Fighting Health Care Fraud

By Asserting Professional Integrity

Sharon Dunn, PT, PhD, OCS
Vice President, APTA

You've Seen the Headlines…

Miami Herald Politics Wires

89 arrested in crackdown by Medicare Fraud Strike Force

WASHINGTON -- Doctors, nurses and other licensed medical professionals were among 89 people recently arrested in nine cities, accused of scheming to defraud the Medicare program of nearly $223 million in false billings, the Obama administration announced Tuesday.

HHS.gov @HHSGov

Medicare Fraud strike force charges 89 individuals for approximately $223 million in false billing: 1.usa.gov/10W3jVz

Reply Retweet Favorite More

36 RETWEETS 5 FAVORITES

12:54 PM - 14 May 13

MLive All Michigan

Jury finds Detroit-area physical therapy providers guilty in $2.3 million Medicare fraud case

By Khalil AlHajal | kalhajal@mlive.com

DETROIT, MI -- The FBI announced a pair of new health care fraud convictions Wednesday.

The guilty verdicts add to a long list of convictions in recent months related to Detroit-area health care agencies that took advantage of Medicare and Medicaid.

Mehran Javidan, who owned Acure Home Care Inc. in Oak Park and Troy, was accused of paying doctors to refer patients for physical therapy treatment that was medically

DID YOU KNOW: If Your Car Is Over 3 Years Old, You Are Being Ripped Off By Not Using This One Ridiculously Easy Trick

SEPTEMBER 2013

The Government is forcing drivers to purchase auto insurance. Drivers who use this trick are able to get their insurance for about

Alexia Fodere

Dr. Christopher Wayne, Florida's 'Rock Doc,' once earned a big part of his income from Medicare physical -therapy payments.

But do you know the rest of the story?

- What follows is a chronological story of the bull's eye on our profession.

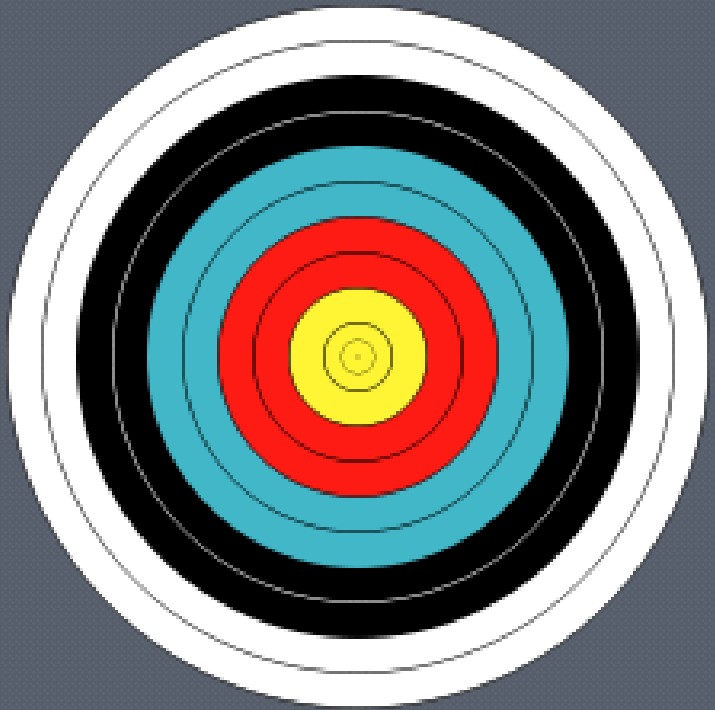
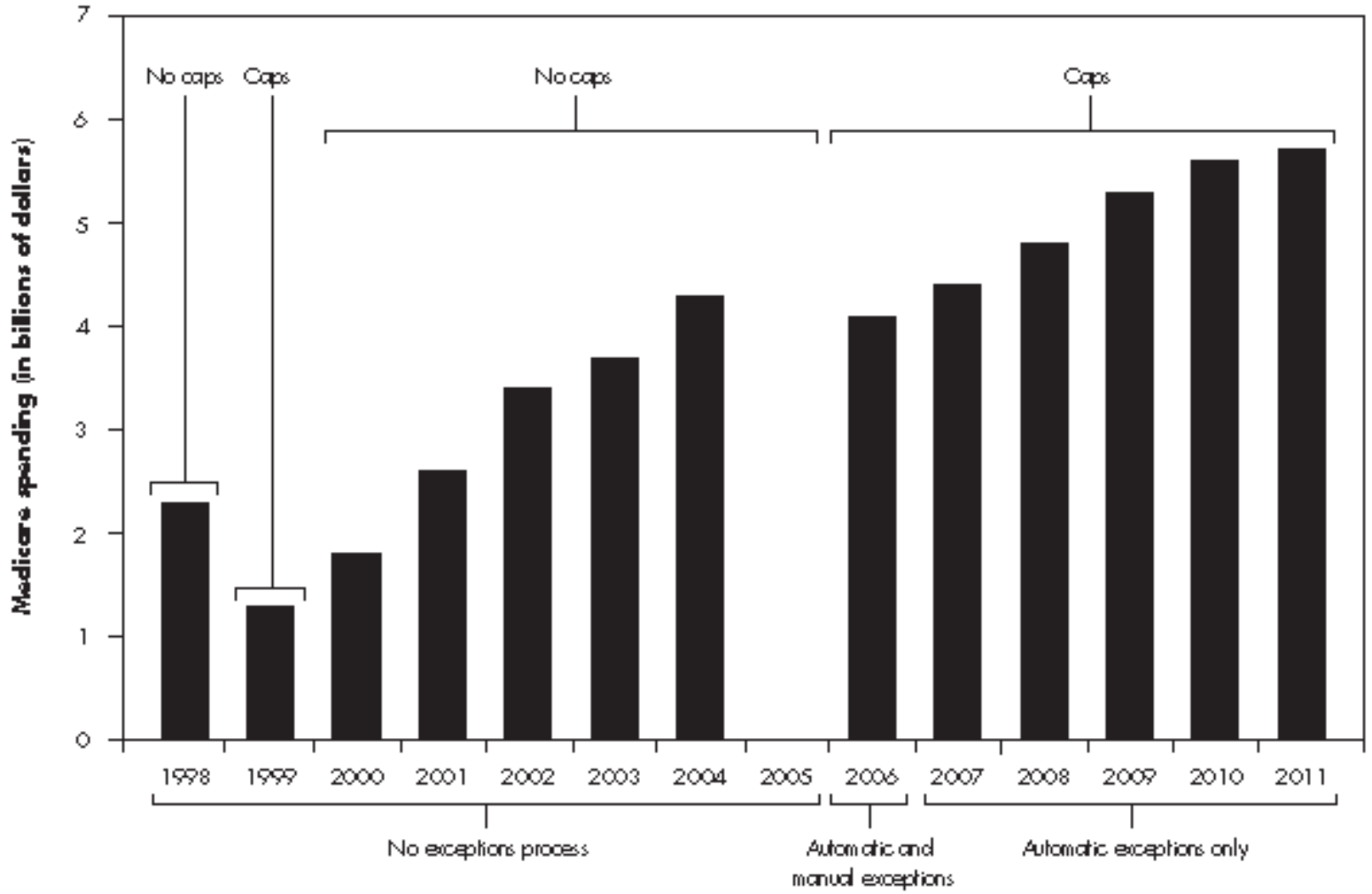


