

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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May 2017
A-07-14-01147

Office of Inspector General

<https://oig.hhs.gov/>

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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 Missouri Physical Therapy Practice improperly claimed at least \$151,000 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 reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, or properly documented, and that were vulnerable for fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including a Physical Therapy Practice (the Therapy Practice) located in the State of Missouri. Our analysis indicated that the Therapy Practice was among the highest Medicare therapy billers in the State of Missouri.

Our objective was to determine whether claims for outpatient physical therapy services provided by 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 they must have a physician's certification of the need for such services. Medicare Part B also covers outpatient physical therapy services performed by or under the direct 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 4,488 Medicare beneficiary days for outpatient physical therapy services totaling \$530,383, provided by the Therapy Practice during CYs 2012 and 2013. A beneficiary 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 days.

WHAT WE FOUND

The Therapy Practice claimed Medicare reimbursement for some outpatient physical therapy services that did not meet Medicare reimbursement requirements. Of the 100 beneficiary days in our random sample, the Therapy Practice properly claimed Medicare reimbursement on 65 beneficiary days. The Therapy Practice improperly claimed Medicare reimbursement on the remaining 35 beneficiary days, each of which had therapy services that were not medically necessary.

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 \$151,290 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements. As of the publication of this report, this unallowable amount may include claims outside of the 4-year claim-reopening period.

WHAT WE RECOMMEND

We recommend that the Therapy Practice:

- refund to the Federal Government the portion of the estimated \$151,290 for claims for outpatient physical therapy services that did not comply with Medicare requirements and are within the 4-year claim-reopening period;
- for the remaining portion of the estimated \$151,290, which is outside of the Medicare reopening and recovery periods, exercise reasonable diligence to investigate the potential overpayments and work with the Medicare administrative contractor to return any identified overpayments in accordance with the 60-day repayment rule; and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Therapy Practice disagreed with all 51 beneficiary days that our draft report identified as not meeting Medicare reimbursement requirements. The Therapy Practice's comments included attachments that detailed specific reasons for its disagreement with these findings. The Therapy Practice said that it believed that our medical reviewers' determinations were incorrect based on two principal assertions: (1) that determinations were inconsistent and (2) the determinations exhibited a lack of understanding of physical therapy treatments and outcomes. In addition, the Therapy Practice said that our sampling methodology and extrapolation process were incorrect.

Because the Therapy Practice included clinical information in its attachments, we conducted a second round of medical review to determine whether these claims complied with Medicare requirements. After reviewing the Therapy Practice's written comments and attachments, and after conducting a second round of medical review, we revised our findings to disallow 35 instead of 51 beneficiary days. In this regard, the results of our review, which identified 35 beneficiary days that did not meet Medicare reimbursement requirements, are the culmination of a thorough and objective process that included two complete medical reviews. Thus, we maintain that 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 not reasonable, medically necessary, or properly documented, and that were vulnerable for fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including a Physical Therapy Practice (the Therapy Practice) located in the State of Missouri. Our analysis indicated that the Therapy Practice was among the highest Medicare therapy billers in the State of Missouri. (Appendix A lists related OIG reports on outpatient physical therapy services.)

OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by 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 permanent kidney 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 physical 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.¹ 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. Modalities such as exercise, heat, cold, electricity, and massage are used. These services are provided in a number of different settings; however, the majority of Medicare payments for outpatient physical 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, be provided in accordance with a plan of care established by

¹ Section 1832(a)(2)(C) of the Act.

a physician or qualified therapist and periodically reviewed by a physician, and have a physician's certification of the need for such services.² Further, Medicare Part B pays for outpatient physical therapy services billed using standardized codes.³ Services furnished by physical therapists in private practice must be performed by or under the direct supervision of a qualified physical therapist.⁴ Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁵ These requirements are further described in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04).

Missouri Physical Therapy Practice

The Therapy Practice operates one physical therapy office located in Missouri. During CYs 2012 and 2013, the Therapy Practice employed six licensed physical therapists.

HOW WE CONDUCTED THIS REVIEW

Our review covered the Therapy Practice's claims for Medicare Part B outpatient physical therapy services provided during CYs 2012 and 2013. Our sampling frame consisted of 4,488 beneficiary days⁶ of outpatient physical therapy services, totaling \$530,383, of which we reviewed a random sample of 100 beneficiary days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary days were allowable 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 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 contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

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

³ Standardized codes used by providers are called Healthcare Common Procedure Coding System (HCPCS) codes to report units of service.

⁴ 42 CFR § 410.60(c).

⁵ Section 1833(e) of the Act.

⁶ A beneficiary 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.

FINDINGS

The Therapy Practice claimed Medicare reimbursement for some outpatient physical therapy services that did not meet Medicare reimbursement requirements. Of the 100 beneficiary days in our random sample, the Therapy Practice properly claimed Medicare reimbursement on 65 beneficiary days. The Therapy Practice improperly claimed Medicare reimbursement on the remaining 35 beneficiary days, each of which had therapy services that were not medically necessary.

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 \$151,290 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements. As of the publication of this report, this unallowable amount may include claims outside of the 4-year claim-reopening period.⁷

SERVICES NOT MEDICALLY NECESSARY

In order for services to be payable, a beneficiary must have the need for physical therapy services (*Medicare Benefit Policy Manual*, chapter 15, § 220). In order for a service to be covered, the service must be reasonable and necessary (§ 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 35 beneficiary days, the Therapy Practice received Medicare reimbursement for which the beneficiaries' medical records did not support the medical necessity of services. The results of the medical review indicated that these services did not meet one or more Medicare requirements:⁸

- Services did not require skills of a physical therapist (34 beneficiary days).
- Services were not specific and/or an effective treatment for the patient's condition (25 beneficiary days).
- There was no expectation of significant improvement within a reasonable and predictable period of time (31 beneficiary days).

⁷ 42 CFR 405.980(b).

⁸ The total errors listed in the bullets below exceed 35 because some of the beneficiary days contained more than one error.

- The amount, frequency, and duration of services were not reasonable (35 beneficiary days).
- Given the patient’s diagnoses, complexities, severities, and interaction of current active condition(s), the care was not appropriate (34 beneficiary days).
- Services were not provided under a physician’s signed plan of care (4 beneficiary days).

For example, the Therapy Practice received payment for physical therapy provided on January 7, 2013, to a 66-year-old Medicare beneficiary. The medical review contractor determined that the therapy service did not meet Medicare coverage requirements because the amount and frequency of the therapy was not reasonable and consistent with the standards of practice. Specifically, the contractor concluded that (1) the beneficiary was performing redundant repetitive exercises with no documentation of functional improvement and (2) the medical records did not indicate a reason why the beneficiary had not been able to learn an independent home exercise program. Thus, the treatment on January 7, 2013, was not medically reasonable or necessary.

CONCLUSION

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least \$151,290 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements. As of the publication of this report, this unallowable amount may include claims outside of the 4-year claim-reopening period.

RECOMMENDATIONS

We recommend that the Therapy Practice:

- refund to the Federal Government the portion of the estimated \$151,290 for claims for outpatient physical therapy services that did not comply with Medicare requirements and are within the 4-year claim-reopening period;
- for the remaining portion of the estimated \$151,290, which is outside of the Medicare reopening and recovery periods, exercise reasonable diligence to investigate the potential overpayments and work with the Medicare administrative contractor to return any identified overpayments in accordance with the 60-day repayment rule; and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

AUDITEE COMMENTS

In written comments on our draft report, the Therapy Practice disagreed with all 51 beneficiary days that our draft report identified as not meeting Medicare reimbursement requirements. The Therapy Practice's comments included attachments that detailed specific reasons for its disagreement with these findings.⁹ The Therapy Practice said that it believed that our medical reviewers' determinations were incorrect based on two principal assertions: (1) the determinations were inconsistent and (2) the determinations exhibited a lack of understanding of physical therapy treatments and outcomes. In addition, the Therapy Practice said that our sampling methodology and extrapolation process were incorrect.

At several points in its written comments, the Therapy Practice contended that the medical reviewers who contributed to the findings in our draft report had made incorrect, subjective determinations. For example, the Therapy Practice commented, "It is obvious this evaluator is not taking into account individual diagnoses, complexities and co-morbidities. It appears as [if] they are taking a textbook patient expectation and applying that to many of our patients." In addition, the Therapy Practice stated in several related contexts that it needed proof or evidence to support or explain the reasons why we recommend disallowances for the 51 beneficiary days.

Furthermore, the Therapy Practice's written comments suggested that it regarded the medical review determinations as the product of inconsistencies that exhibited a lack of understanding of the nature of physical therapy treatments and outcomes. For example, the Therapy Practice stated: "In several cases the reviewer is flip-flopping their statements within the same patient[']s case."

