hour nursing care to assist with toileting, bathing, and dressing. The occupational therapy goals stated that this patient would (1) be independent with toileting, (2) have supervision for toileting transfers, and (3) increase her attention span and sequencing to 30 minutes. However, medical reviewers determined that, because of the patient's physical condition and cognitive status, it was unreasonable to expect significant improvements.

- For 10 services, the skilled care of a therapist or other professional rehabilitation practitioner was not required. The medical records for many of these patients showed that the patients were independent to moderately independent with grooming, needed standby assistance for upper body dressing, needed minimum assistance with sitting and balancing for lower body dressing, or needed standby assistance with verbal cues for toileting. Medical reviewers determined that services at this level did not require the skilled services of therapists or other professional rehabilitation practitioners.

- For 8 services, the patient did not meet the benefit requirements for CORF services. No documentation indicated that the patient had experienced a recent illness or injury or that physical therapy services were required to diagnose an illness or injury. In addition, no documentation suggested a functional limitation due to a malformed body member.

POLICIES AND PROCEDURES NOT FOLLOWED

Care Alliance did not always follow Medicare requirements or its own policies and procedures. If Care Alliance had followed its policies and procedures for reporting therapy service units, ensuring that therapy services were adequately documented and complied with the written plan of treatment, and determining medical necessity, it would have prevented some of the errors identified.

UNALLOWABLE PAYMENTS

Care Alliance received $27,219 in unallowable payments for therapy services in our sample that did not meet Medicare reimbursement requirements. Based on our sample results, we estimated that Care Alliance received $1,664,635 for services provided during CY 2003 that did not meet Medicare reimbursement requirements. (See Appendix B.)

RECOMMENDATIONS

We recommend that Care Alliance:

- refund to the Medicare program the estimated $1,664,635 in unallowable payments for CY 2003;

- follow its policies and procedures for reporting therapy service units, ensuring that therapy services are adequately documented and comply with the written plan of treatment, and determining medical necessity in accordance with Medicare requirements; and

- review services provided after our audit period and submit adjusted claims for any services that do not meet Medicare reimbursement requirements.

CARE ALLIANCE COMMENTS

In its written comments on our draft report, Care Alliance generally disagreed with our findings. Specifically, Care Alliance disagreed with the medical review disallowances of 866 services totaling $19,961 that did not meet Medicare requirements for reporting of service units and requested that we withdraw the disallowances of these therapy services.

In addition, Care Alliance disagreed with 254 therapy services disallowed by the medical reviewers for not meeting Medicare documentation requirements. Care Alliance provided medical records related to 87 of the 254 therapy services that were disallowed by the medical reviewers for not meeting Medicare documentation requirements. Further, Care Alliance asked that we consider the impact of a Therapy Cap that was in effect for part of our audit period.

Care Alliance commented on neither the 104 services disallowed because they were not provided under a plan of treatment nor the 30 services disallowed because they were not considered medically necessary.

OFFICE OF INSPECTOR GENERAL RESPONSE

Service Units Reported

For 773 of the 866 therapy services disallowed for not meeting reporting requirements, Care Alliance did not document the number of units billed by recording either the beginning and ending time of therapy or the length of therapy time to the minute. Care Alliance's assertion that it properly recorded the time that each therapy session commenced and ended is erroneous. Even though Care Alliance maintained a log recording facility entry and exit times, this log documents the amount of time the Medicare beneficiary spent at the facility but does not sufficiently document the time spent in medical treatment.

For 39 of the 866 therapy services disallowed, Care Alliance billed for more units of direct contact therapy than were documented in the records. The records relating to these services did document the amount of time spent on medical treatment, but the amount of time documented was not sufficient to support the amount billed.

Based on Care Alliance's response, we are accepting 54 of the 866 services that we previously disallowed because the individual services were less than 8 minutes in duration. We have revised both our estimates and the report accordingly.

Documentation

Along with its comments on our draft report, Care Alliance provided medical records for 87 of the 254 therapy services previously disallowed for lack of documentation. The documents in 73 of these 87 records were identical to those that the medical reviewers had previously found to be insufficient. However, the additional documentation in 14 of the records caused us to accept 14 therapy services that we had previously disallowed and to revise both our estimates and the report accordingly. We are continuing to disallow 240 of the 254 therapy services previously disallowed for lack of documentation. We have revised both our estimates and the report accordingly.