FIGURE 9–2

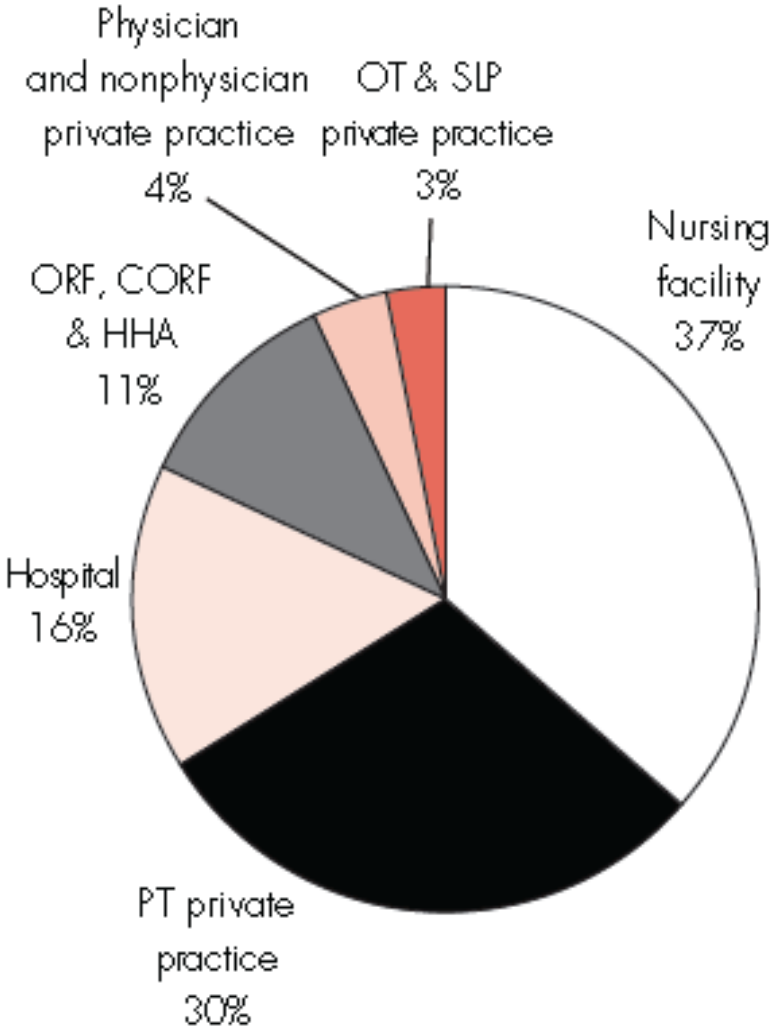
Total Medicare spending on outpatient therapy services, 1998–2011



Note: Caps were in effect for a brief period from September 1, 2003, through December 7, 2003. Data were not available for 2005.

Source: MedPAC analysis of Medicare claims data and CMS contractor reports.

Figure 1 Distribution of outpatient therapy spending by setting, 2011



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive outpatient rehabilitation facility), HHA (home health agency), OT (occupational therapy), SLP (speech–language pathology).

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

QUESTIONABLE BILLING FOR MEDICARE OUTPATIENT THERAPY SERVICES

Daniel R. Levinson
Inspector General

December 2010
OEI-04-09-00540

RECOMMENDATIONS

We found that high-utilization counties had high levels of per-beneficiary spending and questionable billing characteristics compared to national levels. Our findings demonstrate that outpatient therapy services in Miami-Dade County, as well as 19 other high-utilization counties nationwide, warrant additional review as part of ongoing Medicare antifraud activities.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

Target outpatient therapy claims in high-utilization areas for further review. CMS should monitor utilization trends and use this information to target providers in geographic areas that may be susceptible to fraud.

Target outpatient therapy claims with questionable billing characteristics for further review. CMS should use the questionable billing characteristics we identified to analyze and monitor claims data to detect and deter fraud and abuse.

Review geographic areas and providers with questionable billing and take appropriate action based on results. Prior to payment, CMS should review claims submitted by providers with high levels of questionable billing and in geographic areas with high utilization to ensure that they are legitimate. If CMS determines that fraudulent claims have been submitted, it should take steps to suspend payments to these providers and recover overpayments to them.

Revise the current therapy cap exception process. We found that providers in high-utilization counties used the KX modifier and exceeded annual therapy caps at levels much higher than the national average. The current therapy cap exception process does not ensure appropriate utilization of Medicare outpatient therapy services. CMS should consider developing per-beneficiary edits and maximum payment amounts to control overutilization of outpatient therapy services.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on this report, CMS concurred with all four of our recommendations and described actions it would take to address them. We support CMS's efforts to address these issues and encourage it to continue making progress in these areas. We did not make changes to the report based on CMS's comments.