The Therapy Practice also commented on our sampling methodology and the extrapolation process by which we estimated the amount of overpayments conveyed in our first two recommendations: "You're saying one visit wasn't approved by Medicare and therefore extrapolating that to that entire case being disapproved, then extrapolating that for the percentage of cases over a two-year span.... Another problem with your extrapolation equation is that you are taking multiple dates of service from the same patient case that all share one mistake and extrapolating that as 4 mistakes across 2 years of visits."

The Therapy Practice's comments, excluding 203 pages of attachments that we have removed from this final report because of their volume and because they contain personally identifiable information, appear as Appendix E. We have also redacted personally identifiable information within Appendix E itself. We are separately providing the Therapy Practice's comments and attachments in their entirety to CMS.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Therapy Practice's written comments and attachments, and after conducting a second round of medical review, we revised our findings to disallow 35 instead of 51

⁹ The written comments themselves were not tied to particular findings or organized by specific beneficiary days.

beneficiary days. Based on the material that the Therapy Practice provided, we determined that 1 beneficiary day, which our draft report had accepted on the basis of medical necessity but had questioned for an incorrect number of units billed to Medicare, did in fact meet Medicare reimbursement requirements. Because the Therapy Practice's attachments included clinical information for the remaining 50 beneficiary days, we conducted a second round of medical review to determine whether these claims complied with Medicare requirements.

The second round of medical review determined that 15 of the 50 beneficiary days met Medicare reimbursement requirements, and accordingly we revised our findings and recommendations for this final report.

Nonetheless, we disagree with the principal assertions in the Therapy Practice's written comments. The medical reviewers' determinations as embodied in our findings were not inconsistent or subjective and did not exhibit a lack of understanding of the nature of physical therapy treatments and outcomes. Rather, these determinations were the product of a carefully structured process that included two separate medical reviews performed by qualified individuals:

- For the first round of medical review, we provided the medical record documentation associated with the 100 sampled beneficiary days to an independent medical review contractor. (See "How We Conducted This Review" and Appendix B.) For the second round of medical review, we principally used the same independent medical review contractor, though with different reviewers than those who had conducted the first medical review.¹⁰ Both rounds of the independent medical review contractor's medical review were performed by licensed physicians who were board-certified in Physical Medicine and Rehabilitation and who had no affiliation with us, the U.S. Department of Health and Human Services, the particular beneficiary, or the Therapy Practice.
- Second-round medical reviewers were provided with the same medical record documentation that the first-round reviewers had; the results of the determinations that the first-round reviewers had made; and the detailed attachments to the Therapy Practice's written comments. These detailed attachments provided specific information related to each of the 50 beneficiary days. Furthermore, the independent medical review contractor's instructions to its second-round medical reviewer stated: "It is important that you see the provider's comments as that is the basis for the request for re-review. With this said, the focus has to be on whether Medicare coverage criteria were met."
- Although the Therapy Practice's written comments (Appendix E) were not organized according to specific beneficiary days, the detailed attachments were organized in this manner. In almost every case, the information and assertions provided in the detailed attachments also appear, in different form, in the Therapy Practice's written comments.

¹⁰ Two of the 50 beneficiary days that underwent the second round of medical review (and that were subsequently determined to have met Medicare requirements) were evaluated by an analyst and a clinical manager of Wisconsin Physicians Service Insurance Corporation, a Medicare contractor.

We also disagree with the Therapy Practice’s comments about our sampling methodology and extrapolation process. The Therapy Practice asserted that—in its terms—when a beneficiary day “wasn’t approved by Medicare,” we then “disapproved” the “entire case” (that is, *all* services provided to that particular beneficiary within the scope of our audit). The Therapy Practice added that we used “mistakes” from that “same patient case” as the basis for estimating (extrapolating) the total amount of improper Medicare reimbursement. These assertions are incorrect. Our sample unit was one beneficiary day, which 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. Accordingly, we used the unallowable amount of Medicare reimbursement associated with each of the beneficiary days in question to estimate the total amount of improper Medicare reimbursement to our sampling frame. This approach does not require any assumptions about the relationship between the sampled beneficiary days and beneficiary days from the same or other cases (Appendix C).

Moreover, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology.¹¹ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. See Appendix C.

The 35 beneficiary days for which the Therapy Practice improperly claimed Medicare reimbursement are the culmination of a thorough and objective process that included two complete medical reviews. Thus, we maintain that our findings and recommendations are valid.

¹¹ See *John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff’d* 555 F. App’x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 2016 U.S. Dist. LEXIS 6816 at *31-33, 37-39 (W.D. Tex. 2016); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Southern California Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-09-15-02015</u>	12/27/2016
<i>A Northern California Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-09-14-02040</u>	11/01/2016
<i>A Kansas Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-07-14-01146</u>	8/22/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07054</u>	6/30/2016
<i>A South Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Physical Therapy Services</i>	<u>A-06-14-00064</u>	6/14/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07055</u>	4/22/2016
<i>A Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-06-14-00065</u>	3/17/2016
<i>Boulevard Health Care Program, Inc., Improperly Claimed Medicare Reimbursement for Outpatient Physical Therapy Services</i>	<u>A-02-14-01004</u>	10/29/2015
<i>AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-02-13-01031</u>	6/15/2015
<i>An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-05-13-00010</u>	8/20/2014
<i>Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-02-11-01044</u>	6/10/2013
<i>Questionable Billing for Medicare Outpatient Therapy Services</i>	<u>OEI-04-09-00540</u>	12/21/2010

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the Therapy Practice's claims for Medicare outpatient physical therapy services provided during CYs 2012 and 2013. Our sampling frame consisted of 4,488 beneficiary days¹² of outpatient physical therapy services, totaling \$530,383, of which we reviewed a sample of 100 beneficiary days. 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 physical therapy services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data from the NCH file, but we did not assess the completeness of the file.

We performed our audit, which included on-site fieldwork at the Therapy Practice's Missouri office, from July 2014 through November 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- interviewed Medicare officials to obtain an understanding of the Medicare requirements related to outpatient physical therapy services;
- extracted from CMS's NCH file a sampling frame of 4,488 outpatient physical therapy service beneficiary days, totaling \$530,383, during CYs 2012 and 2013;
- selected a random sample of 100 outpatient physical therapy service beneficiary days from the sampling frame (Appendixes C and D);
- obtained medical record documentation from the Therapy Practice for the 100 sampled beneficiary days and provided them to an independent medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- provided the results of our first round of medical review to the Therapy Practice on November 19, 2015, and discussed those results with Therapy Practice officials on December 8, 2015;

¹² A beneficiary 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.

- provided second-round medical reviewers with the same medical record documentation that the first-round reviewers had; the results of the determinations that the first-round reviewers had made; and the detailed attachments to the Therapy Practice’s written comments on our draft report;
- used the results of the sample review, as revised after we received the second-round medical review determinations, to calculate the estimated unallowable Medicare reimbursement paid to the Therapy Practice (Appendix D); and
- discussed the revised results of our second round of medical review with Therapy Practice officials on March 9, 2017.

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 C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part B outpatient physical therapy service claims paid to the Therapy Practice during CYs 2012 and 2013.

SAMPLING FRAME

The sampling frame was an Access database containing 4,488 outpatient physical therapy service beneficiary days, totaling \$530,383, provided by the Therapy Practice during CYs 2012 and 2013. The claims data were extracted from CMS's NCH file. A beneficiary day consisted of all outpatient physical therapy services provided on a specific date of service for a specific beneficiary, for which the Therapy Practice received a payment from Medicare. The beneficiary days were limited to payment amounts that were at least \$75 and excluded all claims under review by a Recovery Audit Contractor.¹³

SAMPLE UNIT

The sample unit was an outpatient physical therapy service beneficiary day.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 outpatient physical therapy service beneficiary 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 physical therapy services made to the Therapy Practice at the lower limit of the 90-percent confidence interval (Appendix D).

¹³ CMS contracts with Recovery Audit Contractors to identify and correct Medicare improper payments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Beneficiary Days in Frame	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Beneficiary Days	Value of Unallowable Beneficiary Days
4,488	\$530,383	100	\$11,725	35	\$4,372

ESTIMATES

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

Point Estimate	\$196,204
Lower Limit	151,290
Upper Limit	241,118

APPENDIX E: AUDITEE COMMENTS

3/2/16

Statement of nonconcurrency

Response to OIG audit A-07-14-01147¹³

This rebuttal to the review was performed by 3 licensed physical therapists. All of which have either a Masters Degree in Physical Therapy, or a Doctorate Degree in Physical Therapy. All three have between 9 and 15 years of treating experience. All three are extremely knowledgeable in the protocols and treatment guidelines of all of these patients. All three have no disciplinary action or sanctions against their licenses.

The following is our rebuttal to the denial for medical necessity for 51 of 100 cases. We have provided significant amount of information proving the medical necessity for these 51 cases. We have provided **factual** data proving our stance. We have provided rebuttals to each statement made by the Medicare reviewer. Every statement made that was denying medical necessity has support on our side including research and documentation from the patient chart. We have research based documentation proving medical necessity.