Plan of Treatment and Medical Necessity

Care Alliance did not comment or provide additional information on 134 services; therefore, we still consider those services to be unallowable.

Effect of the Therapy Cap

The therapy cap was an annual dollar limitation placed on Medicare beneficiaries' utilization of outpatient therapy services. Because we pulled our sample from a population of paid Medicare claims, rather than a population of beneficiaries, this cap had no effect on our sample or on our findings.

The complete text of Care Alliance's comments is included as Appendix C. We did not include the additional medical documentation that Care Alliance provided because it contains Personally Identifiable Information and is too voluminous.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of paid claims for physical therapy, speech language pathology, and occupational therapy services that Care Alliance of America, Inc. (Care Alliance), provided in calendar year (CY) 2003.

SAMPLING FRAME

The sampling frame was a database table containing 6,927 paid claims representing $2,038,991 in Medicare payments to Care Alliance.

SAMPLE UNIT

The sample unit was a paid claim for a Medicare beneficiary. A paid claim consisted of multiple units of therapy services.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 claims, which contained 1,394 therapy services.

SOURCE OF THE RANDOM NUMBERS

Random numbers were generated by the Office of Inspector General, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the services in our sampling frame and selected the sequential numbers that correlated to the random numbers. We then created a list of 100 sample items.

ESTIMATION METHODOLOGY

Using the OIG, OAS statistical software, we estimated the unallowable payments for physical therapy, speech language pathology, and occupational therapy services that Care Alliance provided during CY 2003.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sample Size	Value of Sample	No. of Unallowable Claims	Unallowable Payments
100	$32,359	97	$27,219

Estimates of Unallowable Payments

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$1,885,507
Lower limit	$1,664,635
Upper limit	$2,106,378

APPENDIX C: CARE ALLIANCE OF AMERICA, INC., COMMENTS

CADWALADER

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June 12, 2009

BY FEDERAL EXPRESS

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
61 Forsyth Street S.W., Suite 3T41
Atlanta, Georgia 30303

Re: Care Alliance of America, Inc. (Report Number A-04-05-02011)

Dear Mr. Barbera:

We are attorneys for Mobile Medical Industries, Inc. d/b/a AllianceCare ("Alliance Care"), successor to Care Alliance of America, Inc. ("Care Alliance"). On behalf of Alliance Care, we are writing in response to the draft report entitled "Review of Comprehensive Outpatient Rehabilitation Facility Therapy Services Provided by Care Alliance of America, Inc." (the "Draft Report"), enclosed with your letter dated April 14, 2009 to Ms. Maxine Hochhauser, President and Chief Executive Officer of Alliance Care, a copy of which is enclosed as Exhibit A. Alliance Care appreciates the courtesy given by the Office of Inspector General ("OIG") in agreeing to extend the facility's time until June 15, 2009 to respond to the Draft Audit Report.

As discussed in more detail below, Alliance Care hereby objects to certain of the proposed adjustments in the Draft Report, and requests that your office withdraw certain findings described in the Draft Report, for the following reasons: (i) the Provider Manual cited in the Draft Report as authority for disallowing 773 therapy claims does not require a Comprehensive Outpatient Rehabilitation Facility ("CORF") to record the time of each separate intervention or modality within a given therapy session -- an understanding that has been confirmed by the Centers for Medicare & Medicaid Services ("CMS") Health Insurance Specialist responsible for interpreting the CORF billing requirements; (ii) CMS has also confirmed that the Provider Manual cited as authority for disallowing payments for 54 therapy services provided for less

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than 8 minutes in duration, and for 39 therapy services billed for more units than documented, are not applicable when more than one service was provided during the therapy session; (iii) materials being submitted herewith provide adequate documentation with respect to eight of the disallowed claims; and (iv) the impact of the therapy cap, in effect from September 1, 2003 until December 7, 2003, should be taken into account when determining whether the disallowed claims resulted in any overpayment to Alliance Care. We also incorporate by reference the letters with respect to this matter from [redacted] prior counsel for Alliance Care, dated December 15, 2006 and February 7, 2007, to [redacted] and [redacted] respectively, previously submitted to your office, copies of which are enclosed as Exhibits B and C.

Time Recording Disallowance. According to the Draft Report, 773 of the therapy services provided by Alliance Care and reviewed on audit were disallowed under "Error Code 19" on the ground that Alliance Care had not recorded either the beginning and ending time or the length of time to the minute for each specific intervention or modality provided in a given therapy session billed by Alliance Care. In fact, Alliance Care did properly record the time each therapy session commenced and ended, and submits that it was not required to also separately time and record each intervention or modality provided during the therapy session.