Figure 1: Counties With Highest Utilization of Medicare Outpatient Therapy Services, 2009

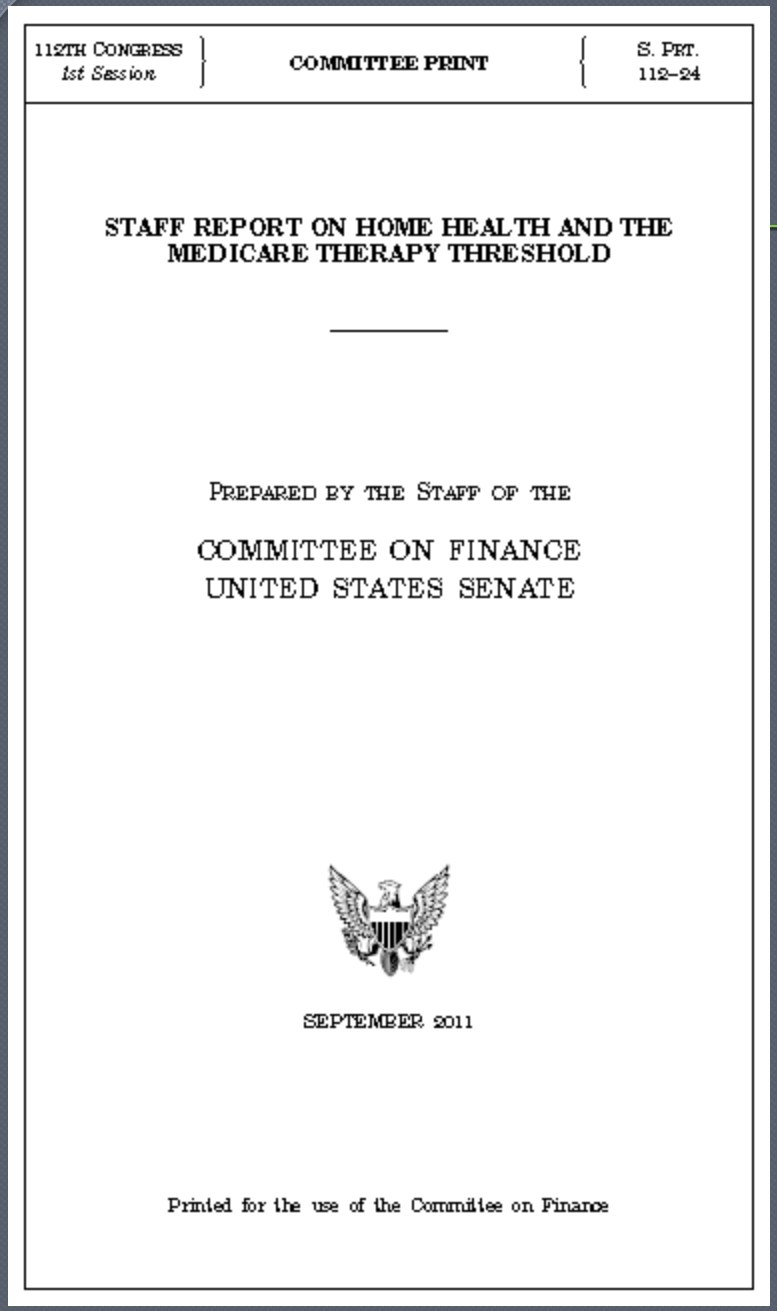
Questionable billing characteristics. By using past OIG work on Medicare billing and in consultation with representatives of the Medicare PSCs, we identified six billing characteristics that may indicate fraud in outpatient therapy services. For example, a high prevalence of these characteristics may indicate inappropriate billing, such as providers' billing for services that were unnecessary or not provided. These characteristics were:

Key Questionable Billing Practices

- Overutilization of KX modifier
- KX modifier need identified on first date of service
- Multiple providers per beneficiary
- Excessive length of episode
- Multiple services leading to exceeding cap
- More than 8 hours billed in a single day by one provider

Table 1. Medicare Outpatient Therapy Services in Miami-Dade County Compared to National Levels, 2009

Outpatient Therapy Utilization	Miami-Dade County Average	National Average*	Ratio of Miami-Dade County Average to National Average
Medicare payments per beneficiary	$3,459	$1,078	3:1
Number of services per beneficiary	158	49	3:1
Medicare payments per provider serving beneficiaries in a county	$83,867	$10,131	8:1
Number of services per provider serving beneficiaries in a county	3,628	458	8:1



112TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
112–24

STAFF REPORT ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD

PREPARED BY THE STAFF OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

SEPTEMBER 2011

Printed for the use of the Committee on Finance

- Senate finance Committee released an investigative report on 4 home health agencies in October 2011. 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" tasked with developing programs to target the most profitable Medicare therapy treatment patterns.
  - Therapists and regional managers that were pressured to follow new clinical guidelines developed to maximize Medicare reimbursements.
  - Top managers instructed employees to increase the number of therapy visits provided in order to increase case mix and revenue.
  - A competitive ranking system for management aimed at driving therapy visit patterns toward profitable levels.
  - Evidence that management discussed increasing therapy visits and expanding specialty programs to increase revenue.

APTA
American Physical Therapy Association

NEWS RELEASE

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

APTA RE-AFFIRMS COMMITMENT TO ELIMINATING FRAUD AND ABUSE

For Release October 7, 2011

Contact: Maryann DiGiacomo
703/706.8526
maryanndigiacomo@apta.org

ALEXANDRIA, VA -- The American Physical Therapy Association (APTA) commends the Senate Finance Committee for the report it released on October 3 regarding the provision of Medicare home health care services. The report, prompted by articles published in the *Wall Street Journal* in 2010, uncovered efforts on behalf of some companies to pressure therapists to provide excessive services to Medicare beneficiaries. Fraud and abuse has no place in the provision of health care services and APTA is committed to working with the Committee, Congress, and the Centers for Medicare and Medicaid Services (CMS) to address the problems that exist.

"Physical therapy is an essential health care service that Medicare beneficiaries count on to help them regain function and independence," stated APTA President R. Scott Ward, PT, PhD. "No physical therapist should be placed into a situation by an employer to provide excessive or unwarranted services to Medicare beneficiaries or any other patient. Physical therapists are licensed professionals and those practicing inappropriately should be reported to their state licensure boards."

"As a health care profession, physical therapists who provide unwarranted care for financial gain of their employer or themselves is unacceptable," said Cindy Krafft, PT, MS, president of APTA's Home Health Section. "APTA commits to working with the Senate Finance Committee, Congress, and CMS to ensure appropriate delivery of physical therapist services in all practice settings."

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INAPPROPRIATE PAYMENTS TO SKILLED NURSING FACILITIES COST MEDICARE MORE THAN A BILLION DOLLARS IN 2009

Daniel R. Levinson
Inspector General

November 2012
OEI-02-09-00200

WHY WE DID THIS STUDY

In recent years, the Office of Inspector General has identified a number of problems with billing by skilled nursing facilities (SNF), including the submission of inaccurate, medically unnecessary, and fraudulent claims. Further, the Medicare Payment Advisory Commission has raised concerns about SNFs' improperly billing for therapy to obtain additional Medicare payments. In fiscal year (FY) 2012, Medicare paid $32.2 billion for SNF services.

WHAT WE FOUND

SNFs billed one-quarter of all claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded; many of these claims were for ultrahigh therapy. The remaining claims in error were downcoded or did not meet Medicare coverage requirements. In addition, SNFs misreported information on the MDS for 47 percent of claims. SNFs commonly misreported therapy, which largely determines the RUG and the amount that Medicare pays the SNF.