This medical review has very little support for the statements made. Most of the statements were only based on the feelings and/or opinions of the Medicare reviewer. Oftentimes, it is obvious the Medicare reviewer doesn't understand the physical therapy treatment approaches so examples are provided below. This Medicare review has numerous inconsistencies between approved and not approved patients. Conflicting recommendations are made within the same patient review.

First, this summary below summarizes our stance. Following this summary, each patient of the 51 cases has an individual summary proving that every single patient had followed the guidelines of medical necessity set by Medicare.

We understand there are limitations to interpretation of a medical record when a medical reviewer is not able to deduct all the relevant information from a note. When a physical therapist states certain things, they are expecting a certain amount of information to be deducted from those statements. A distant medical examiner isn't always privy to understanding what those statements mean. A lot of our objective data is written in the assessment of the soap note. The physical therapist interpretation of the treatment prognosis, rehab potential, progression, whether to continue therapy and why this patient requires skilled one on one physical therapy is all included. Please accept the summary to help clarify the areas where misinterpretation could have happened when someone that never met these patients is asked to interpret medical necessity.

We have gone through each and every statement made by the Medicare evaluator on every single patient. This took an excessive amount of time over 350+ hours of our time,

¹³ **Office of Inspector General Note**—The Therapy Practice specifically requested that its written comments have neither a letterhead nor a signature block. We are redacting specific proprietary information, as well as personally identifiable information, near the end of this appendix.

over and above our full-time jobs. I hope you give us the respect that we deserve as medical professionals and read and understand our summaries of these patients. We only used factual data from these treatments. As you will see it is hard not to take these accusations personally. These accusations of saying these patient visits were not medically necessary is hard to comprehend when we know that the person making this distinction does not have the full story or the full understanding of these patients' conditions. Without the full and complete understanding of these patients sometimes it could be easy to just state that these visits were not medically necessary and that is why we analyzed and explained each and every statement made for each patient.

Part A

In the following section you will see some of the many examples that the Medicare reviewer has prejudice biases:

1.

It seems like a certain evaluator within this review seems to grade them with a pattern. The person would always say no to the first five boxes of seven saying "excessive treatment" and should've gone to a home exercise program. This evaluator always wanted to discharge to a home exercise program instead of performing physical therapy in the clinic. No matter if the patient was seen 3 times or 16 times it was always wanted by the examiner to be discharged to home exercise program. It gives no reasoning why they should've been discharged to home exercise program it was just their opinion. I question if this Doctor would think that any of these patients should've had physical therapy and not just a set of home exercises?

It is obvious that this Medicare reviewer does not understand what a home exercise program is designed to do and how it works. We give patients home exercises on day one. Those exercises are to be done on a daily basis if they are able to. Exercises that they cannot be done on their own, they will do in the clinic. Those treatments in the clinic, involve hands on treatment, modalities, along with exercise machines or exercises with equipment that the patient does not have. We provide recommendations on progressing, when to change exercises, mechanics on how to perform them, proper techniques, but most importantly, we prescribe exercises daily dependent on how the patients respond to those exercises and treatments. In every treatment program, the patient has to be progressed step-by-step-by-step. You can't progress to the next step until the previous step is accomplished. Some patients need to go through 10 steps of progressions to get to complete recovery. This reviewer feels that this patient should have been discharged to his/her home exercise program much sooner than what the plan of care calls for. Therefore, this reviewer thinks that we can educate this patient on futuristic steps when we don't know the progress or the response the patient had to the previous steps. You can't give them exercises for steps 3,4 and 5 when you don't know how they responded to step 2. You can't give them step 5 instructions until you know

how they responded to steps 3 and 4. We don't know what step 5 is until we complete step 4. Step 5 exercises will be dependent on how they responded to the steps 3 and 4. For them to think that they can be discharged to home exercise program this early on in the recovery process is extremely unrealistic. **It just shows that they don't understand how we, as physical therapists, treat in the clinic and how we use the home exercise program as part of the treatment.**

Several of these evaluations the Medicare evaluator stated that this patient should have been discharged previously to a home program. In these cases it was documented that the patient tried a home exercise program on their own for periods of time, but in those cases, it failed. That is why the patient wasn't discharged. It is shown in the summary of these patient cases where we tried discharging them, but it was then found to be inappropriate so therefore therapy continued. **It is unethical and unrealistic to just discharge the patient to home exercise program when we know that they will regress without our treatment and we know that the home exercise program is not enough to continue to improve their status.** It is not logical for a medical examiner to state that these discharges should've occurred when really that would be unrealistic for any future progress of these patients.

2.

They are denying medical necessity due to a plan of care initially stating 2 to 3 months could be necessary. They are not taking into account that re-evaluations are completed on a visit basis and when the patient prognosis isn't good, or when patients attitude to therapy changes, or when they plateau then the discharge will occur. The discharge often occurs prior to completing the full plan of care. It is obvious that this Medicare reviewer doesn't understand that treatment plans don't often continue through the entire timeframe. Oftentimes, the timeframes are cut short because the patient's status changes for multiple reasons. On the initial expectation of the duration, it's not correct to deny a visit just because the initial plan of care said it could last two months. You have to look at each case and determine how the patient is responding through those treatments to determine if therapy was appropriate and effective. In these treatments, the therapy was effective and appropriate, but they are being denied due to the plan of care timeline being supposedly longer than what the evaluator wanted to see. In fact, we didn't see the patient that long in most of these cases. In several cases, medical necessity was denied because the evaluator "thought" the plan was initially set for too long of a timeframe, however, the evaluator is not taking into account any individual responses to treatment that these patients have had. It is impossible for a therapist to always know exactly how many visits it will take to get a patient recovered or to discharge.

Patients' situations, diagnoses, complexities and other issues change day by day. The patient is always an evolving situation. Our re-evaluation done daily is what determines how long the patient will be seen. That is a fluid situation. Again, it's impossible to know exactly what date every Medicare patient will be discharged when you are making and educated prediction on day one. That is always a decision the changes regularly.

These denials by the evaluators are not based on facts or research data. They are based on opinions. The opinion to deny therapy due to the initial plan of care stating a longer timeframe than what the evaluator wanted to see is not an objective way to perform an audit, especially when the patient most likely didn't come to therapy for as long as the initial plan of care suggested. **These reasons defend against the notion or suggestion that the plan of care was deemed too long for medical necessity. This proves that reasoning for denial isn't based on the factual data of the individual patient and the actual visits seen.**

In an initial evaluation it is impossible to always know exactly how the patient will respond or how long therapy will continue to be appropriate for them. To deny physical therapy medical necessity because of what the initial evaluation thought it could entail is not truly examining what actually happened throughout the course of treatment. This occurred in multiple instances in this evaluation and is obviously incorrect in the assumption that the plan of care, frequency, and duration was exactly what happened.

Medicare reviewers often denied treatment because the plan of care will say 12 weeks. But in fact, we saw the patient sometimes for only 3 visits, other times for 12 visits, and other times for 8 visits. Just because a plan of care states that it looks like this patient might need longer physical therapy, it's not a guarantee. When we do our plan of care we do our best at predicting how much therapy outpatient will need. That is based on the patient's condition, severity, co-morbidities and how we think the patient will respond to treatment. As we go through therapy, all patients respond differently. It is impossible to predict how a person will respond to treatment. Therefore, sometimes, patients are discharged sooner than the original expectation due to noncompliance, poor response to therapy, or their prognosis decreasing. This evaluator is denying treatment because the plan of care was thought to be excessive in asking for 12 weeks of physical therapy when, in fact, we only saw the patient for 3 or 8 visits. That is not a reason to deny medical necessity. There is no support for that. It is not ethical or realistic to deny medical necessity because it looked originally that the patient might need 3 months of therapy, but afterwards they only needed a couple weeks of therapy.

3.

Several times in the evaluator denials, the evaluator states that the patients would "normally be fixed in 10 treatment sessions over 8 weeks". There is **no clinical research or objective proof** that proves that 10 visits should always be the number of visits seen for that diagnosis. The evaluator used this statement several times with several different diagnoses. They are taking this general statement and incorrectly applying it to a multitude of patients. They provide no research or data to prove this general statement. For them to make the statement, they need to provide research that proves it for all of these diagnoses that they said it for. It is obvious this evaluator is not taking into account individual diagnoses, complexities and co-morbidities. It appears as they are taking a textbook patient expectation and applying that to many of our patients. That is not logical either. **Therapy is not finite, it is often a combination of science and variable factors.**

After several patients being denied for visits over a total of 10, they then denied patients with only 3 visits, one of which was a total knee replacement. These Medicare reviewers are very contradictory to themselves and within the same patients.

