



Fraud and Abuse: Part 1

This article was developed from a presentation by Gayle Lee, J.D., Senior Director of Health Finance and Quality for the American Physical Therapy Association, at the 2013 FSBPT annual meeting.

How the government is working to reduce healthcare fraud and abuse – and how physical therapists can reduce the risk of an audit

The Institute of Medicine reported that \$765 billion per year has been lost to fraud, waste and abuse, with \$75 billion due to fraud.

Concerns included overutilization of services, increased costs for payers and the health system, corruption of medical decision-making, unfair competition among providers and serious harm to patients.

There were 1,200 prosecutions in 2011 as opposed to about 100 prosecutions in 1991 and 1992.

The players

The players involved in this issue include the Centers for Medicare and Medicaid Services (CMS) central and regional offices, the CMS contractors, the CMS Office of the General Counsel (Stark Regulatory Authority), Health and Human Services Office of the Inspector General, Department of Justice, FBI, state attorney generals and state regulatory agencies (licensing boards).

The contractors

The Medicare Administrative Contractors (MACs) are involved in claims payment, provider education, local coverage decisions, provider audits and medical review. They can perform probe reviews based on a provider or service. If they find problems from the probe, they will review more claims. MACs will be consolidating from 15 into 10 jurisdictions soon. The contractors have to competitively bid for their contracts every three years.

The Comprehensive Error Rate Testing Contractor (CERT) program produces a national payment improper payment rate for the Medicare Fee for Service based on a statistically-valid random sample of claims. It reviews documentation to support a claim being billed and paid correctly; the CERT findings let MACs know where to focus their medical review and audit efforts.

Recovery Auditors (RAs) identify and detect overpayments and underpayments, recoup

overpayments and take initiatives to prevent future overpayments. The RA is paid based on a contingency fee, which is big concern to provider groups. Issues they review must be approved by CMS and put on a website. RAs are performing manual medical reviews for outpatient therapy claims exceeding \$3,700. There are four auditors nationwide.

Uniform Programming Integrity Contractors (UPICs, formerly PSCs, ZPICS) have a primary goal to identify cases of suspected fraud, review hotline referrals, investigate them thoroughly and take immediate action to ensure that Medicare monies are not inappropriately paid out. They also perform announced and unannounced site visits and medical reviews. All cases of potential fraud are referred to the Office of Inspector General. There are seven UPICs and they bid for their contracts.

Program integrity strategies

CMS's strategies to reduce improper payments include strengthening provider enrollment, improving pre-payment reviews, focusing post-payment reviews on vulnerable areas, improving oversight of contractors and developing a robust process of data analysis to address identified vulnerabilities.

Provider enrollment

Enrollment screening has been segmented into three categories:

- Limited Risk (licensure checks) – physician or non-physician practitioners, occupational therapists, speech language pathologists, medical groups or clinics, hospitals, skilled nursing facilities
- Moderate Risk (site visits, licensure checks) – Comprehensive Outpatient Rehab Facilities (CORFs), physical therapists enrolling as individuals or groups in private practice, revalidating home health agencies, revalidating Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers
- High Risk (licensure checks, fingerprinting, site visits) – Newly enrolling home health agencies, newly enrolling DMEPOS suppliers

Provider enrollment: revalidation

The affordable care act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria (applies to those providers and suppliers that were enrolled prior to March 25, 2011).

MACs will send out notices to begin the revalidation process for each provider and supplier. Providers and suppliers must wait to submit the revalidation only after being asked by their MAC.

Investigative techniques

Predictive modeling

Health and Human Services has begun predictive modeling to uncover bad claims before they are paid by using risk-scoring tools to analyze claims as they come in. Banks and insurance companies already employ such techniques to find potential fraud. They compare providers with their peers with respect to billing. If providers fall outside the norm, they would be flagged.

Red flags in system for PTs

Red flags would include frequent use of the KX modifier (aberrant from the norm) if, in a private practice setting, the billing is going under one PT provider number rather than each separate PT enrolling and if there are an excessive number of codes billed per session.