Table 1: Percentage of SNF Claims That Were in Error, 2009

Type of Error	Percentage of SNF Claims
Inaccurate RUGs	**22.8%**
Upcoded	20.3%
Downcoded	2.5%
Did Not Meet Coverage Requirements	**2.1%**
Total error rate	**24.9%**

Source: OIG analysis of medical record review results, 2012.

WHAT WE RECOMMEND

We recognize that the Centers for Medicare & Medicaid Services (CMS) has recently made several significant changes to SNF payments. However, more needs to be done to reduce inappropriate payments to SNFs. We recommend that CMS: (1) increase and expand reviews of SNF claims, (2) use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs, (3) monitor compliance with new therapy assessments, (4) change the current method for determining how much therapy is needed to ensure appropriate payments, (5) improve the accuracy of MDS items, and (6) follow up on the SNFs that billed in error. CMS concurred with all six recommendations.

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510–6200

May 2, 2012

To Members of the Health Care Community:

According to the Government Accountability Office (GAO), few programs are as much at risk for fraud, waste and abuse as the Medicare and Medicaid programs. Estimates of the amount of fraud and misspending in these programs vary widely, from $20 billion to as much as $100 billion. Just this week, testimony before the Senate Finance Committee underscored the seriousness of this problem, as witnesses testified that while much has been accomplished in the fight against fraud and abuse, much more needs to be done. As Senators and members of the Finance Committee, we have a duty to ensure that taxpayer funds are being spent wisely.

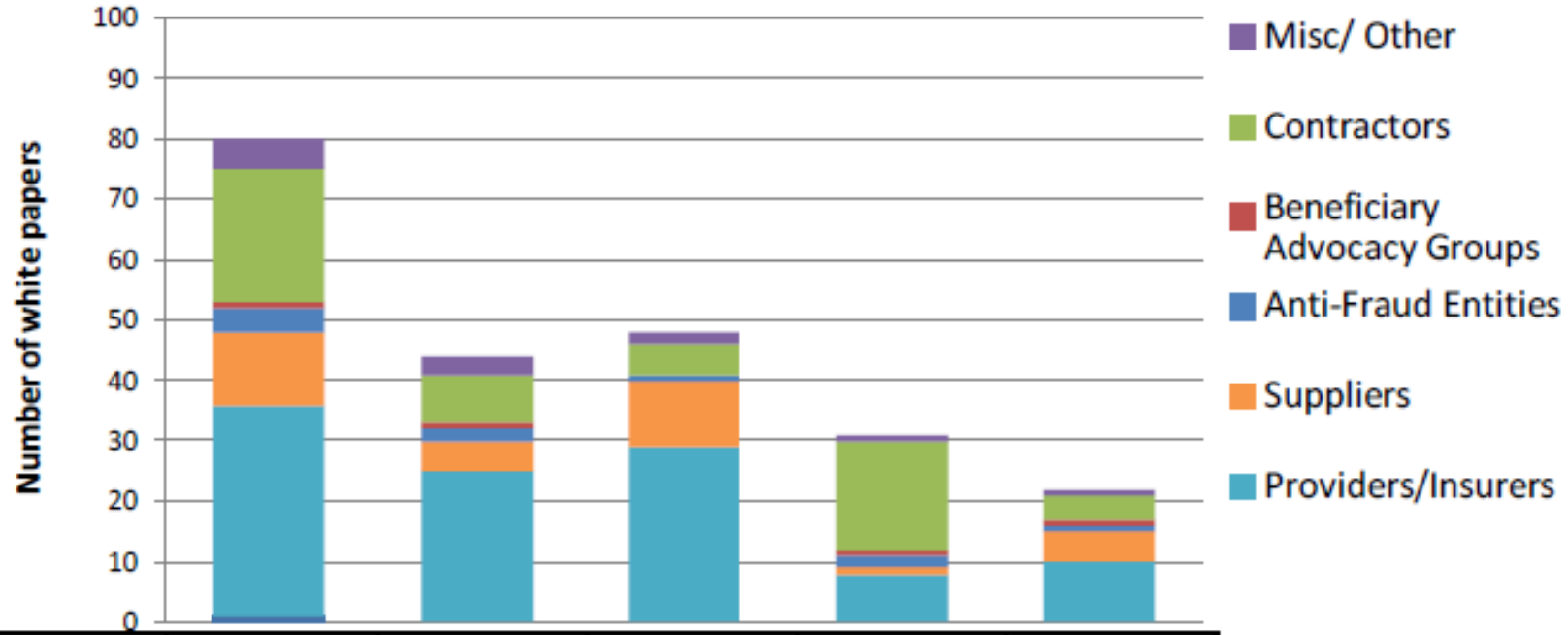
Opportunities To Curb Waste, Fraud and Abuse in Medicare and Medicaid

An Overview of White Papers Submitted At The Request Of The United States Senate Finance Committee

A Joint Initiative by Senators Baucus, Hatch, Grassley, Carper, Wyden and Coburn

January 2013

Figure 2: Frequency of Key Themes Inclusion in White Papers



Key Themes	Improper Payment	Beneficiary Protection	Audit Burden	Data Management	Enforcement
Number of white papers discussing theme	79	44	48	31	22
Percent of white papers discussing theme	54%	30%	33%	21%	15%

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

SPECTRUM REHABILITATION, LLC, CLAIMED UNALLOWABLE MEDICARE PART B REIMBURSEMENT FOR OUTPATIENT THERAPY SERVICES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

June 2013
A-02-11-01044

WHY WE DID THIS REVIEW

Medicare Part B covers outpatient therapy services. Total payments for these services have increased annually, with the rate of growth in payments exceeding the rate of growth in numbers of beneficiaries treated. In addition, previous Office of Inspector General work has identified claims for outpatient therapy services that were not reasonable, medically necessary, or properly documented.

These deficiencies occurred because Spectrum did not have a thorough understanding of Medicare reimbursement requirements related to outpatient therapy services and did not have adequate policies and procedures to ensure that it billed services that met Medicare requirements.