In a high number of these cases, the Medicare reviewer stated that these people should have been discharged sooner than what they were. They're all stating that they should have been discharged between 8 to 10 visits based on the diagnosis. We needed to progress these patients through more complete exercise programs adding to their home exercise program, changing what is appropriate for their home program and add new exercises as they get stronger and more flexible. These reviewers contradict themselves often. They are stating that they should've been discharged sooner, but then also complained that the home exercises are redundant and repetitive. How can we discharge people sooner, therefore not having as many visits to change the home exercise program (HEP), but then the evaluator will protest that the patient had repetitive exercises at home? We need to continue treatment to give them progressions and new exercise programs. We can't progress them and keep adding new exercises if we are discharging them as fast as the reviewer says we should. They are stating we should've discharged them soon, but not have done a simple or redundant exercise program at home. This is not reasonable thinking and is proof that the reviewer(s) lack strong, supportive evidence for their reasons stating that this is not medically necessary.

4.

This reviewer also denied physical therapy for a patient on the third visit stating that this patient had previous physical therapy and, therefore, should not have been treated a second time. They must have assumed the condition was the same but, in fact, the previous therapy was for a lumbar spine and the second condition was for a knee. **They are denying this case due to careless auditing, lack of attention to detail, and not basing it on the facts.** We expect this denial to be repealed.

Is it appropriate to state that just because you had physical therapy for your spine in the past that you will not need physical therapy for your knee in the future? Well this is what this Medicare evaluator is stating.

5.

These reviewers often stated that these patients could be performing exercises at home on their own and do not need skilled physical therapy. Several of these patients had high fall risks and were in therapy from a history of a fall and injury. These reviewers cannot be taking the patient's history and fall risk into account when stating these patients could be performing home exercise programs only, and not receiving handhold assistance with treatment in the clinic. They are not taking into account the safety factors. They are just assuming all patients can just do home exercise programs on their own. This is not an appropriate way to make a decision on these patients if all of these patients with a high fall risk were discharged to a home exercise program, it would have been a disservice and a potential dangerous situation. **If patients have a high fall**

risk and they lose their balance while performing exercises on their own, why would that be appropriate to discharge them to only a home exercise program? High fall risk patients require hand hold assistance from a skilled physical therapist for safety. Discharging them would increase their risk of falling further. These discharge recommendations by the reviewers are putting these patients in harmful situations.

Also with a high risk of fall, a future fall could have caused worsening of their injury or a new injury. There is no way any physical therapist thinking logically, realistically, or ethically could discharge these patients. Medicare tracks fall risks and strives to minimize re-admissions or secondary admissions with the same diagnosis especially from falls. These patients wouldn't pass under these guidelines of safe discharge if they would've been discharged with a high fall risk. **This Medicare reviewer is going against Medicare plan of actions to decrease fall risks and decrease re-admissions for recurrent injuries.**

In one of these patients, there was a fall documented a week before the date of evaluation by the evaluator, and that evaluator still thought the discharge should have occurred prior to that date being evaluated. That means the fall would have happened at the same time or after the discharge that the evaluator wanted. I don't understand how that could be a reasonable recommendation. Discharging people to unsafe environments or unsafe situations is a grave risk we are not willing to take.

It is not ethical or responsible to discharge a patient that is unsafe or could do further damage to themselves. A lot of these home exercise programs include balance exercises that could include their eyes closed or putting them on difficult surfaces to challenge their balance. To ask them to try and perform balance exercises at home without someone to hold onto them or to catch them if they fall is irresponsible. We would never ask someone to put themselves in a dangerous position at home performing a home exercise program that would most likely injure them. **No realistic physical therapist would discharge a patient to perform home exercises on their own without someone there to hold onto them or that is confident enough to catch them if they would lose their balance.** That is why they come to physical therapy. We are trained in how to protect a patient in these difficult exercises. That is what are trained to do. In all of these cases, the reviewer never talked about safety issues or the fall risk potential. So it is obvious that these reviewers are not taking that into consideration. That is a critical mistake.

6.

In many cases, these evaluators have reasoning for denial stating that we are using "redundant exercises" for treatments. Again, they don't take into account previous physical therapy plan of actions that failed. In one case, a patient left a previous physical therapist at a different location due to a constantly changing exercise routine; they got too confused and worsened. This evaluator can't state that in all cases a redundant exercise program is always a poor choice. We, as physical therapists, always adjust our treatments to the individual needs. It is obvious that the evaluator was

making a general statement used for multiple patients in this review and it is easily seen that in those cases the redundancy of the exercises was done for a specific reason, and was appropriate for that patient. If we would have continued with constantly changing exercise routines for this patient, the patient would have left and, again, failed another physical therapist treatment plan. Again, the reviewer is recommending another failing situation.

7.

In several cases the reviewer is flip-flopping their statements within the same patients case. In the same review, they have stated that the treatment is too slow and is "dragging on too long" but then a few sentences later will state that the "treatment was too aggressive for the patients needs". How can you complain about not progressing them fast enough but then say that you were too aggressive in nature. The evaluator is stating that these "aggressive exercises" included quad sets, seated knee extension, heel slides, short arc quad, straight leg raises, bridging, Aerodyne bike, ultrasound, and calf stretching with a towel. **Every physical therapist and sports associated physician will know those nine treatments are very conservative in nature. They are used early on in treatment and are known as very low level exercises.** There is no reason to believe that these exercises could be assumed aggressive in anyone's condition. This proves that this reviewer is not well-versed in the treatment approach of these conditions. If these exercises are known to be too aggressive then activities like the patient walking into the clinic would be considered too aggressive also. You can look in therapeutic exercise textbooks and it will confirmed that these exercises are not aggressive in nature whatsoever.

How can heel slides, calf stretching, ultrasound which are all passive exercises for the patient how could they be considered too aggressive when there's no muscle activation being performed? If those are too aggressive, what exercises could be less aggressive? **It doesn't get any less aggressive than that.** Again, it shows that we don't feel this Medicare examiner accurately conveys knowledge of physical therapy exercises well.

8.

Another reason they gave for denial was that the documentation did not have a pain scale, but, in fact, there was a pain scale documented in the initial evaluation. However, that was the reason why the patient was denied medical necessity. First off the denial for not having a pain scale isn't accurate, so that can't be a accurate reason for the denial. This denial should be easily reversed. Secondly, the reviewer talks about pain and symptoms rather than functional improvement or functional limitation. We treat function, not just pain. This shows their lack of understanding of physical therapy goals. There is no logical reasoning behind denying medical necessity because of lack of pain scale documentation. How can this be allowed in such an important review?

9.

Protocols are written to achieve a specific end point. Protocols have guidelines for stretching, strengthening, and specific treatments to occur at certain time frames for these post-surgical patients. Protocols are meant to be followed, specifically when written as a prescription for physical therapy from a referring physician. In certain patient cases, we were treating under the protocol of the physician holding back certain exercises, like strengthening, due to recovery from surgery that involved precautions are restrictions. Several times, the evaluator stated that we should've discharged this patient sooner than we did. Why would a reviewer expect a therapist to break protocol specified by a referring provider? The evaluator(s) recommended discharge prior to even getting through the full protocol. They recommended discharge prior to when we we're allowed to start to perform any strengthening exercises. **How are we supposed to discharge a patient to a home exercise program that needs to include strengthening, but we aren't far enough into the rehab program that will even allow us to start strengthening exercises?** When we are following the physician protocol after surgery and strengthening needs start at week eight, but the Medicare reviewer says we should've discharge this patient prior to week 8, how can anyone expect this patient to recover from the surgery? **This timeframe would keep them from ever being shown home exercise programs or treatments in the clinic that had anything to do with strengthening.** We can't have them practice strengthening in the clinic to teach them for a home exercise program if they aren't allow to do that action yet due to surgical protocols.

In the biography section of every individual review, the medical examiner states that he/she "is familiar with guidelines and protocols in the area of treatment under review". This obviously is not correct! This proves that this reviewer does not understand post surgical protocols. We as physical therapists are required to follow the physicians protocols. We can't discharge a patient in the middle of a protocol. If we don't follow the protocol, we risk undoing the surgical repair or allowing for a very poor recovery. We have to follow the surgeons protocol! Denying those treatment from happening on a patient that requires them, is absolutely ridiculous. This reviewer needs to understand this! Does this reviewer not want these patients to have good outcomes?

How can this Medicare evaluator recommend a discharge earlier if the patient didn't progress through at least the majority of the physician protocol? **If a patient having surgery requires 12 weeks of physical therapy but this Medicare reviewer recommends discharge between 8 and 10 visits over eight weeks how can anyone expect this patient to have an excellent outcome?** These patients have excellent prognosis, but this medical reviewer is recommending discharge well before a good outcome could be achieved. This will only lead to further exacerbations or poor recoveries from these current conditions. These are abhorrent recommendations by the reviewer. Another review in this case recommended a discharge prior to the 3rd treatment visit for a total knee replacement. It seems hard to believe that this reviewer understands post-surgical rehabilitation. This would be highly frowned upon by orthopedic surgeons.