Audits

Once a provider is flagged, they may be subject to an audit. The auditor looks for compliance with rules, documentation and coding. Auditors frequently extrapolate the results of an audit and therefore seek larger recoupment than may be anticipated. Prior to 2013, for Medicare overpayments, the federal government and its carriers and intermediaries had three calendar years from the date of issuance of payment to recoup overpayment. This has been changed to five years based on a provision in the taxpayer relief act. The three-year statute of limitations does not apply to recovering overpayments made as a result of false pretenses or fraud.

Timeframe to collect overpayments - Medicare and Medicaid overpayments must be reported and returned by no later than 60 days after the date on which the overpayment was identified. Interest begins to accrue from the date of the first demand letter requesting the overpayment if the overpayment is not received by the 31st calendar day from the date of the letter.

Recoupment procedures will begin on day 41 from receipt of the letter unless an appeal is filed within 30 days from the date of the overpayment request. If providers are unable to pay the entire amount of the overpayment in full, they may contact the contractor to request an extended repayment plan.

Risk areas for physical therapists

Outpatient settings:

- Missing certificates on the plan of care
- Billing for services furnished by aides/techs
- Providing inadequate supervision
- Billing for one-on-one codes instead of group therapy
- Billing for co-treatment
- Failing to comply with the eight-minute rule
- Failing to comply with CCI (Correct Coding Initiatives) edits
- Submitting claims for services that the provider knows are not reasonable and necessary

- Code gaming – unbundling (hot pack, dressings)
- Upcoding (from unattended to attended E-Stim, for instance)
- Billing for ‘not medically necessary’ services without an ABN
- Billing for maintenance care
- Billing for excessive duration and frequency of services
- Billing for services not furnished
- Billing for student services
- Documentation deficits or fraudulent modifications post-denial or requests for records
- Signatures not legible
- Used a stamped signature
- Plan of care not signed by the physician
- Plan of care not recertified
- Duration/frequency not in compliance with that identified in local coverage decision
- Documentation is insufficient
- Frequent use of the KX modifier (aberrant from the norm)
- In a private practice setting, the billing is going under one PT provider number rather than each separate PT enrolling

Post-acute care settings:

Home health

- Documenting medical necessity
- Incomplete documentation (lack of measurable goals or rationale for number of therapy visits furnished)
- Supervision and use of PTAs
- Overlap of services between acute and post-acute care
- Establishment and management of maintenance therapy
- Timely submission of claims and request for documentation
- Evidence to support patient homebound status

Skilled nurses facilities

- Documenting medical necessity and justification for modes of therapy
- Use of different modes of therapy (individual, concurrent and group therapy)
- Adherence to MDS scheduled assessment periods
- Use of physical therapy aides and students
- Upcoding Resource Utilization Groups (RUGs)

Inpatient rehabilitation facilities

- Adherence to three-hour rule (intensive therapy requirements)
- Distinction of skilled versus unskilled therapy
- Use of different modes of therapy (individual, concurrent and group therapy)
- Use of physical therapy aides
- Completion of pre-admission screening and post-admission evaluation

- Physician involvement
- Interdisciplinary team meetings

Examples of recent reports

Senate finance committee home health report

The Senate finance committee released an investigative report on four home health agencies in October 2011. The report included the following findings:

- Managers encouraged therapists to meet a 10-visit target that would have increased their payments from Medicare.
- An “A-Team” was tasked with developing programs to target the most profitable Medicare therapy treatment patterns after 2008 when a change to rules occurred.
- Therapists and regional managers were pressured to follow new clinical guidelines developed to maximize Medicare reimbursements and revenue.
- Top managers instructed employees to increase the number of therapy visits provided in order to increase the case mix and revenue.
- A competitive ranking system for management was aimed at driving therapy visit patterns toward profitable levels.
- Evidence that management discussed increasing therapy visits and expanding specialty programs to increase revenue.

