



## Fraud & Abuse: Part 2

*This article was developed from a presentation by Stephen M. Levine, PT, DPT, MSHA, a partner in Fearon & Levine Consulting, at the 2013 FSBPT annual meeting.*

### ***How some therapists beat – or lost – the charges of Medicare abuse and fraud***

The definitions of fraud and abuse are very different.

#### **Definitions**

*Fraud* is knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

*Abuse* is that which may directly or indirectly result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment but the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

*False Claims Act:* Any person who knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval; knowingly makes, uses or causes to be made, a false record or statement to get a false or fraudulent claim paid or approved; conspires to defraud the government by getting a false claim paid or approved or knowingly makes, uses or causes to be made, a false record or statement to conceal, avoid or decrease an obligation to pay money or property to the Government.

*Knowing and Knowingly:* Has actual knowledge of the information, acts to deliberately ignore the truth or falsity of information or acts in reckless disregard of the truth or falsity of the information, and no specific intent to defraud is required.

*Reckless disregard:* An act of proceeding to do something with a conscious awareness of danger, while ignoring potential consequences of doing so.

## Cases of abuse

### *Private practice neurological caseload*

*Case facts:* A disgruntled employee reported a practice that triggered an audit of Medicare patients. It was initiated by a Medicare Administrative Contractor (MAC) and referred to Western Integrity Center (WIC). It involved five patients; 201 lines of service were reviewed and denied. The payer requested a \$90,000 refund.

*Audit time frame:* 2008-2010, records reviewed were from January 1, 2006 to December 31, 2008

*Practice profile:* There was one location that provided PT/OT services. The practice was enrolled as a PTPP, billed over 50% Medicare, had multiple episodes of care per patient and multiple certification periods within an episode. There was high use of the KX modifier, and it was typical for beneficiaries to be seen under both PT and OT plans of care (POC).

*Timeline:* The complaint was filed in September 2008; records were requested in January 2009 and the referral to WIC was in February 2009.

*Reason for Review (letter to provider):* "The review was conducted because analysis of your billing data showed that you may be billing inappropriately for services you rendered to Medicare beneficiaries. The Western Integrity Center is reviewing these claims in conjunction with the medical records to ensure that the services billed were properly supported by the required medical record documentation and were reasonable and necessary for Medicare reimbursement."

This was a probe audit. The given reasons for denial were insufficient information, "not medically necessary" and non-covered service. The other issues were use of unqualified personnel, billing for more than one provider's services under an individual provider number and reporting of the KX modifier in 81% of cases.

There were long episodes of care for patients with dates of onset years prior to the episode being reviewed. WIC could not determine progress given the lengths of stay. Clinical approaches did not support skill service definitions. Also, there was some confusion about differences between OT and PT plans of care and provider status.

*Data:* The average number of units per day was 16; the average number of visits per episode was high and lengths of stay were above average. The evaluating therapist was not always the treating therapist (which was noted as an observation); the home exercise program was documented in broad/vague terms and infrequently, and the patient demographics were not consistently noted on documents.

This is what occurred:

- March 2009 - The FBI made an onsite visit. The agent identified himself and asked for the PT owner's identification and the file of the employee who reported the complaint. He interviewed the PT and discussed the complaint and the resulting Medicare audit. He also inquired about billing practices, demographics of the practice, referral sources and their patterns and the Medicare payment policy. The FBI agent walked through the clinic and observed care. The therapist documented the visit in detail and met with his staff to debrief and educate.
- September 2009 - The claims were all denied and the money was requested back. The therapist proceeded to the first level of appeal. The provider has 120 days from the date of denial to request re-determination. A carrier/Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC) can recoup on post-payment audits on the 60<sup>th</sup> day after the denial letter if an appeal is not filed by that date. Most providers will be unsuccessful at this level but must go through it to protect future appeals.
- October 2009 – The therapist engaged a Medicare attorney to assist with the second level of appeal. The attorney becomes the provider's contact with CMS and the Safeguard contractor and makes sure all timelines are adhered to by the provider, audit contractor and CMS. The attorney provides legal advice related to the content of appeal documents submitted during the re-determination appeal and hires experts to work with the provider in assembling appeals documentation and understanding any compliance-related issues moving forward. He also provides attorney/client privilege. The second level of appeal was triggered when the provider receives the second denial letter from the carrier/FI/MAC. The Qualified Independent Contractor (QIC) is responsible. The provider has 180 days from the date of the unfavorable determination to request the re-consideration. This is the provider's opportunity to educate the auditor as to how their records and practice meet the compliance requirements being questioned and to achieve a reversal of the denial. The QIC must render its decision within 60 days; if the deadline is not met, the appeal can be escalated to the next level. Only evidence submitted before the issuance of the QIC's decision can be considered in subsequent appeals absent "good cause." There is no live testimony. The carrier/FI/MAC can recoup following an unfavorable decision by the QIC even though the provider has additional appeal rights.
- February 2010 – The provider submits appeal materials, including documentation of practice support from physicians, other referral sources and patients. He also provides practice highlights, a clinic overview, clinical outcomes, patient satisfaction and pertinent examples of evidence for the clinical programs. Also included are the credentials of all staff and their roles in the practice, Information was tabbed by patient with the dates seen and there were clinical staff and support staff signature pages, clinic forms and documentation that included evaluation, re-evaluation and certifications integrated into treatment notes according to date and all billing records related to case.