There are several instances when the Medicare reviewer is recommending discharge sooner than performed in several post-surgical cases. It is blatantly obvious that these Medicare reviewers are not well versed on these post-surgical protocols. These post-surgical protocols are well documented in literature and used by all orthopedic surgeons in how to progress range of motion and strength to recover after surgery. If these patients were truly discharged sooner, then they would have not followed these normal procedures following surgery. We do not understand why anyone that is well-versed in these protocols would suggest that a discharge should have occurred prior to completing those protocols. Again these protocols are routine and used after every single surgery. **Following these protocols is a rule, not a suggestion.**

Being a responsible physical therapist includes respecting and following physician protocols. We follow the protocols from the physician. I don't understand why the Medicare reviewers feel it is in their power to overstep the medical recommendations of the treating surgeon for these patients.

If research shows that 3 to 4 months of strengthening needs to occur after a rotator cuff repair, and that is consistently seen in the published literature, then why can this Medicare reviewer state that this patient should have been discharged in less than 10 visits within 8 weeks? It is impossible to get to the strengthening portion of the rehab program in this timeframe. Most rotator cuff protocols delay strengthening for 6 to 12 weeks. This is commonplace in the medical community.

10.

On several cases, statements were made against our notes stating that symptoms increased temporarily and, therefore, should have triggered a discharge from treatment. Or they had stated that the symptoms were not decreasing fast enough and the patient should have been discharged sooner. But in multiple cases, it was not taken into consideration that the patient's function was significantly improving even though pain wasn't necessarily decreasing. That makes us question if the Medicare reviewer understands the true goals and treatment approaches of a physical therapist. Yes, we work to decrease pain, but more importantly, we work to increase function and activity tolerance. If a patient can't walk or lift anything, and has pain, it is more important to regain the ability to walk or regain the ability to lift, even if they had pain. It is better to be able to function with pain than not function at all. We are in question why this Medicare reviewer states that these patients should've been discharged because they had continued pain when, in fact, that isn't their main goal for physical therapy. Pain is never the main goal for physical therapy. Function always is the main goal. Our job as physical therapist is to regain function so that they can live safely and independently. Pain or symptoms should never overshadow function, but this is what the Medicare reviewer has done in several cases. This should be deemed an incorrect determination of ranking pain over function.

11.

In several circumstances here the Medicare reviewer denied the medical necessity because it is claimed that the physical therapist supposedly chose a wrong ICD-9 diagnosis code. In one case, the ICD-9 diagnosis code of a knee strain on the plan of care compared to the initial script for physical therapy stated knee pain. They denied physical therapy because those two diagnoses didn't match. This is inaccurate. They do not have to match! There is nothing inaccurate here. When the physical therapist diagnoses a patient, it is legal for a physical therapist to create a diagnosis and put it on a plan of care for a physician signature. If the physician agrees with the diagnosis, they will sign the plan of care. It isn't acceptable for a Medicare reviewer to deny medical necessity due to the difference between knee pain and knee strain. There is no difference in therapy between those 2 diagnoses nor any restrictions in therapy between the two diagnoses. The knee strain diagnosis was placed on the plan of care and was signed by the physician. There is no support to deny medical necessity. The Medicare reviewer seems to be trying hard to find reasons to deny these claims. This is not a mistake by the physical therapist. Please look at the rules of diagnosis coding for physical therapy.

12.

In many cases, the medical reviewer avoided talking about any severities or co-morbidities that were involved in making these patients significantly more involved than a normal textbook case. But in one case, the Medicare reviewer honed in on one co-morbidity that was fibromyalgia. The only reason this reviewer talked about a co-morbidity was that they were going to use it to try and deny medical necessity. The issue was that fibromyalgia was never even addressed as the diagnosis that we were treating. We were treating a totally separate diagnosis involving the hip. The Medicare reviewer told us this patient needed to be discharged after only a couple of visits because of this co-morbidity. The reviewer was jumping to conclusions and making assumptions that this patient was **not** here for hip dysfunction. It is documented in the evaluation that the hip was the main issue being treated. This Medicare reviewer is only talking about one co-morbidity and doesn't even address the hip diagnosis, which was the reason for treatment. There is an obvious discrepancy in how these patients were being assessed by the Medicare reviewer(s). They only take into account the co-morbidities when they serve to suggest a reason for denial of medical necessity. How can they say that fibromyalgia was the treatment diagnosis when every treatment and exercise was aimed at treating the hip? Fibromyalgia is a diffuse body pain diagnosis. Treatment for that does not only involve one joint. There is absolutely no support in the documentation that we were treating the patient for fibromyalgia, but the evaluator somehow feels they can make the determination that the patient was being seen for that diagnosis. There is no documented proof that the evaluator is correct with this determination. Again, I question the intent of this reviewer's decision to deny medical necessity on this patient.

13.

Other cases were denied medical necessity because they had physical therapy prior to this case. In every single case, the physical therapy that was done prior was not for the same condition. The reviewer did not take the necessary steps to delve into the facts further, rather, they suggested this patient had physical therapy previously and then went straight to denial of medical necessity because of that. This is stretching their authority as a Medicare reviewer. In one case, they denied medical necessity because they had physical therapy previously and that patient was being seen for a total knee replacement. The date of service reviewed was the second treatment visit. This is a gross mistake. How can anyone deny physical therapy for the second treatment visit of physical therapy for a total knee replacement? They stated the reason was that this patient had been seen for physical therapy in the past. That is grossly wrong. The therapy was for their spine, not for anything that has anything to do with their knee.

How could it be expected for this patient to have been educated on a home exercise program for a new diagnosis when the plan of care was a separate diagnosis? In some instances the reviewer chastised us for treating different areas of the body when the plan of care was not written for those areas of the body. So why in this case is the Medical Examiner expecting us to have treated the low back in the first case when it was only written for treatment for the knee? Again this Medicare examiner flip flops on reasons for denials.

Additionally, this patient should be allowed physical therapy for this diagnosis. **They state that this patient should've been discharged to a home exercise program after one visit of an initial evaluation for a total knee replacement. How can this Medicare evaluator assume that this patient is going to have an excellent outcome after being denied three months of physical therapy for such an extensive surgery?** This again is a significant abuse of their reviewing power. Every orthopedic surgeon I know understands that therapy after a total knee replacement is required and necessary.

14.

In several patients, medical necessity was denied for not having any objective measurements. In that same patient that was denied medical necessity on the 2nd visit after a total knee replacement, the Medicare examiner states there is no evidence of objective measurements. While the treatment visit immediately preceding that visit was the initial evaluation, there is an entire objective section with several objective charts showing active range of motion, passive range of motion, girth, and muscle strength testing. All of those are easily seen in the initial evaluation. The charts are in the notes! A reviewer cannot say there is not objective information. It is very frustrating to read that someone made the statement when it is grossly false. This is another entirely false accusation and is seen easily in the notes.

15.

Many times the evaluator states that 90 minutes (or more) of treatment is too much for the patient, and that is a reason for denying medical necessity. There is no support to believe why a patient should not have 90+ minutes of physical therapy if they can tolerate it and they are showing great improvement with it. As physical therapists, we strive to push the patient as aggressively as they can tolerate. The longer the patient participates in therapy, the faster they will often recover as they will gain more flexibility and more strength in a quicker time frame. **I don't understand why it can be stated that these patients were doing too many exercises when in fact there was no adverse reaction to the treatment? When a patient is progressing well and improving in function, how can it be stated that a patient was performing too many exercises?** Again it is a stretch for a reviewer to make and trying to deny medical necessity. In all of these cases, there were no signs of adverse reactions to treatment. In all of these cases the patients were progressing well and improving. To discharge sooner means less dedicated time with a licensed physical therapist, less time to respond to therapy treatment, and less time to learn exercises they will be encouraged to do outside the clinic. This denial of care isn't allowing for adequate treatment. They can't make both statements. Either they want the patient to be treated and be fixed or they are just trying to find excuses on why patients should not have physical therapy. We cannot logically discharge a patient when they are progressing well and still need to progress through more exercises.

Is there any clinical research at all that proves that 90 minutes of exercise is detrimental to these patients? What reasoning do they have for these specific patients that this amount of exercise was detrimental? Realistically, they do not have any documented support for the statements?

Why would we not want to advance these patients to their potential? Why would we not want them to get better faster with a better outcome? Recommending a patient not perform exercises, for no substantial reason, when in fact they are progressing well with a more encompassing treatment approach goes against all medical belief about exercise and the benefits of exercise.

16.

