


HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

PHYSICIAN'S
PRACTICE
COMPLIANCE
CONFERENCE

Risky Business: Physical Therapy in the Physician Office
Nancy J. Beckley, MS, MBA, CHC
Sheila K. Nicholson, Esquire, MBA, MA, PT
October 13, 2009



Today's Objectives

1. Why are rehab and therapy services offered "incident-to" being targeted for compliance audits and overpayment recovery?
2. Accountability – in delivery and billing for therapy services.
3. Improving – internal controls for compliance in therapy services.
4. Documentation – do your therapy forms facilitate compliance proactively?
5. Coding & Billing – does your daily note facilitate the required link between coding and documentation?
6. Monitoring & Auditing – do your monitoring and auditing activities reflect the high risk associated with both therapy and with services provided "incident-to"?

Current Regulatory Compliance Wave

- HIPAA – 1996
- BBA – 1997
- Clinton Administration
 - Sec HHS - Next to violent crime
 - Operation Restore Trust
- OIG Compliance Guidance – Hospitals (1988)
 - 2000 – OIG Draft Compliance Guidance – Physicians & Small Practices
 - Federal Sentencing Guidelines
- Evolution of Stark laws
- DRA – False Claims Implications (Medicaid & States)
- Congress loves “uncovering fraud” and recouping \$\$\$
 - Recovery Audit Contractor: Demo to Permanent
- Medicare “Strike” Force
 - The Real Miami Vice migrates to Houston, Detroit & Los Angeles

Enforcement Fads

- 1970's – Political corruption
- 1980's – Defense fraud
- 1990's – Health care fraud (not going away)
 - \$\$ returned on excellent ROI
- 2000's – Corporate governance/accounting fraud
 - In many instances a convergence of corporate America with publically traded healthcare entities
 - 9/09/2009 – President Obama address to Joint Session of Congress: Use Fraud in Medicare program to pay for healthcare reform.

Background



Medicare Part B pays for services that are billed by physicians but are performed by nonphysicians. These services often are called "incident to" services, or services provided under the "incident to" rule. "Incident to" services may be vulnerable to overutilization and may put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care. Little is known about Medicare services performed "incident to" the professional services of a physician.

Non-physician personnel services billed by physicians

These services are called "incident-to"

May be vulnerable to overutilization

Background



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

MAY 1 2006

Washington, D.C. 20201

TO: Leslie V. Norwalk
Deputy Administrator
Centers for Medicare & Medicaid Services

FROM: *Brian Ritchie for*
Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Physical Therapy Billed by Physicians

In 2002, the Office of Inspector General (OIG) initiated work associated with Medicare payments for physical therapy. In October 2003, we reported interim results to your office detailing aberrant billing patterns by certain physicians and carrier efforts to target physicians' physical therapy claims. Since the issuance of our 2003 memorandum, we have completed the results of our medical review of claims paid by Medicare in the first 6 months of 2002 and we have updated our claims data analysis of physicians who show aberrant billing patterns for physical therapy claims.

Based on a simple random sample of 70 physical therapy line items billed by physicians and rendered in the first 6 months of 2002, we found that 91 percent of physical therapy billed by physicians and allowed by Medicare during the first 6 months of 2002 did not meet program requirements, resulting in \$136 million in improper payments. In addition, we analyzed Medicare claims data from 2002 to 2004 and identified aberrances in physicians' billing patterns and unusually high volumes of claims. Finally, based on our review, we identified a number of issues associated with physical therapy billed by physicians under the "incident to" rule.

Background: 1st QTR 2007



Using Part B Medicare National Claims History data for the first quarter of 2007, we identified all days during which Medicare allowed services for physicians in a single day that exceeded 24 hours of physician worktime. We randomly selected 250 of these "physician-day" combinations and requested that the physicians identify who performed each service that Medicare allowed on the selected day(s). We asked the physicians to submit all relevant credentials for the nonphysicians they identified. Our contractor's nurse-reviewers determined whether the nonphysicians were qualified to render the particular services. In making these determinations, the nurse-reviewers considered any relevant Medicare requirements, State laws and regulations, and the nurses' own professional judgment as to whether the particular service generally falls within the standard competencies of the particular type of nonphysician provider who rendered the service.