As described in detail in [redacted] letters (Exhibits B and C), Medicare does not require a provider to document the number of units billed for a specific intervention or modality by recording the beginning and ending time for that specific service or the length of time to the minute such service was provided. Pursuant to Medicare Benefit Policy Manual Chapter 15, § 220.3 (enclosed as Exhibit D), "the amount of time for each specific intervention/modality provided to the patient may be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing". (Emphasis added.) See also Medicare Claims Processing Manual, Chapter 5 § 20.2 (enclosed as Exhibit E). Rather, it is sufficient to record the time the therapist began treating the patient and the time treatment ended, as Care Alliance has done.

Alliance Care has confirmed that the Policy Manual accurately reflects CMS' interpretation of the CORF billing requirements. In this regard, we contacted [redacted] the Health Insurance Specialist responsible for interpretation of the CORF billing requirements, from CMS' Division of Practitioner Services, Center for Medicare Management. [redacted] advised that recording the time in and time out for the entire treatment session, rather than the time spent providing specific intervention or modalities, is sufficient and appropriate. A copy of the e-mail confirming the foregoing is enclosed as Exhibit F. Likewise, the fiscal intermediary for Care Alliance, First Coast Service Options, Inc. ("First Coast") has verified that this practice is proper. In the "Billing issues FAQs" page of its web site, First Coast states:

The deleted text has been redacted because it is personally identifiable information.

> Q: Should the treatment encounter notes for therapy services capture total timed code treatment minutes and total treatment time?
>
> A: Yes. It is a requirement that the total timed code treatment minutes and total treatment time is captured in the treatment encounter notes. However, the amount of time for each specific intervention/modality provided to the patient is not required, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent and, in addition, the identification of each specific intervention/modality provided and billed, for both timed and untimed codes, needs to be recorded.

Citing CMS Internet Only Manual (IOM) Pub. 100-04, Chapter 5, Section 20.2 (emphasis added) (enclosed as Exhibit G). A First Coast Medicare A Bulletin reiterates that "the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment. [H]owever, the total number of timed minutes must be documented". First Coast Medicare A Bulletin, Vol. 8, Number 6, September 2006, p. 44 (emphasis added). A copy is enclosed as Exhibit H. See also [redacted] letters of December 16, 2006 and February 7, 2007 (Exhibits B-C herein).

Accordingly, your office should withdraw the disallowances of the 773 therapy services cited in the Draft Report to the extent that they are based on the incorrect view that the beginning and end time for each intervention or modality within a given therapy session must be recorded and documented.

Service Unit Reporting. The Draft Report found 54 therapy services unallowable because Alliance Care had billed for single units although the services were provided for less than 8 minutes in duration, identified as "Error Code 6". The Draft Report also found another 39 therapy services unallowable because Alliance Care had billed for more units of direct contact therapy than were documented in the record, identified as "Error Code 6A". For authority, the Draft Report cites to the Medicare Intermediary Manual, Pub. No. 13, part 3, Section 3653(I), which states: "Providers should not bill for services performed for [less than] 8 minutes". This section is inapplicable to the 93 therapy services reviewed on audit and does not support the disallowance. This section only proscribes billing fewer than 8 minutes for "any single CPT code". This provision does not preclude billing when, as here, "more than one CPT code is billed during a calendar day". In the latter case, "the total number of units that can be billed

is constrained by the total treatment time", not by the discrete time associated with a single CPT code.

CMS' [redacted] has also confirmed that each timed service provided to patients need not be identified to Medicare by CPT code where multiple codes are combined to meet the 15-minute requirement of coverage. E-mail from [redacted] Health Insurance Specialist, CMS, Division of Practitioner Services Center for Medicare Management to Stephanie Marcantonio, Cadwalader, Wickersham & Taft LLP (May 26, 2009, 8:26 a.m.) (Exhibit F hereto). In that circumstance, according to CMS, the CORF should identify the CPT code of the procedure the therapist spent the most time providing. Id. Citing Publication 100-04, Chapter 5, 20.2 – "Reporting of Service Units With HCPCS, C. Counting Minutes for Timed Codes in 15 Minute Units".

