

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**

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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

A Florida physical therapy practice improperly claimed at least \$52,000 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 (CY) 2014. Previous Office of Inspector General (OIG) reviews have identified claims for outpatient physical therapy services that were unreasonable, medically unnecessary, improperly documented, and 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, they must be provided in accordance with a plan of care established by a physician or qualified therapist and periodically reviewed by a physician, and the need for such services must be 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 12,965 Medicare beneficiary claim days for outpatient physical therapy services totaling \$972,550, 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 some 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 86 beneficiary claim days. However, the Therapy Practice improperly claimed Medicare reimbursement on the remaining 14 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 \$52,515 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 \$52,515 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

In written comments on our draft report, the Therapy Practice disagreed with most of our findings and recommendations. Of the 14 beneficiary claim days that we identified as not meeting Medicare reimbursement requirements, the Therapy Practice disagreed with 3 beneficiary claim days and partially disagreed with 9. Further, it stated that it intended to contest our findings regarding two beneficiary claim days through the Medicare appeals process.

OUR RESPONSE

During our audit, we obtained an independent medical review of all sampled beneficiary claim days, and our report reflects the results of that review.

Therefore, we maintain that all of our findings and recommendations 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 (CY) 2014. Previous Office of Inspector General (OIG) reviews have identified claims for outpatient physical therapy services that were unreasonable, medically unnecessary, improperly documented, and 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

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, the services must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified therapist, and periodically reviewed by a physician; and the need for such services must be 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 Vero Beach, Florida. From January 2012 through December 2013, the Therapy Practice's professional staff consisted of one physical therapist and three 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 12,965 beneficiary claim days⁷ of outpatient physical therapy services, totaling \$972,550, 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 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

³ Sections 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) of the Act; 42 CFR §§ 410.60 and 410.61.

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.

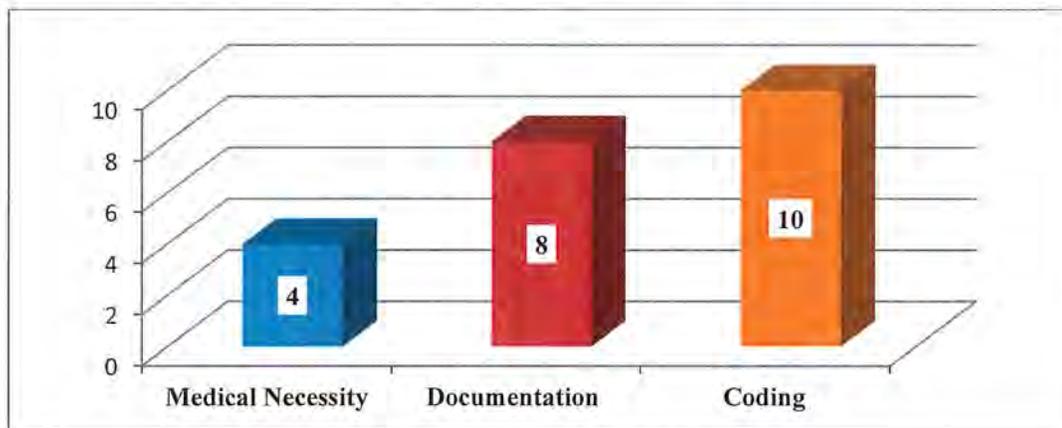
based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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 some 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 86 beneficiary claim days. However, the Therapy Practice improperly claimed Medicare reimbursement on the remaining 14⁸ beneficiary claim days as shown in the figure below.

Figure: Beneficiary Claim Days by Type of Error



As illustrated in the figure:

- 4 beneficiary claim days had therapy services that were not medically necessary,
- 8 beneficiary claim days did not meet Medicare documentation requirements, and
- 10 beneficiary claim days 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 improperly received at least \$52,515 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

⁸ The total errors exceed 14 because some beneficiary claim days contained more than one error.

SERVICES NOT MEDICALLY NECESSARY

For services to be payable, a beneficiary must have the need for physical therapy services (*Medicare Benefit Policy Manual*, chapter 15 § 220). 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).

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 four⁹ 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 indicated that these services did not meet Medicare requirements:

- Services were not specific or an effective treatment for the patient's condition (two beneficiary claim days).
- The amount, frequency, and duration of services were not reasonable (two beneficiary claim days).
- The care was not appropriate given the patients' diagnoses, complexities, severities, and interaction of current active conditions (four beneficiary claim days).