This Medicare reviewer is stating that a "typical course of treatment for a post-surgical rotator cuff complete tear and repair along with biceps tenodesis surgery would include up to 12 treatment sessions over 6 weeks" It is obvious that this Medicare examiner is not well versed what is involved with this condition. It is widely accepted across the medical community that this type of surgery routinely will require no less than 12 weeks of physical therapy. At 6 weeks time, they are still only allowed to do passive range of motion. That is all! Often, these surgeries require a patient to be passive range of motion only for the first 4 to 8 weeks depending on the severity of the shoulder repair. So how can anyone recommend a discharge completing physical therapy after 6 weeks

when the therapist would not be able to progress them through active-assisted range of motion, then to active range of motion, and then to resisted range of motion with strengthening? **Discharging physical therapy after six weeks when the therapist would not be able to progress them to active-assisted range of motion and then to active range of motion and then to resisted range of motion with strengthening would be devastating to the patient! That statement that this Medicare examiner stated proves that they have no idea how to treat a rotator cuff repair patients after surgery.** I do not know any orthopedic surgeon that would recommend discharge after six weeks of therapy following this surgery. All of the referring orthopedic surgeons I have asked would recommend no less than 12 weeks. I challenge you to ask some orthopedic surgeons if they always discharge a patient after six weeks following a rotator cuff repair with a biceps tenodesis. This Medicare reviewer is stating that a **typical course of treatment** for this condition would only include six weeks of therapy. I know that is incorrect. That is not typical; **6 weeks is not the typical course of treatment.** This statement is not an accurate objective statement and is difficult to read without getting extremely upset. The Medicare examiner making this denial obviously lacks the knowledge in this specific situation. The problem is that everyone reading this isn't a medical professional and are obviously unaware of the standard protocols, but this is severely wrong.

17.

In one case the Medicare reviewer stated that this was the 36th treatment session when actually it was only the 11th treatment of a total of 14. In that same case the medical reviewer stated that this patient should've been healed within 8 weeks; our total treatment time was only 6 weeks. They still denied this case for medical necessity which we know has to be a mistake. How can such an important review have such drastic mistakes done on them? This review could close our business and these mistakes are being extrapolated to our entire caseload of Medicare patients over 2 years. These mistakes are drastic and could have a grave impact on successful, well respected clinicians! These reviewers should be held highly accountable and blatant mistakes such as this should never happen..Please respect that.

18

There are several cases that it was recommended by the Medicare reviewer that patients should have been discharged from therapy prematurely. To protest, it was documented multiple times that these specific patients required continued queuing, verbal assistance, and reminders from the skilled physical therapist on how to perform those exercises. Even with pictures and directions on how to perform the exercises,

some patients still require queuing and corrections from the therapist. The medical reviewer still did not acknowledge that and still continued to recommend discharge should have occurred sooner, thus, the reviewer thought the visits were not medically necessary. **My question is if a patient still required assistance to perform those exercises correctly, then how could a patient be discharged to home exercise program knowing that they were going to do those exercises wrong most likely?** Why would a Medicare reviewer deny the fact that these specific patients needed constant queuing and still they thought they should be discharged. The reviewer is not acknowledging that sometimes a therapist is making subjective and objective decisions for the benefit of the patient. Denying the fact that this patient required cueing and still recommending discharge at this time, one would be avoiding the possibility to get the patient to a successful outcome. **How is that recommendation a good recommendation?**

19.

In some of these cases, we were working to change the assistive devices throughout the course of treatment; that is changing from a walker to a cane or something similar. Using a different assistive device requires consistent education on how to use it correctly. Some of these patients do not have the neurological control to make a quick transition from one assistive device to another. Often, it takes a few weeks or several treatments to master the use of that assistive device correctly and in a safe manner. A few times, this Medicare reviewer recommended discharge in the middle of that education and treatment program. They did not acknowledge that a change in the assistive device was occurring, but recommended discharge anyway. **That would put the patient at a significant fall risk. If they are not using the assistive device correctly, how can they be expected not to trip and fall?** Why would that recommendation be thought to be appropriate?

20.

There were several visits that the Medicare evaluator denied medical necessity because the goals were not met. There's no reason for the Medicare evaluator to make that accusation in all of these visits that were evaluated, none of them were the discharge visit. All goals will not be met until the discharge visit. If all the goals were met during the treatment, then we would be seeing the patient with no goals. It doesn't even make any sense on why the evaluator wants to see all goals met during the middle of the treatment. **Why would the Medicare evaluator expect to see all goals met if it wasn't the last visit?** Some goals were always being progressed and that was documented. When certain goals were met, those were documented as met, but other

goals were still documented as progressing. When all goals were met, the patient was discharged. There is no reasoning behind denying medical necessity in the middle of a treatment plan because all goals were not met. You would never expect all goals to be met halfway through a treatment plan. Again this is a stretch for the Medicare evaluator to make and there is no reasoning behind why this would support the no medical necessity. So again it makes us believe they were trying to find reasons to deny medical necessity

This evaluator has denied medical necessity due to not meeting goals. The reason was that after six weeks of therapy goals were met. The denial was because the goals were not 100% met, yet the goals were met greater than 75%. Plus this was not the last visit to see him. This was not the discharge. The patient did meet 100% of their goals at the discharge. It is not right for the evaluator to deny medical necessity due to not meeting goals when in fact to be near goal completion is a progression and an accomplishment. It is 0 to 100% progression to meet the goal. If your goal is 75% met, it is not fair to say they are denied because the goal is met. There is 75% improvement along the way. Meeting goals takes time and a consistent progression, not just all or none.

It begs the question, again, in our minds how hard was this evaluator trying to find reasons to deny medical necessity.

21

Several times the Medicare evaluator denies medical necessity because the evaluator stated that significant progress was not likely. That statement was made against documented charts that showed consistent and regular progress both objectively and functionally throughout the entire course of therapy. There is no support for that statement in any of these circumstances documented by the evaluator. How can the evaluator state that no significant progress was likely when in fact it was happening and did happen in every single case? We have seen in every one of those charts that significant progress was occurring without any plateaus or regression. Evidence of this is in the individual reviews that we sent with this.

22.

There were a few dates of service that were denied for medical necessity because the patient was not discharged to home exercise program soon enough. But on those dates of service it was documented that exercises were still being added and deleted because the patient was still having flare-ups with certain exercises. **It is apparent to see that the exercises were still requiring a skilled physical therapist to determine if the exercises were aggravating or helping their conditions. So if exercises were still being tested to determine the effectiveness of the treatment then how could a Medicare examiner recommend a discharge prior to the date of service?** It does

leave room for the thought that the Medicare evaluator wasn't taking into account the full situation here. If the treatment program wasn't set up yet and exercises were still requiring changes to them, then why could someone feel that this patient should have been discharged previously?

23.

There are several cases where the Medicare reviewer stated the discharge should've occurred prior to the third visit which doesn't allow for adequate follow up assessments. This is a disrespectful and non-logical statement in many ways. We as physical therapists need to develop exercise programs based on individual needs. These programs are developed over a course of several treatment visits as we add exercises and then determine the response the patient has to those exercises after they have tried them for a day or two on their own. For a patient to be discharged to a home exercise program to fix their condition, they will need several progressions throughout the course of treatment. The first two dates of service is not enough time to add to exercises and see the patient in follow up several times to determine the effectiveness of the treatment. This is compared to a physician treating a patient with high blood pressure. There are several high blood pressure medications that could be used to treat high blood pressure on a patient. The doctor will choose which medication they feel is best for this patient, however, they do not know the response to the treatment until after the patient comes back and gets their blood pressure retested to determine if the adequate drop happened proving a good response to treatment. If the patient never comes back for reevaluation after that medication has been started, the doctor and the patient will not know if the treatment is effective and if the right medication was being used. They could be taking a medication that is not adequately dropping the blood pressure. Not all medications work the same for each patient. That is why there are a variety of different blood pressure medications. If the patient still has high blood pressure, the doctor will change to a different medication and expect a follow up to determine the response to the new treatment medication. That will continue to happen until the correct patient response has happened. **That is due to several follow-up appointments managing a diagnosis. The same is true in physical therapy. If we don't follow up with the patient regularly to determine effectiveness of every exercise that we add, then we will not know the actual response the patient has for each treatment. This will lead to not knowing the status of the patient and possible not helping the patient or hurting them. So how can it be thought appropriate to discharge a patient prior to only 3 visits which would be only 1 follow up appointment?**

24.

In some cases they were denied medical necessity although the patient still couldn't walk with normal mechanics. The reviewer said they should be discharged to a HEP. What the reviewer is not considering is that gait training and education is not done by a HEP. It happens from constant cueing and one-on-one assistance to retrain walking patterns. Gait is a very difficult technique. Retraining someone to walk is not done by a handful of exercises. All therapists know that gait retraining takes a high level of skill to retrain the neurological components of walking. There is no way a patient can retrain them self in how to walk. To discharge a patient that still requires the one-on-one skilled assistance with relearning how to walk is not appropriate nor is it something that a skilled therapist should do. It would be a disservice to the patient.

25.