This interpretation is corroborated by Alliance Care's fiscal intermediary. First Coast issued clarifying guidance in a Medicare A Bulletin, stating that "[w]hen only one service is provided in a day, providers should not bill for services performed less than 8 minutes". First Coast Medicare A Bulletin, Vol. 8, Number 6, September 2006, p. 43 (Exhibit H). The First Coast Bulletin goes on to provide, however, that "[w]hen more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service . . . determines the number of units billed". Id. In this regard, First Coast instructs that where multiple services are provided for seven minutes or less, and the total time providing the services is greater than eight minutes, but less than twenty-three minutes, the provider should bill one unit for the service performed for the most minutes.

For example, 5 minutes of manual therapy and 7 minutes of gait training would be identified as one unit of gait training, even though neither of the services was provided for 8 minutes. The other examples provided in Section 20.2 of the Medicare Claims Processing Manual further demonstrate that the practice of combining multiple-code services to support one unit of billing is proper. In Example 2, where 40 minutes are spent providing two separate services, one 20 minute service should be billed as one unit, and the other should be billed as two units. This is so even though the general rule is that services provided for less than 23 minutes should be billed as one unit. In Example 3, when 33 minutes of therapeutic exercise and 7 minutes of manual therapy are provided for a total of 40 minutes, the time should be billed as 2 units of therapeutic exercise and 1 unit of manual therapy.

Accordingly, it was appropriate for Alliance Care to bill for each of the 93 therapy services under review, if the time spent providing such service, when combined with the time spent providing additional services under one or more other CPT codes, exceeds 8 minutes and is otherwise consistent with the total time of therapy services being billed in the session.

Mr. Peter J. Barbera
June 12, 2009

As described in [redacted] letter of February 7, 2007, there has been no change in policy since 2003 with respect to reporting and billing of timed therapy code treatment minutes. Rather, the policies described above apply with equal force to the audited claims. The alleged lack of documentation for the time spent on a specific intervention or modality is not a valid basis to deem a claim non-compliant. Moreover, billing a single unit for services provided for less than 8 minutes or billing more units than are documented for that service, when multiple services have been provided during the same therapy session, is consistent with CMS' billing policy. The claims should be allowed if the provider documented the time the therapy session commenced and ended and the number of units billed is consistent with such time.

In light of the foregoing, we request that the OIG reconsider [redacted] prior letters (Exhibits B and C), including the chart provided by [redacted] with respect to Error Codes 6 and 19 (enclosed as Exhibit I hereto), identifying the claims that should be recognized as allowable.

Adequate Documentation Provided. The Draft Report also alleges that certain claims were unallowable because the documentation provided by Care Alliance did not adequately support the claims. Alliance Care hereby submits for your review patient records consisting of supporting documentation for eight of the reviewed claims. This documentation is enclosed as Exhibits K through R, and is summarized in a chart enclosed as Exhibit J. The enclosed documentation supplements the chart of the contested audit findings with respect to Error Codes 6 and 19, previously submitted by [redacted] (Exhibit I). Alliance Care requests that the OIG reverse its original determination and sustain these eight claims based also on the enclosed documentation.

Effect of Therapy Cap. As you are aware, the Draft Report concerns therapy services provided during calendar year 2003. Section 4541(a)(2) of the Balanced Budget Act of 1997 imposed a financial limitation on reimbursement of all outpatient rehabilitation services (the "Therapy Cap"). The application of the Therapy Cap was subject to a moratorium from January 1, 2000 through December 31, 2002, and its application was delayed until September 1, 2003. During the period from September 1, 2003 through December 7, 2003, however, the Therapy Cap was in effect. See Medicare Claims Processing Manual, Chapter 15 § 10.2. There is no indication in the Draft Report that the estimated total of $1,769,024 in proposed disallowed claims takes into account the effect of the Therapy Cap. Alliance Care respectfully requests that the OIG consider the effect, if any, that the Therapy Cap would have on any extrapolated estimated liability.

For the foregoing reasons, Alliance Care respectfully requests that your office reconsider the findings in the Draft Report and withdraw certain of the findings, noted above. Alliance Care

would be happy to meet with you and your colleagues at OIG at your earliest convenience to discuss a possible amicable resolution.

Please do not hesitate to contact me at (212) 504-6749 or [redacted] at [redacted] with any questions you may have with respect to the above.

Sincerely yours,

Stephanie Marcantonio

Stephanie Marcantonio

SM/mls

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[redacted]