We recommend that Spectrum:

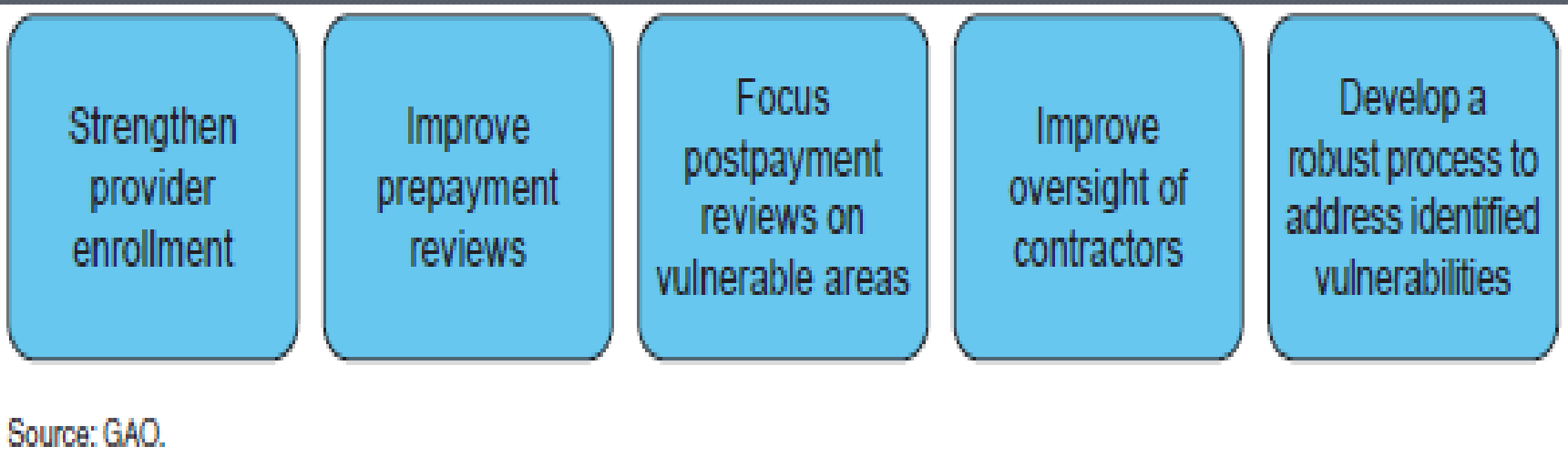
- refund $3,112,501 to the Federal Government;
- strengthen its policies and procedures to ensure that outpatient therapy services are provided and documented in accordance with Medicare requirements; and
- obtain a better understanding of the Medicare reimbursement requirements related to outpatient therapy services, through such means as attending provider outreach and education seminars.

Healthcare Policy Landscape

Better compliance seen as "no-brainer" savings

- ACA "hangover" effects — access addressed, cost looming
- Bipartisan agreement, "easy" political issue
- Budget constraits mean no stone unturned
- Dozens of health groups geared up to fight other cuts

Government Strategies to Reduce Improper Payments



Source: GAO.

On Auditors/Contractors: Which One Does What??

MACs
RACs
&
ZPICs

Oh My!!

Summary of Contractors

Contractor	Claim Types	Claim Selection	Claim Volume	Purpose of Review
CERT	All Claim Types Medicare	Random	Small	Measure improper payment rates
PERM	All Claim types for Medicaid	Random	Small	Measure improper payment rates
MAC (medical review department)	All claim types with Medicare fee for service	Targeted	Depends on this issue and amount of improper payments	Prevent improper payments Provider education
RA (formerly RAC)	All claim types with Medicare fee for service Will begin reviewing Medicaid claims	Targeted	Size depends of the magnitude of improper payments	Detect past improper payment find program vulnerabilities
ZPIC	All claim types with Medicare fee for service Medi- Medi in some states	Targeted based on potential fraud and abuse	Size depends of the magnitude of potential fraud and abuse	Identify fraud, waste, and abuse

Example

- RA or CERT find high payment error for a specific service
  - May suggest the MAC review these services
  - Request overpayment from provider
- MACs begin widespread probe and determine what providers have problems (high denials)
  - Provider education
  - Medical review
  - If problem continues or they suspect fraud, they make referral to ZPIC
  - Request overpayment for services
- ZPIC does analysis, possible onsite and or medical review.
  - Request overpayment
    - Extrapolated
    - Actual
  - If the problem is significant
    - Make referral to law enforcement,
    - Ask for payment suspension or revocation

Government Enforcement Trends Impacting the Practice of Physical Therapy and the Art of Staying Compliant

David M. Blank

Senior Counsel
Office of Counsel to the Inspector General
Administrative and Civil Remedies Division
U.S. Department of Health and Human Services

January 22, 2013
American Physical Therapy Association
Combined Sections Meeting
San Diego, California

Health Care Fraud Investigations

- Where do cases come from?
  - Hotline Referrals
  - Compliance Monitoring
  - Competitors
  - Cooperators
  - States
  - Audits and Studies
- Tools used to investigate fraud:
  - Subpoena
  - Testimonial Subpoena
  - Informal Interviews
  - Data Analysis