For example, the Therapy Practice received payment for physical therapy services provided to a 77-year-old Medicare beneficiary. The beneficiary sought physical therapy services for low back pain and a history of lumbar spondylosis and scoliosis. When evaluated, the beneficiary had decreased pain. The impairments that were identified would be expected to respond to therapy treatments within a reasonable and predictable period of time. However, according to the medical review contractor's determination, the description of the treatments was not specific or clear regarding the therapy performed aside from using heated packs on the patient. Therefore, the documented care was not appropriate, given the patient's diagnosis, impairments, and other conditions.

DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS

Medicare documentation requirements state that outpatient physical therapy services must be made in accordance with a written plan established before treatment begins (42 CFR § 410.60). The plan must contain the type, amount, frequency, and duration of the physical therapy services to be furnished and must indicate the diagnosis and anticipated goals (42 CFR § 410.61). Goals should be measurable and pertain to identified functional impairments. In addition, the signature

⁹ The total errors exceed 4 because some beneficiary claim days contained more than one error.

and professional identity of the person who established the plan and the date it was established must be recorded (*Medicare Benefit Policy Manual*, chapter 15 § 220.1.2).

Therapists must also maintain a treatment note for each treatment day and each therapy service (*Medicare Benefit Policy Manual*, chapter 15 § 220.3B). The treatment note must document the: (1) date of treatment, (2) identification of each specific service provided and billed, (3) total timed code treatment minutes and total treatment time in minutes, and (4) signature and professional identification of the therapist who furnished or supervised the service (*Medicare Benefit Policy Manual*, chapter 15 § 220.3E).

For eight beneficiary claim days, the Therapy Practice received Medicare reimbursement for which the treatment notes did not meet Medicare requirements.

For example, the Therapy Practice received payment for physical therapy services provided to a 69-year-old Medicare beneficiary. However, the medical review contractor found no documentation of therapeutic exercise or manual therapy time. Therefore, the use of therapeutic exercise and manual therapy were not substantiated in the medical record as billed.

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 Identifier¹⁰ (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 10 beneficiary claim days, the Therapy Practice received Medicare reimbursement that did not meet Medicare coding as follows:

- Nine beneficiary claim days contained timed units that did not match treatment notes.
- One beneficiary claim day was for services that the therapist on the claim had not rendered.

For example, the Therapy Practice received payment for physical therapy provided under HCPCS code 97140¹¹ to a 77-year-old Medicare beneficiary. The therapist provided treatment notes stating, "Refer to exercise flow sheet for details on today's therapy session. Today's total treatment time is 45 minutes." However, the flow sheet did not indicate that manual therapy techniques were performed to warrant the billing of two units of HCPCS code 97140.

¹⁰ An NPI is a unique identification number for health care providers.

¹¹ HCPCS code 97140 represents manual therapy techniques.

CONCLUSION

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least \$52,515 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

We recommend that the Therapy Practice:

- refund \$52,515 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 14 beneficiary claim days that we identified as not meeting Medicare reimbursement requirements, the Therapy Practice disagreed with 3 beneficiary claim days and partially disagreed with 9. Further, it stated that it intended to contest our findings regarding two beneficiary claim days through the Medicare appeals process.

The Therapy Practice's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

During our audit, we obtained an independent medical review of all sampled beneficiary claim days, and our report reflects the results of that review.

Therefore, we maintain that all of our findings and recommendations 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 12,965 beneficiary claim days of outpatient physical therapy services, totaling \$972,550, 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 Vero Beach, Florida, during the months of February 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 12,965 outpatient therapy service beneficiary claim days, totaling \$972,550, 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, who determined 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 12,965 outpatient therapy service beneficiary claim days, totaling \$972,550, 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 \$40.

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
12,965	\$972,550	100	\$7,451	14	\$757

ESTIMATES

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

Point Estimate	\$98,179
Lower Limit	52,515
Upper Limit	143,842

APPENDIX D: THE THERAPY PRACTICE COMMENTS

Lori S. Pilcher
Regional Inspector General for Audit Services
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61 Forsyth Street, SW, Suite 3T4I
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Subject: Office of Inspector General (OIG) Draft Report: "A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services." (A-04-15-07055)

Dear Ms. Pilcher,

Thank you for the opportunity to review and respond to the OIG draft report referenced above.