A patient was denied medical necessity due to having too long of a plan of care. The reviewer stated that the plan of care was for 18 weeks. That is not accurate. The documentation shows that we had 2 separate plan of cares that totaled only 10 weeks. We had one plan of care for 3x per week for 6 weeks. Then after 4 weeks time we got another signed plan of care for an additional 6 weeks. With the 2 weeks of overlap we have a total of 10 weeks. The medical examiner denied coverage saying that 18 weeks was excessive. We do not have a plan of care for this patient for 18 weeks. We have a total of 10 weeks covered in the signed plan of cares. This patient should not be denied medical necessity when the reason for denial is not factual.

26.

In the notes you will see several examples of decision making that was done by the therapist that only a PT could do. In one patient, "she wasn't responding well to trunk rotation as she had increased symptoms down the leg". So we "switched treatment to muscle energy corrections". There is no possible way a patient could make that distinction on their own. What do they do if they get worse with a treatment? What do they turn to? Do they keep it up? No pain no gain? Is this good pain? Is this an aggravating exercise? That is why they need follow up in physical therapy! Only a skilled PT can make that distinction. We changed her treatment to a manual treatment that is a muscle energy technique. This could not be performed by the patient on their own. They required our assistance and hands on treatment. I believe this proves the patient needs our assessment and our hands on approach.

Another time a patient worsened with right hip flexion that increased her radicular symptoms down her leg. So we as skilled PT's were required to make an assessment on what to do. We changed treatment to lumbar stabilization and flexion exercises with LE stretching. Who else could make that decision? The evaluator seems to believe the patient could make that decision on their own as they wanted this patient discharged.

That would mean either this patient is as educated as we are as physical therapists with our Masters/Doctorate degrees, and the patient can make these clinical determinations, or that we as physical therapists aren't very technically educated and any patient can make decisions like physical therapists can on how to assess painful responses to treatment.

Does this examiner not think physical therapists are necessary to make clinical determinations?

Part B

For these denials to remain, we will need evidence against all of our individual responses to each patient, but also we need proof on the following:

Why should have these patients been discharged when exercises are still being changed or progressed, and when the exercises are still being tested as to the effectiveness they have on the patient. You need to prove why patient follow up for the therapist to determine the effectiveness of the new exercises isn't necessary.

We need proof why it was appropriate to discharge these patients to unsafe environments when they have a high fall risk and why it is appropriate to go against the Medicare initiatives aiming to decrease fall risks and decrease readmissions and re-injury.

We need to see proof why a patient should be discharged when they still need to be educated on gait mechanics? We need to be proven that patients can retrain themselves on gait mechanics. We need to see how a patient can be taught all of the neurological components to all of the phases of gait, in how to take a step so they can self-assess their impairments and create a plan of exercises in how to fix that impairment on their own.

We need to be proven and shown how a patient with a total knee replacement should've been discharged after only one visit with all of the impairments that they had.

We need to be shown and proven support for why it is reasonable to discharge a patient that requires our hands-on treatment. Why discharge a patient that has excellent prognosis with hands-on joint mobilizations,. We need to see how they could do it on their own to regain the same outcome. We want to be proven how these patients could recover on their own when the required hands-on mobilizations that they couldn't do on their own.

We need to be proven how a patient can perform self-joint glide mobilizations while performing end range stretches that would allow them to be discharged to the treatment as a home exercise program. If it is impossible to perform self glide joint mobilizations to the shoulder and also perform end range of motion stretch at the same time which is required for the patient to regain the motion, then we need to see how they can still recover on their own.

When we know that certain diagnoses have to be progressed through several steps to get to full recovery then we need to be proven why it is appropriate to discharge early on in that step-by-step process. We need to be proven why that is appropriate to discharge when you know that the patient will not be progressed through the necessary steps to get to a full and proper outcome.

We need to be shown why it would be appropriate to discharge a patient to a home exercise program when, in fact, the notes showed that we had tried just that, discharge the patient to a home exercise program, but it failed and the patient was regressing.

If we discharge the patient temporarily to an independent home exercise program and they started to regress then we need to be shown and proven why an appropriate action for that patient is to not bring them back and continue treatment.

If a patient cannot stretch themselves to end range positions, which is required to gain increased range of motion, then we need to be shown why it's appropriate to discharge a patient to a home exercise program that is unable to get to end range stretches independently.

Patient required queuing to perform the exercises and couldn't do the exercises correctly from memory and from diagrams given to them. We need to be shown why it was appropriate to discharge that patient from physical therapy to a home exercise program and still expect an excellent recovery.

We need to be proven why a patient should be discharged after the initial home exercise program was given, how they are expected to progress on their own without continued physical therapy, and without going through the necessary step progression. We need to see how one visit, with no follow up to reassess the patient's response to those exercises is appropriate and in the patient's best interest.

We need to be proven why there is reasoning to deny medical necessity strictly for the reason that a plan of care states therapy might need 12 weeks, but in reality we only saw the patient for 6 weeks.

We need to be shown support for why a patient that was requiring vital sign monitoring due to co-morbidities such as strokes or heart attacks could be discharged to a home exercise program that would not have any monitoring?

We need to be shown and proven how all of these patients know what safe parameters are and which ones need to be followed while exercising.

If a patient could not perform self-stretching on their own and had significant loss of joint range of motion after a surgery, we need to be shown why it's appropriate to discharge a patient after only getting 50% of the range of motion compared to prior level of function and prior to surgery?

If they cannot stretch on their own to regain the motion due to co-morbidities, why is it appropriate and realistic to discharge them when you know they will not continue to improve if they don't continue with skilled physical therapy

We need to be shown and proven why it is be appropriate to overstep a treating physician's protocol by discharging a patient halfway through the treatment protocol plan after surgery.

If a patient required eight weeks of passive range of motion followed by eight weeks of strengthening why is it appropriate and we will need proof why it would be appropriate to discharge that patient at the eight week point after surgery.

If a patient is requiring hands-on joint mobilization and stretching done by the physical therapist to improve range of motion as quickly as possible and these reviewers feel like discharges need to be happening quicker, then I need to be shown proof why these patients should be discharged and refused continued hands-on manual treatment when in fact that's what they need to get to a quicker discharge. Why would it be appropriate to discharge the patient when they could not perform those mobilizations independently on their own?

If a doctor has a post-surgical protocol that states no strengthening or resisted motions to the shoulder until after 12 weeks post-surgery, then how is it recommended to discharge that patient sooner than 12 weeks after surgery as no strengthening could have been taught or added to a home exercise program? We will need proof on why this was recommended by the Medicare reviewer and why it was appropriate to overstep the orders by the treating physician that performed the surgery.

We have to be shown why it would be appropriate to discharge a patient to a home exercise program when is clearly stated in the notes that the patient required constant queuing to perform the exercises with correct form and correct body mechanics. If she

wasn't performing them correctly, she was risking additional injury. This patient required constant reminders and explanation on how to perform the exercises even with the provided handouts explaining the exercises. We need support to prove why it would be appropriate to discharge this patient knowing full well that they would be discharged to an unsafe situation with a significant risk for re-injury as they couldn't do their HEP safely or correctly.

When a doctor orders passive range of motion only, that means that only a physical therapist is allowed to move the patient's arm with a total relaxation. There are no exercises that a patient can perform independently that is true passive range of motion. So with several patients being stated in this review that they should've been discharged in the timeframe when only passive range of motion was allowed, we need to be shown why it would be appropriate to discharge a patient against physician orders to a home exercise program involving passive range of motion when it is **impossible** for a patient to perform passive range motion on their own.

For several patients, it was recommended that patient be discharged to a home exercise program within the first three visits. I want to see proof how a patient can be educated through the entire progression of exercise, multiple step-by-step processes, in only three visits, and expect an excellent outcome. Then we need proof on how the patients will be able to deal with abnormal responses to these exercises that they add on their own? And if they say we can teach them all of these exercises for future steps and how to deal with abnormal responses, then how can they be complaining of us treating these patients for too long in the clinic?

We need to see proof why all of these patients with different co-morbidities and severities all should have been fixed in 10 visits over the course of 8 weeks? We need proof how all of those frequency and duration statements directly correlate to all of the patients that they stated that for.

We need proof on why patients with prior therapy for a different diagnosis should be denied therapy for the new diagnosis due to "prior physical therapy".

If a patient has a high fall risk and can't do the HEP safely on their own including balancing with their eyes shut, we need proof on why it was appropriate to discharge them to the unsafe situation.

We need proof on why it is appropriate to deny coverage for therapy stating there was no pain scale, but the fact was that there was a pain scale in the documentation.

We need proof on why it is appropriate to deny therapy stating there is no objective data when, in fact, there are several objective charts in all of those cases.

We need proof on why it is appropriate to deny coverage for physical therapy when function is improving, but pain might not be improving yet. Why is pain superseding functions and why is that the correct way of thinking?