Wall Street Journal article of December 22, 2010

Dr. Christopher Wayne, an osteopath, took in more than \$1.2 million from Medicare in 2008, a large portion of it from physical therapy. (That’s more than 24 times the Medicare income of the average family doctor.) The regimen of physical therapy Dr. Wayne said he usually provided – 30 minutes each of heat packs, massage, electrical stimulation and ultrasound – is also unusual. He said he trained “girls” (not physical therapists) to provide physical therapy.

Office of Inspector General Report regarding Skilled Nursing Facilities, November 2012

OIG reviewed a sample of skilled nursing facility (SNF) claims for 2009. It found SNFs billed one-quarter of all claims in error in 2009 resulting in \$1.5 billion in inappropriate payments. The majority of the claims were upcoded; many of these claims were for ultrahigh therapy. SNFs commonly misreported information regarding therapy on the MDS and therapists were being pressured to provide more minutes of therapy for patients.

How to protect yourself

- Be familiar with Medicare coverage criteria (keep a copy of applicable local and national coverage policies).
- Know how to access key Medicare reference documents (Medicare Benefits Policy and claims processing manuals).

- Sign up for the Medicare contractor list service and email alerts for open door forums and other educational outreach opportunities.
- Conduct periodic self audits.
- Have at least one dedicated compliance officer.
- Implement the team approach – make sure all personnel have a vested interest in ensuring compliance.
- Contact Medicare contractors, Medicare Regional Offices and APTA for information.
- Capitalize on continuing education opportunities.

Appeal rights

You have an appeal right when your carrier/intermediary/MAC determines an overpayment occurred on pre-payment or post-payment review. There are five levels of appeal and each level has different requirements. That includes re-determination, re-consideration, administrative law judge (at this point the government will start to recoup money), Medicare Appeals Council and Federal District Court.

Asserting Professional Integrity Campaign

Of 871 respondents to an APTA survey, 18% said they had witnessed fraud in the past 12 months and another 7% said they were not sure. Key concerns were cuts in payment (60%), regulatory burden (53%) and fraud and abuse (23%).

Primary areas of compliance concern were:

- More changes to already complex Medicare requirements
- Stricter documentation rules as it relates to electronic health records
- Keeping up-to-date with software improvement to health records and similar systems
- Pressure to see more patients and efficiently manage their time

APTA's goal is to be a leader and partner in the effort to eliminate fraud and abuse from healthcare and strengthen the good reputation of physical therapy in the healthcare system.

Other goals are to educate members, nonmembers, new professionals and students so they can avoid pitfalls that invite more scrutiny and payment cuts, and focus on delivering value and quality in practice. APTA also will advocate on behalf of physical therapists and the professions to reduce or prevent further burdensome regulation and oversight and preserve freedom to practice and communicate efforts and highlight solutions through every channel while showing buy-in from partner organizations who are key stakeholders in healthcare.

Moving forward APTA is

- Developing a CE module to address physical therapists' key concerns to reduced payments and burdensome regulations, to define fraud and abuse and connect the dots between compliance and their concerns.

- Partnering with other key healthcare stakeholders.
- Publishing a white paper on APTA's value/vision statement that recommends solutions to the problems which it will share with policymakers.
- Publishing articles in "PT in Motion" and "Perspectives."
- Creating tools for advocacy.



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Gayle Lee, JD has over 15 years of experience working on health care issues impacting the rehabilitation industry. Currently, Gayle serves as the Senior Director of Health Finance and Quality for the American Physical Therapy Association (APTA). As the department's Federal payment policy expert, Gayle's key areas of responsibility include Medicare, Medicaid, HIPAA, and health care reform. She specifically works on regulations that impact physical therapists that practice in skilled nursing facilities, home health agencies, rehabilitation hospitals/units, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, and private practice settings.

Gayle came to APTA from the American Rehabilitation Association, where she was Assistant Counsel and Policy Coordinator. She worked on issues that affected rehabilitation hospitals/units and CORFs. Gayle received her law degree at the Washington College of Law at the American University in Washington, DC and completed her undergraduate work at Pennsylvania State University located in University Park, Pennsylvania.