The OIG states that its analysis "indicated that this selected therapy practice was among the highest Medicare therapy billers in the state of Florida." We believe it is important to be clear as to why the data may have indicated such. Following Medicare policies, our three (3) licensed physical therapy assistants' (PTA) services were billed under the provider number of our licensed physical therapist (PT). Not only does our practice treat a high percentage of Medicare patients, but also the majority of those patients we treat are postoperative. Many have undergone total joint replacements, arthroscopies, tendon repairs or other major surgeries which require intensive physical therapy protocols to return to their prior active lifestyles.

While going through this process with your office, the volume and complexity of the Medicare rules, regulations and policies that must be adhered to for therapy services was overwhelming at times. Since we now have a better understanding of the complexity of these policies, the fact that the OIG's findings are that our documentation and coding met the Medicare program's requirements in 86% of the cases reviewed is a testament to the quality of care provided and the efforts expended on compliance.

Based on our review of the sample claims and Medicare requirements, we believe there are discrepancies in the OIG's findings and recommendations, some of which are discussed below.

FINDINGS

1. 4 beneficiary claims had therapy services that were not medically necessary. With all due respect, we disagree with this statement. Two patients with external fixators, for example, were each denied for therapy provided after the fixator was removed. These patients each had a broken wrist, one had the added complexity of being mentally challenged. The OIG auditors agreed with the passive therapy provided while the external fixator was in place; however, felt that continued therapy after fixator removal was not medically necessary. If either of these patients were to reach their full rehab potential for upper body functioning, active treatment after fixator removal is a critical component of the treatment plan. This is similar to the passive range of motion a patient may have after rotator cuff repair which is followed by a more active treatment regimen to restore function. Another claim stated that treatment administered was not appropriate for the condition. The treating therapist disagreed and felt that there was appropriate documentation. The auditor's report indicated that it was for treatment of the left hip however, the diagnosis and treatment was for the left knee. We believe that we only provide and bill Medicare for medically necessary treatment.

2. 8 beneficiary claim days did not meet Medicare documentation requirements. The OIG's findings in this category revolve around the documentation of treatment time. Our understanding today of the Medicare program's requirements is that there are two elements of time that should be documented: the number of minutes spent in each code that represents timed treatment (22 minutes of 97110 for example), and the total time the patient spent in treatment including non-timed codes. With very few exceptions, this documentation requirement was met; in the remaining few instances, a therapist reviewing our documentation quite easily determined treatment time due to the inherent detail of our documentation. While one could argue the semantics of how this was documented, we believe Medicare documentation requirements were met.
3. 10 beneficiary claim days did not meet Medicare coding requirements. The draft reports states "One beneficiary claim day was for services that the therapist on the claim had not rendered." We feel compelled to clarify that the service was provided by a PTA and inadvertently billed under the physician's name and NPI rather than the supervising physical therapist. The billing department mistakenly chose the wrong provider, however, the service was provided as billed, in accordance with Medicare policies. This was merely a billing error. This category goes on to state "Nine beneficiary claim days contained timed units that did not match treatment notes." As in #2 above, we disagree with the auditor's interpretation that the amount of treatment did not match the time and units billed and feel this is a semantical interpretation.

RECOMMENDATIONS

- 1) Based on the findings noted above, the report recommends refunding \$52,515 to the Federal Government. However, we have identified issues with some of the findings and intend to exercise our appeal rights appropriately.
- 2) In accordance with our compliance program, and especially because of the complexity of Medicare program requirements, we believe in continuous process improvement. We also maintain that many of the deficiencies noted in the coding and documentation are mostly due to a difference in interpretation of Medicare guidelines. Moving forward, we have reviewed and revised our documentation verbiage for clarity as appropriate in line with the OIG's auditor's interpretation of our documentation, and will continue to look for ways to improve our documentation and coding.

Of the 14 claims we disagree with 3 claims, partially disagree to 9 claims and agree to 2 claims. While we do not agree with all of your findings as noted above we only wish to appeal to 2 of the claims. We believe that there is overwhelming and unequivocal evidence in these two cases that the treatment was not only medically necessary but also appropriately documented and billed.

Overall we found this to be an educational experience and appreciate the opportunity to provide you with this response.

[REDACTED]

[REDACTED]

Office of Inspector General Note- The deleted text have been redacted because it is personally identifiable information.