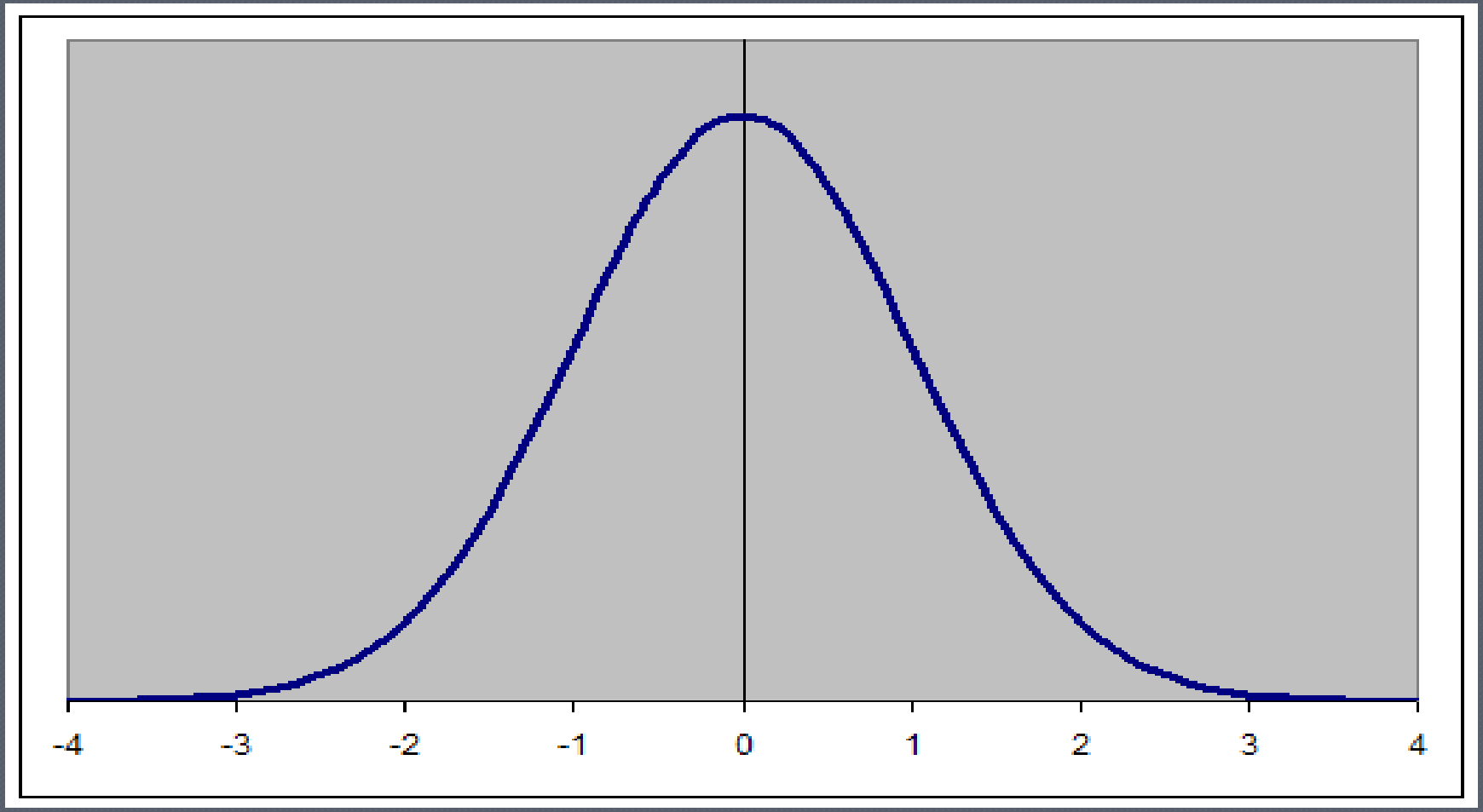
Forensic Data Analysis

- What is it?
  - Data Mining:
    - Process of sorting through large amounts of data and extracting previously unknown information to identify aberrant billing trends that would otherwise remain hidden.
  - Advantages:
    - Allows for a flexible approach to fraud detection;
    - Uses a larger data warehouse;
    - Identifies a wide range of trends; and
    - Quicker results based on near real-time data.
- How is it used?
  - Identifies abnormalities.
  - Identifies patterns and trends of abuse.
  - Identifies cost-saving areas.
  - Allows for assessment of quality of care.

Data Analysis

- The Data:
  - 92.1 million beneficiaries
  - 1.3 million providers
  - 10 billion claims
  - 3 billion new claims annually
- Algorithms allow for the identification of problematic billing trends.
  - 100% Medicare Part A and B claims data dating back to 2001.
  - 2006: 100% Medicare Advantage and Part D data.
  - Data includes: HCFA-1500 Fields, provider demographics, cost reports, beneficiary eligibility data, and other CMS resources.
- The Simple:
  - Physical Therapist Provider Number – place of service – hours of billing.
- The Complex:
  - Identifying normative billing patterns for physical therapist and/or clinics and analyzing that data set to identify outliers.
  - The bell curve method.

Investigation Techniques: The Bell Curve



In the News….

- Chyawan Bansil, P.T., Ph.D. (Oct. 29, 2012)
  - Nerve conduction studies and electromyography tests.
  - $1 million fraud.
  - 13 months in prison and more than $2.75 million in fines and restitution.

- Godwin Chiedo Nzeocha (Oct. 19, 2012)
  - Operated Houston-based physical therapy clinic.
  - Created fraudulent patient charts indicating therapy was provided. No therapy was ever rendered.
  - Billed $42 million and received $27 million.
  - Indicted in March 2010. Captured by Nigerian authorities in June 2011 and extradited in June 2012.
  - Pleaded guilty to conspiracy to commit health care fraud.

In the News…

- Strike Force Takedown (Oct. 4, 2012)
  - Los Angeles: 16 people arrested, including three doctors and one physical therapist.
    - $53.8 million fraudulent scheme.
  - Brooklyn: 15 people arrested, including one doctor and four chiropractors.
    - Paid cash kickbacks to beneficiaries for physical therapy that was never provided.
    - $13.8 million fraudulent scheme.
- Irina Shelikhova (June 14, 2012)
  - Paid kickbacks to Medicare beneficiaries to induce them to receive unnecessary physical therapy services and diagnostic testing services.
  - Approximately $70 million fraud scheme.
  - Indicted in October 2011. Arrested June 14, 2012 while entering the U.S. through JFK.
- Strike Force Takedown (May 2, 2012)
  - Miami: 59 people arrested, including three nurses and two therapists.
    - $137 million fraudulent scheme involving home health, PT/OT, DME, and infusion.

In the News…

- Jose Diego Calero (March 2012)
  - Director of Premier Quality Physical Therapy Inc. in Florida.
  - Billed Medicare for PT and OT that was never prescribed or not provided as claimed.
  - $4.8 million fraudulent scheme.
  - Indicted in 2009. Arrested in March 2012 by U.S. Border Patrol while illegally crossing from Mexico.
- Maksim Shelikhov (November 2011)
  - Owned and operated a New York physical therapy clinic.
  - Fraudulent scheme involving physical therapy and nerve conduction tests.
  - $71 million fraudulent scheme.
  - Indicted in October 2010. Arrested November 14, 2011 by Canadian authorities.

Additional Culprits

http://oig.hhs.gov/fraud/fugitives/profiles.asp#other-fugitives

Compliance Issues Facing Physical Therapists

Abuse (Improper Payments)

Unintentional Abuse, or Waste (Much more common in PT):

- Incorrect coding
- Insufficient documentation
- Providing medically unnecessary services (e.g. do not need skills of a therapist)
- Plans of care missing signatures

There is a high improper payment rate for physical therapy services, making PTs a target for audits & increased regulation

Professional Responsibility

Code of Ethics for the Physical Therapist

HOD S05-09-07-12 [Amended HOD S06-00-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-06; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

APTA
American Physical Therapy Association

Principle #3: Physical therapists shall be accountable for making sound professional judgments.
(Core Values: Excellence, Integrity)

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.
(Core Values: Integrity, Accountability)