Findings: 1st QTR 2007

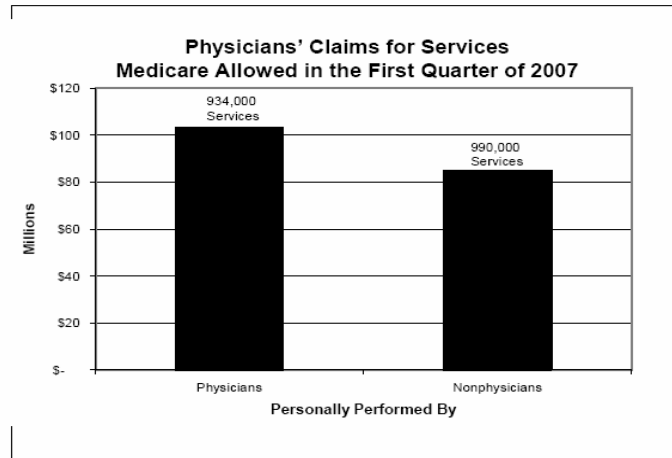


Unqualified nonphysicians performed 21 percent of the services that physicians did not perform personally. In the first 3 months of 2007, Medicare allowed \$12.6 million for approximately 210,000 services performed by unqualified nonphysicians. These nonphysicians did not possess the necessary licenses or certifications, had no verifiable credentials, or lacked the training to perform the service. Nonphysicians with inappropriate qualifications performed 7 percent of the invasive services that physicians did not perform.

Background



CHART 1
Who Performed
the Services
When Medicare
Allowed
Physicians More
Than 24 Hours of
Services in a Day



Source: OIG analysis of 2007 Medicare NCH data and document review results, 2008.

Recommendations



Therefore, we recommend that the Centers for Medicare & Medicaid Services (CMS):

1. Seek revisions to the bill to Medicare ensure that physicians who licensed physicians
2. Require physicians personally perform the services performed by nonphysicians who did not have the training of a therapist.
3. Take appropriate action to address the claims for services that we detected that:
 - a. were billed by physicians and performed by nonphysicians that were, by definition, not "incident to" services and
 - b. were for rehabilitation therapy services performed by nonphysicians who did not have the training of a therapist.

Breakout

TABLE 1
Categories of Services and Who Performed the Services When Medicare Allowed Physicians More Than 24 Hours of Services in a Day

Categories of Services That Medicare Allowed			
Service Category (Service Description)	Percentage of All Services That Medicare Allowed for the Physicians (Percentage of Service Category)	Percentage Performed by Physicians	Percentage Performed by Nonphysicians
Invasive	34%	38%	62%
-Routine Venipuncture	37%	4%	96%
-Surgical Procedures	31%	88%	12%
-Non-oral Drug Administration and Chemotherapy	29%	27%	73%
-Other Services	3%	63%	37%
-Rehabilitation Therapy	18%	13%	87%
-Rehabilitation Therapy	18%	13%	87%
-Cardiovascular	10%	52%	48%
-Diagnostic Radiology	6%	60%	40%
-Other Noninvasive	23%	47%	53%
Total	100%	45%	51%

Source: OIG analysis of document review results, 2008.

Breakout

Rehabilitation therapy services account for 18 percent of the services that Medicare allowed for the physicians. Rehabilitation therapy is the treatment of functional limitations to prevent the onset and/or slow the progression of physical impairments after an illness or injury.²¹ These

services performed by physical therapists, occupational therapists and speech language pathologists are provided by physical therapists, occupational therapists and speech language pathologists. Although CMS (and before that HCFA) had for seven years consistently interpreted the law differently, this new interpretation has prevented thousands of therapy providers from

modalities. Nonphysicians performed 87 percent of these services.

Most of the rehabilitation therapy services that Medicare allowed for physicians were therapeutic exercises, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation. Other services included neuromuscular reeducation and manual therapy. The physicians were allowed relatively few physical and occupational therapy evaluations.

What is the Rule Now?