Due to the efforts by this provider, the decision was favorable. (The keys to success were that the provider responded in a timely and thorough fashion, handled onsite agency interviews professionally, explained and updated events to the staff and engaged an attorney familiar with the appeals process). The denials were completely overturned and there was no subsequent pre- or post-payment review. It was recognized that compliance and clinical excellence co-exist as inherent components of this practice.

- May 2010 – The provider was notified of reversal of denials
- August 2010 – The provider had funds repaid to practice

*Northern California payer: Medicare*

*Case facts:* Audit activity was initiated based on a claims trend in the geographic area. Medicare requested records and denied claims. The provider appealed the decision and the decision was upheld. When the provider appealed on the second level, the decision was also unfavorable. The provider appealed at the third level of Administrative Law Judge.

*Issues:* There was a lack of appropriate certification of the plan of care, the owner National Provider Identifier (NPI) and Medicare provider number was used for billing of services provided by other PTs in the clinic and there was a lack of documented medical necessity for billed services.

*Outcome:* 780 cases were paid, five were denied. The therapist avoided payback of approximately \$79,000. The cost for the appeals process was \$15,000.

*New England; Payer: Medicare and Anthem BC*

*Case facts:* An apparently disgruntled employee initiated action. The Program Safeguard Audit requested 10 records with five days to comply and picked up the records in person. Eight months later, Anthem Blue Cross Special Investigations Unit (SIU) demanded documents on 10 patients and initiated confiscation of clinic/office materials by the FBI and the Department of Justice.

*Issues:* There was total disorganization of the clinic processes relating to coding, documentation, compliance and storage (files were not locked), and there was lack of awareness/compliance with regulation, the practice act and payment policies (particularly in aquatic therapy).

*Outcome:* A corrective action plan was developed but not followed. The government decided to pursue criminal charges in addition to \$1 to \$1.5 million in Civil Money Penalty (CMP); criminal charges were later dropped. The provider was asked to pay \$250,000 and received five years in prison to be stayed if he corrected his behaviors.

*Midwest – Payer: BCBS*

*Case facts:* The audit was initiated based on a claims trend of billing for aquatic therapy and

land-based therapy on the same date of service. The BCBS audited the practice and referred the case to the local U.S. Attorney's office. The FBI then confiscated all practice management data from one of two clinics.

*Issues:* There was a lack of appropriate documentation to support billed charges and use of support personnel to provide and bill services. Also, the therapist was providing direct contact vs. group therapeutic procedure in terms of coding.

*Outcome:* It took more than two years for the government to close the case with no action based on the provider's activities to demonstrate education and compliance. The provider received education regarding the billing of therapy services. There was no payment, but the fact that a provider is under investigation by the FBI sets up uncomfortable situations.

### **Additional activity**

*Practice Profile:* A provider with two locations and three physical therapists billed Medicare with no signed certifications, no signatures on referrals and no signatures on treatment notes. Documentation included the functional goals, but there was no mention of them after the IE. The provider had to pay \$900,000 liability in addition to the cost of counsel and appeal efforts.

*Practice Profile:* A provider had one location with two physical therapists, a PTA and an OT. He improperly billed BCBS for services as reflected in the number of units billed versus the time documented in the records (and schedule). The outcome was a \$500,000 payment to Blue Cross in addition to the cost of appeals.

### **How to prepare for an audit**

It is important to know and understand the rules.

- Compliance plans are proactive and are a central source of information on regulations/policy/company directives for a practice. They will be required soon.
- Corrective action plans are not required but detail specific education and training, ensure ongoing compliance and provide benchmarks to assess improvement.
- Corporate integrity agreements have written standards, training and education.
- Minimize errors and prevent penalties before they occur.
- Be aware of federal laws, regulations, payer communications and Medicare Manual provisions.
- Be familiar with the Office of Inspector General reports and fraud alerts.
- Know where previous improper payments have been found.
- Pre-audit with self examination to determine if claims are being submitted in error and if there are vulnerabilities.
- Correct problems before the government or payer arrives.

- Be consistent with standard of care.
- Off-site storage must be under lock and key.
- Understand definitions of medical necessity used by Medicare and private payers in your practice.
- Ensure documentation supports medical necessity.
- Be prepared to respond to requests for medical records.
- Designate an audit contact person, closely track medical record requests and respond in a timely fashion.
- Appeal when necessary.
- Utilize experts/consultants in areas of need.
- Hire experts through legal counsel.
- Stay involved with your professional association.



**Stephen M. Levine, PT, DPT, MSHA**

*Partner, Fearon & Levine Consulting*

Steve Levine is a partner in Fearon & Levine, a national consulting firm focusing on practice management and payment policy in the outpatient rehabilitation setting, with particular expertise in the areas of documentation, coding, and compliance. Dr. Levine is a nationally recognized expert in the areas of CPT coding and relative values, RBRVS, fraud and abuse, payment/reimbursement strategies for physical therapy services, electronic health records, and physical therapy documentation, utilization review, and medical necessity. He has worked extensively with federal investigative and law enforcement agencies, including the OIG and DOJ in the areas of fraud, abuse, medical necessity, over-utilization, and medical policy review.