We need proof on why having a diagnosis of knee strain vs. a diagnosis of knee pain as a reason for denial for therapy.

We need proof why an evaluator can overstep the physician and physical therapist and diagnose a different disease process when that diagnosis is not talked about at all in the plan of care or initial evaluation done by the physical therapist. Why is that appropriate when every treatment that was completed was for the actual diagnosis that was on the plan of care and none of the treatments done were aimed towards the diagnosis that the Medicare evaluator stated was the diagnosis.

We need proof why it is appropriate to deny medical necessity on a patient that the evaluator said we saw 36 times, but actually saw them only 11 times.

We need proof on why all of these patient's protocols from the treating physicians should not have been followed.

We need proof as to why 90+ minutes of exercises and treatment is detrimental to these patients.

We need proof as to why discharging a patient that is half way through assistive device training is appropriate.

We need proof as to why patients that are half way through their therapy progress should have all of their goals met.

We need documented research that a shoulder patient should show long lasting benefits of strengthening after just 2 weeks. We need proof why it was appropriate to discharge a patient after just 2 weeks because they didn't show enough strength improvements.

Part C - these are discrepancies between the same patients or patients with the same diagnoses.

There are huge discrepancies when these patients are being told to be discharged to a home exercise program because of the diagnosis. If the Medicare reviewers want to make that statement they would have to be consistent if they had research to prove their reasoning, but they do not have the research and that is why they were not consistent in their reasons for denials. That makes us believe that one or more evaluator has biases on discharging patients earlier than is appropriate, and another

evaluator does not. This makes this Medicare evaluation a very subjective evaluation based on perspectives of different evaluators. This refutes the statements that this evaluation must be based on objective evidence. The objective evidence is very poor. You will see in the below comparisons that the discrepancies disprove objective evidence for any reasoning why they can recommend discharging to home exercise program because of the diagnosis.

██████████¹⁴ passed the review with the diagnosis of shoulder sprain/pain. He was seen 15 times and it was seen as medically necessary. ██████████ was seen 13 times for shoulder pain, sprain/strain, (the same diagnosis). And she was approved for therapy. Although, ██████████ was denied on the 6th visit for the same diagnosis and expected to be discharged to home exercise program. Also ██████████ was seen 10 times for the same diagnosis and was also denied due to being recommended to a discharge for a home exercise program. Why the huge discrepancy? The evaluator(s) state that "a typical course of treatment for this condition would include up to 10 treatment sessions over 8 weeks". **How can some patients be allowed visits beyond the 10 treatment sessions, but then others denied when they are under the 10 treatment sessions? This discrepancy proves subjectivity. It proves that they do not hold objective proof for this review.**

Another discrepancy is ██████████ was evaluated for cervical radiculopathy and neck pain and was seen 16 times and was allowed physical therapy. Although ██████████ was evaluated for the same diagnosis was seen for 11 visits, but was denied physical therapy. Again the evaluators try and say that these people should be discharged to a HEP, but they are not consistent with their recommendations.

██████████ was seen on the 3rd visit for low back pain and was denied physical therapy and ██████████ was denied on the 8th visit for low back pain. Although ██████████ was seen 41 times for low back pain and was allowed physical therapy. So how can a low back pain be denied physical therapy on the third visit when other low back pain diagnoses were allowed more visits? A huge discrepancy.

██████████ was a patient with knee pain that was denied on the 3rd visit when other patients with the same diagnosis, including ██████████, who was approved with 4 visits, ██████████, with the same diagnosis, was approved with 5 visits. Again, more inconsistencies.

██████████, a total knee patient, was denied on the 2nd visit, but ██████████ was allowed 8 visits on a total knee. Again, standards are not kept consistent from patient to patient.

¹⁴ **Office of Inspector General Note**—The deleted text on this page and later in the report has been redacted because it is personally identifiable or proprietary information.

Another discrepancy was [REDACTED]. He was denied for having an excessively long plan of care that was 18 weeks long. That wasn't the case. We only had 10 weeks total on all of the plan of cares that were signed. How can we be denied for a reason that isn't factual or correct?

The reviewers response cannot be that they have underlying conditions or other co-morbidities that allow for varying decisions because in most of these 51 cases they did not acknowledge or take into consideration the patients co-morbidities or severity of the case. They can't play both sides of the coin. There is a enormous lack of consistency.

Part D - Our requests

I am requesting the number of reviewers that reviewed this group of patients and under each reviewer the number of dates of services that were approved and how many were denied medical necessity. I do not need names of the reviewers, just the dates reviewed and which patients they reviewed.

We are putting on record that we are requesting the OIG and any Medicare reviewing body to only label any information on this review that is associated with this review at this location to be labeled as a "a company from Missouri" instead of [REDACTED]. This business is a small business and a small medical community that would have drastic effects on the clinic and individual providers. If a negative connotation would be derived from this review, that would lead to grounds for defamation of character for the individuals and the clinic. Please respect this request to avoid any future litigation. It is obvious from this review that there is serious question on the validity of the review and to the lack of support from the reviewer(s) comments. To state on record, in documentation, that this review had visits that were seen that were not medically necessary could lead to a negative connotation towards the clinicians that work at this clinic. While it is obvious that the clinicians here are disagreeing with the above statements and, so forth, to put that in writing when it is not proven, would be a defamation of character. With a previous audit that was performed to a small therapy company/therapist in Illinois, the OIG labeled that audit as a "A physical therapist in Illinois". We expect the same generic labeling done to all public documentation that is associated with this audit.

For such an important review that could have detrimental effects to a business and physical therapists' careers, it would've assumed these reviews would have been double checked to make sure nothing was missed. I assume I am wrong because several mistakes have been made. One of which including a patient being denied for care for excessive treatment when the reviewer stated that the patient was seen 36

times when actually they were not; they were only seen 11 times. Another patient was being denied due to incorrect billing when the reviewer stated that manual therapy was billed 97116, but that's not the manual therapy code. The same reviewer called gait training 97140, but that is not gait training. The gait training code is 97116 and manual treatment is 97140. These are just a couple of the abundant mistakes that were made in this review that is showing the lack of accuracy of this medical review. There are numerous areas where it is seen that some of the reviewers do not understand physical therapy and what happens in treatment. This proves the examiner(s) was not appropriate for this review.

Our review pointed out each one of the reviewer's statements and refuted each statement individually in the summaries following this. We have individual summaries for each of these 51 cases. If the reviewer wants to try and support their denials, then we need to see facts supporting their statements. Their facts need to refute each of our statements for each and every patient. They will need to go line by line from our summaries and refute our factual data.

I've had my own auditors look at these cases and they have a totally different opinion on them. The reviews are subjective and will receive different evaluations by different evaluators. You're taking one visit out of many visits that are performed in a series of physical therapy visits making up a full course of treatment. You're saying one visit wasn't approved by Medicare and therefore extrapolating that to that entire case being disapproved, then extrapolating that for the percentage of cases over a two-year span. That is incorrect. You should be taking that visit and extrapolating that error rate out of the total number of visits seen by all the cases over that 2 year time frame and then make that extrapolation percentage. **There is no way to extrapolate saying that because one visit towards the end of the physical therapy course of treatment was denied, that you assume every visit prior to that visit and after that visit are also not approved.** If you were going to say one visit isn't approved, you cannot consider every other visit within that course of treatment not approved also. Every visit within that case would have to be individually evaluated for medical necessity and whether or not it met your guidelines.

Another problem with your extrapolation equation is that you are taking multiple dates of service from the same patient case that all share one mistake and extrapolating that as 4 mistakes across 2 years of visits. If you would find the same mistake with all of them, then that is 1 mistake not 4 mistakes. One patient has 4 dates of services that are evaluated. If one date of service fails, you will ultimately fail the following 3 visits. That number 4 is taken in to an equation that extrapolates that 4 times more errors in the "average of our notes" are incorrect. That is appropriate and is an incorrect correlation.

The Medicare examiner often states that "an independent exercise program prior to this date could've met the patients needs". This could have meant that they should've been

discharged to home exercise program the visit prior to this date and means that every visit prior to this would've been medically necessary, therefore, should not be included in a certain percentage of patients or visits that they then deduct or get to a certain percentage of all visits throughout a two-year process. The correlation and equation the OIG uses to calculate the total overpayment is not a correct determination.

Our statements will disprove those statements made by the medical reviewer(s) and therefore prove medical necessity. It is hard for us to read a statement saying there is no objective data up to this date of service when in fact there are multiple objective charts in the initial evaluation and in several progress notes prior to that date of service. This happened multiple times. It is many examples like this one that makes us question how much reading and studying was done on these patient charts while performing these Medicare reviews. Whomever is reading this should understand our frustrations with those unsupported statements leading to these denials. We have spelled out exactly those dates of service and pointed out the objective charts in the notes. This should make it much easier for when you review these again to see that the information you thought was missing was actually there.