A3. CMS implemented a rule in 2005 that prohibited all other therapy providers except physical therapists, occupational therapists and speech language pathologists from providing physical medicine and rehabilitation services "incident to" a physician. CMS maintains that adoption of the rule was required by an obscure change in the Medicare law enacted in the mid-1990s. Although CMS (and before that HCFA) had for seven years consistently interpreted the law differently, this new interpretation has prevented thousands of therapy providers from

Medicare Compliance Roles

- Physician
 - Therapist
 - Assistant – What role in incident-to?
- Techs (in the eyes of CMS)
 - Exercise Physiologist
 - Athletic Trainer (ATC)
 - Therapy Technicians (Tech)
 - Recreational Therapist
 - Graduate PT pending licensure
- Clinic Office Staff
 - Past & Present: Practice & Policy

According to the OIG

- Selected Physical Therapy and Occupational Therapy Providers in Texas (Texas)
 - Review of 100 claims, 10 Therapists
 - Problems identified:
 - 2,709, over **99%**, of the 2,734 services contained in 100 sampled claims submitted by the 10 therapists did not meet one or more of Medicare's reimbursement requirements.
 - Why?
 - The therapists did not maintain adequate documentation.
 - The therapists did not meet the plan of care requirements.
 - Someone other than the billing therapists performed the services.

According to the OIG

- Absolute Therapy CORF (Florida 11/2006)
 - 100 sampled claims, **20%** error rate
 - In 20 claims, 246 therapy services did not meet Medicare requirements = **\$5,928**
 - Why?
 - services rendered under unapproved or incomplete plans of care
 - documentation did not indicate that the POC was reviewed at least every 60 days
 - documentation did not meet Medicare standards to support that services were actually provided
 - Absolute had written policies and procedures that, if followed, would have precluded the errors the medical reviewers identified
 - Payback requested: **\$411,781**
 - **Rebuttal.....**
 - First case where existence of compliance plan is noted including policies and procedures

Even Smaller Fish Are Fried...

- Healthworks Rehab & Fitness (West Virginia) self-discloses and pays back for improper billing of iontophoresis
- OIG alleges Healthworks inappropriately billed Medicare for the performance of ionto services, which is not a covered service under Medicare because it is considered experimental.
 - Not covered by their LCD, (allowed by Highmark, WPS etc)
- Key Issues of concern
 - Missed the billing safety net at the rehab provider
 - Missed the claims edits at the Medicare contractor
- REAL Issues – this was similar to a finding in the RAC demonstration project in California regarding SLP services:
 - The rehab provider billed improperly, but why was it paid?
 - Further RAC implications.....?
- A bigger lesson – conducting audits where a potential concern exists under attorney-client privilege
- Use of the self-disclosure protocol?

Corporate Integrity Agreements

- Small to mid-size rehab providers debuting on list of CIAs
- Theme of **whistleblowers**
 - Repeatedly registered concerns re: coding/billing
 - Concerns purportedly not addressed
 - HR train wreck waiting to happen
- Theme of entering into Settlement Agreement to avoid prolonged and expensive litigation

Medicare Strike Force

- Packing “heat” in Miami
 - Joint “strike” effort of Feds & State officials
- New fraud has moved from DME and Infusion to rehab
- Successful Medicare Strike Force program replicated in Houston, Detroit and Los Angeles
- Schemes involving physicians, therapists and former drug runners, or any combination thereof...

RACs Make A Move

- Recovery Audit Contractor demonstration program wildly successful and finds rehab an easy catch
- Demo finding of SLP billing of untimed codes > 1 unit = \$3.2 million error (\$\$ is recouped, non-appealable)
- **Untimed codes** for rehab approved by CMS for automated review for most states with approved issues as of 9/10/2009
- Untimed codes risk for your charge master or fee schedule
 - Evaluations
 - What other codes?

RAC – Automated Issues – Shooting Fish in a Barrel?

- Rehab automated issues
 - Untimed Codes
- Other RAC automated issues likely
 - LCD “cap” on number of units
 - ICD9 code supports medical necessity
- Rehab complex issues likely
 - Properly certified POC
 - Quick and easy – nothing much to reach for the reviewer
 - Minutes support codes billed – a bit more reading for the reviewer
 - Therapy in excess of caps (KX), did chart support medical necessity – a lot more reading – but potential for payback for clinic, and the entire rehab industry

Guide to Practice

- Medicare has no secrets....
 - New documentation requirements 1/1/2007
 - Objective measures: **YES** or **NO**
 - Subjective interpretation: logical
 - Problem to address: concurrent v. retrospective
 - Documented problem areas in OIG cases
 - Lessons to learn from:
 - RAC, PSC (ZPIC), CERT
 - PCA, probe reviews

Documentation: Best Intent

- Documentation format
 - Design of forms
 - Content of forms
 - Clinical v. administrative issues
- Chart format & flow
 - Day to day current chart
 - Discharged patient chart
 - **Chart sent for review**
- Prepare every chart for defense