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

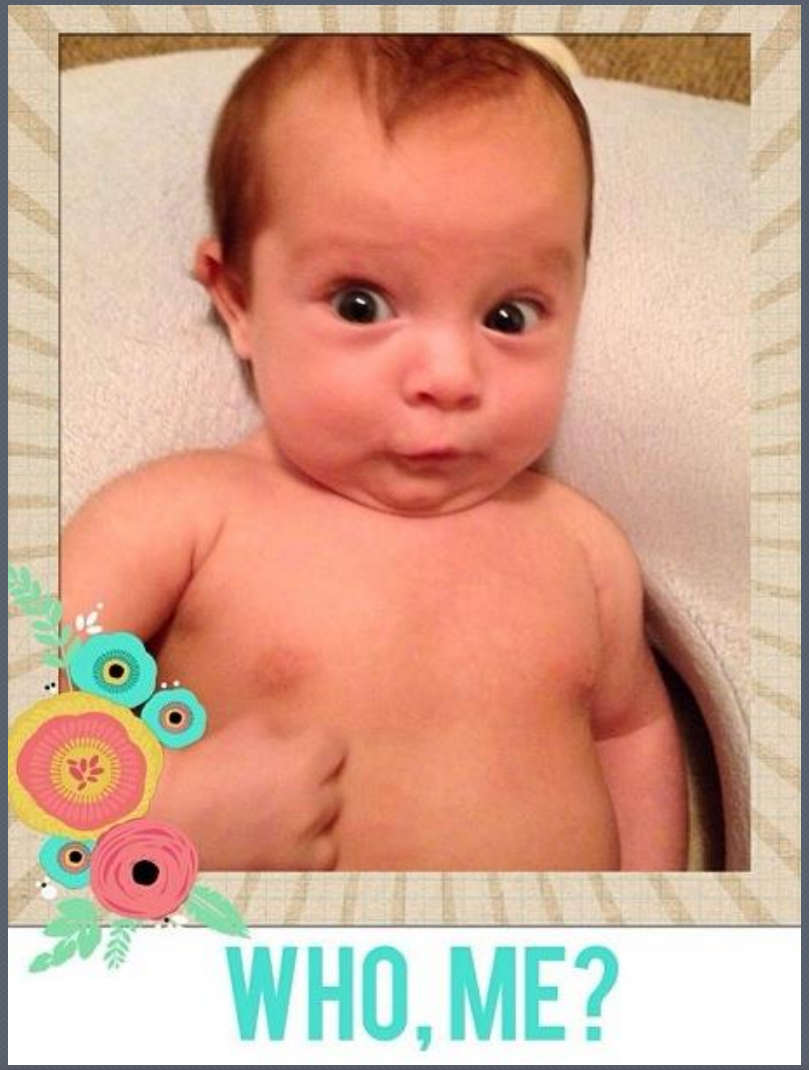
7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients/clients.

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.



RUG Levels and Payment

Therapy Minutes Received by Therapy Level

Therapy Level	Therapy Minutes Received During the Look-Back Period
Ultrahigh	720 or more
Very High	500–719
High	325–499
Medium	150–324
Low	45–149

Source: Centers for Medicare & Medicaid Services, *Resident Assessment Instrument Manual (RAI) Version 2.0*, ch. 6. See also *RAI Manual Version 3.0*, ch. 6.

RUG Category	RUG	Therapy Level	Per Diem Rate FY2009	Per Diem Rate FY2010
Therapy RUGs				
Rehabilitation Plus Extensive Services	RUX	Ultrahigh	$623	$617
	RUL	Ultrahigh	$547	$546
	RVX	Very high	$472	$468
	RVL	Very high	$440	$437
	RHX	High	$400	$396
	RHL	High	$393	$386
	RMX	Medium	$458	$449
	RML	Medium	$420	$413
	RLX	Low	$325	$319
Rehabilitation	RUC	Ultrahigh	$529	$529
	RUB	Ultrahigh	$485	$485
	RUA	Ultrahigh	$462	$463
	RVC	Very high	$425	$421
	RVB	Very high	$404	$401
	RVA	Very high	$363	$364
	RHC	High	$370	$365
	RHB	High	$353	$349
	RHA	High	$328	$326
	RMC	Medium	$340	$335
	RMB	Medium	$331	$326
	RMA	Medium	$323	$320
	RLB	Low	$300	$294
	RLA	Low	$256	$252

Skilled, Rehabilitative, Maintenance

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 179	**Date: January 14, 2014**
	Change Request 8458

SUBJECT: Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius

I. SUMMARY OF CHANGES: In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

http://www.cms.gov/Regulations-and Guidance/Guidance/Transmittals/Downloads/R179BP.pdf

Skilled??

30.4.1.1 - General

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

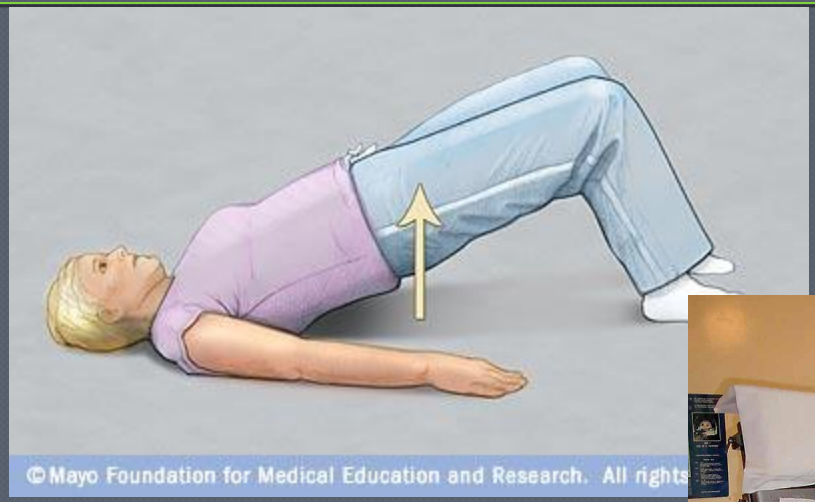
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