Key Elements: Required

- Evaluation – and Plan of Care
 - Certification
 - May be “up to” 90 days
 - Updated POC and re-certification as necessary
- Daily Encounter Note
 - Flow sheet or log of incremental exercises
 - Minutes, minutes and minutes
- Progress Note
 - Every 10 visits or 30 days (which ever is first)
- Discharge Note
- **National rehab documentation rules vs. local policy**
 - Guidelines vs. mandates
- Therapy caps – documentation for medical necessity of exceeding the cap

Coding Risk Areas

- Minutes supporting timed codes
- Modalities
 - Constant attendance v. unattended
 - Electrical stimulation, ionto
- Medical Necessity
 - Supportive ICD-9 to CPT crosswalk
- CCI edits
 - Component codes
 - Mutually exclusive codes
 - Watch for pairs that exclude combinations of PT, OT & SLP
- Procedures
 - **Group code** – when is group a group, and not a group?
 - **Aquatics** – special case: NCD, LCD & incident-to

Recording Time - #1 CERT Issue

- Time for each timed modality & procedure
- 8 Minute rule
- Total time in “timed” codes
- Total therapy time
- Time in/time out

Minutes

Minutes	Can Bill
0-7	0
8-22	1
23-37	2
38-52	3
53-67	4

The Patient Complaint

- Complaint may originate due to
 - Care received (or not received)
 - Concern over bill, EOB, co-payment etc
 - On behalf of self or others
- The path of complaint will determine
 - Practice Act – licensing board issues
 - Malpractice insurance issues
 - Criminal & civil issues
 - HHS, DOJ, OIG Fraud Referral
- CASE Study
 - A patient complaint – no merit = \$\$\$\$

Resources You Have

- Compliance program
 - Update
- Utilization review program
 - Update
- Peer Review
 - Inside
 - Outside
- Patient policies & procedures
 - Update
- Administrative policies & procedures
 - Update

Compliance: Path to Success

- Routine monitoring activities
 - All “eyes” on deck
 - Correct process items
 - Therapists
 - Front office
 - Billing/software
- Scheduled audit topics/activities
 - Break apart the documentation requirements
 - Surface concurrent problems
 - Redesign process
 - Retrain
 - Reaudit
 - Address items from hotline or staff concerns

Compliance Issues: Snatched From the Headlines

- Hotlines
- Code of Conduct
- Monitoring & Auditing
 - Looking for new ideas?
 - Forget the charts...
 - Look no further than our old friend....MRSA

Do You Need A Compliance Plan?

Any health care entity which does not
have a compliance program is
'institutionally nuts'."

Karen Morrisette, Deputy Chief
Criminal Division Fraud Section of the
United States Department of Justice

Auditing and Monitoring

- **Monitoring**
 - Your routine program designed to surface issues to be managed and topics for routine and special audits
- **Auditing**
 - Routine audits based upon areas identified in your annual risk assessment
 - Special audits based upon routine findings, hotline concerns, problems that have surfaced
- **Attorney-Client Privilege**

Self-Disclosure

- It is a crime to maintain **any** healthcare reimbursement to which you are not entitled
- Paybacks and refunds
 - Routine, self initiated
 - Routine, automatically deducted by MAC
- Self-disclosure
 - Specific protocol
 - Does not guarantee anything
 - Seek advice of counsel experienced in the self-disclosure protocol
 - Think West Virginia.....

Knock..Knock

- Subpoena
 - May be accustomed to subpoenas for WC and liability cases
 - Ensure they are carefully read and seek advice of counsel experienced in federal subpoenas
- Search Warrant
 - Think 'crime scene' tape
- Do your employee's know what to do – has it been outlined in annual compliance training?

Helpful Tools for You

- RAC "Commonplace Book"
- Risk Assessment Check List
- Sample Audit Topic/Schedule
- Chart Audit Tool

Questions?

Contact Information

Nancy Beckley, MS, MBA, CHC

Bloomington Consulting Group, Inc

Nancy@BloomingtonConsulting.com

<http://BloomingtonConsulting.com>

<http://BloomingtonConsulting.com/blog>

D: 813-340-4376 O: 813-654-4130

Sheila K. Nicholson, Esquire, MBA, MA, PT

QUINTAIROS, PRIETO, WOOD & BOYER, P.A. - Partner

Snicholson@qpwbllaw.com

<http://qpwbllaw.com>

D: 813 - 286-8818