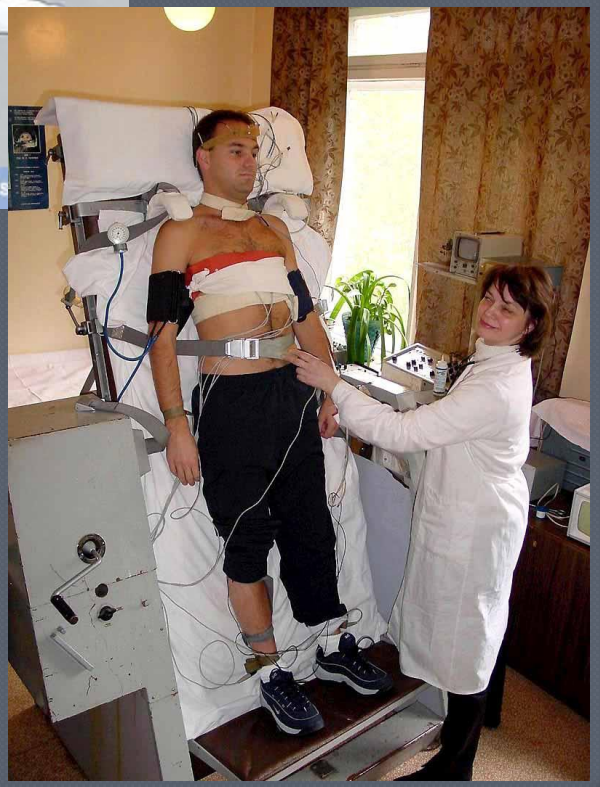
- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the ***establishment*** of a safe and effective maintenance program; *or, the services must require the skills of a qualified therapist for the* ***performance*** *of a safe and effective maintenance program.* ***NOTE:*** *See Section E Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.*

- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Skilled or Unskilled?





Skilled or Unskilled?

Know and Assess Your Risks By Setting

- Outpatient
- Post-Acute Care
  - HH
  - SNF
  - IRF

Risk Areas for Physical Therapists In Outpatient Settings

- Missing Certifications on 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 8 minute rule
- Failing to comply with CCI edits
- Submitting claims for services that provider knows are not reasonable and necessary

Risk Areas for Physical Therapists In Outpatient Settings

- Code Gaming
  - Unbundling (hot pack, dressings)
  - Upcoding (E-Stim)
- 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 request for records

Risk Areas for Physical Therapists in Outpatient Settings

- Signatures not legible (physician on plan of care or PT)
- 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

Risk Areas for Physical Therapists in 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

Risk Areas for Physical Therapists in Post-Acute Care Settings

- Skilled Nursing 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 RUGs groups

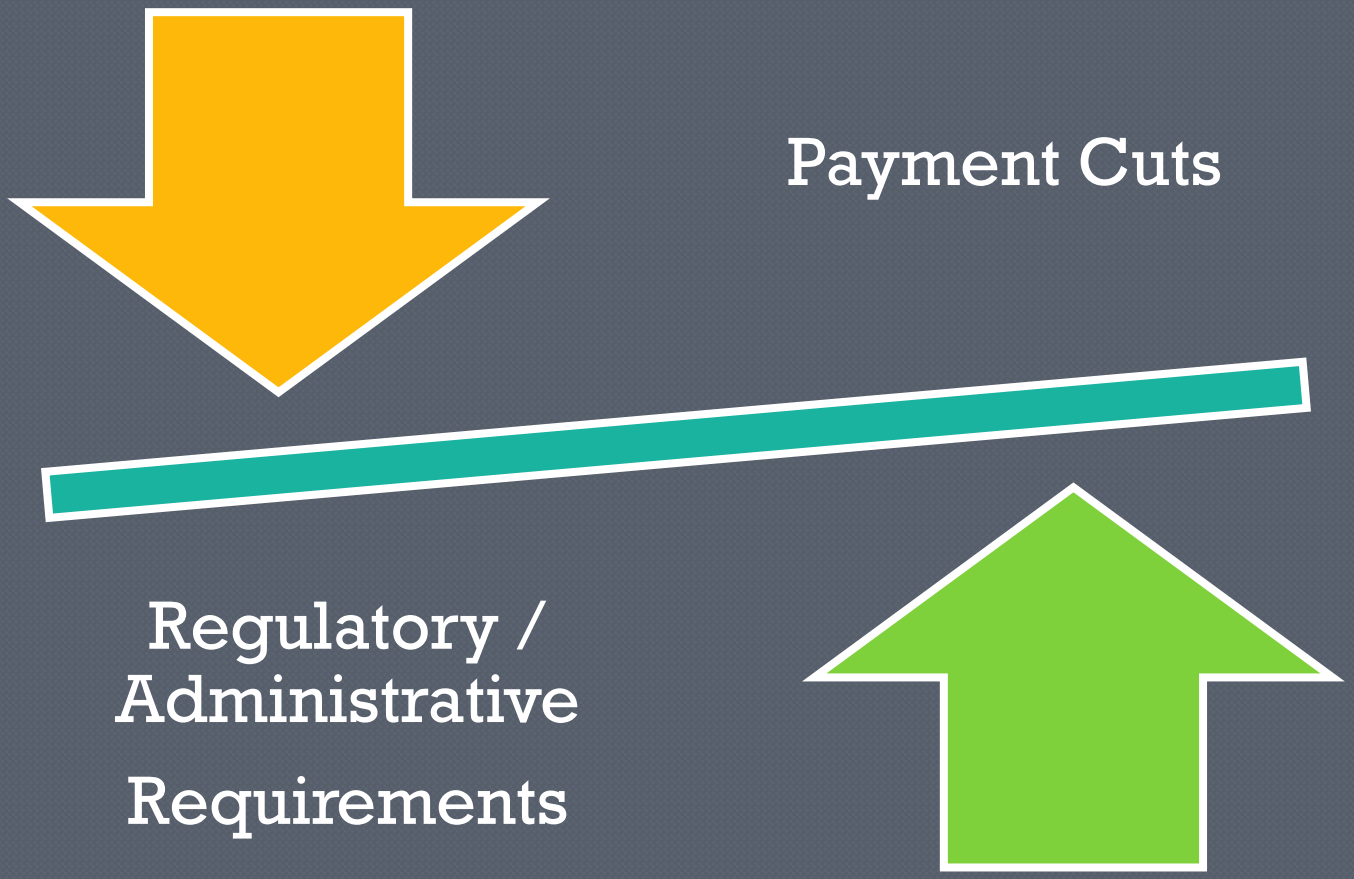
Risk Areas for Physical Therapists in Post-Acute Care Settings

- 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 preadmission screening and post admission evaluation
  - Physician involvement
  - Interdisciplinary team meetings

Compliance

- Important for PTs to remain in the bell curve
- Know the federal and state regulations
- Stay up to date
- Implement compliance plans to prevent fraud & abuse
- Know how to respond appropriately to an audit
- Know where to report fraud and abuse

Immediate: Here and Now



Health Care Reform:

Achieving the Three Part Aim

Health Care Reform

The Patient Protection and Affordable Care Act (ACA) signed into law on March 23, 2010[1]

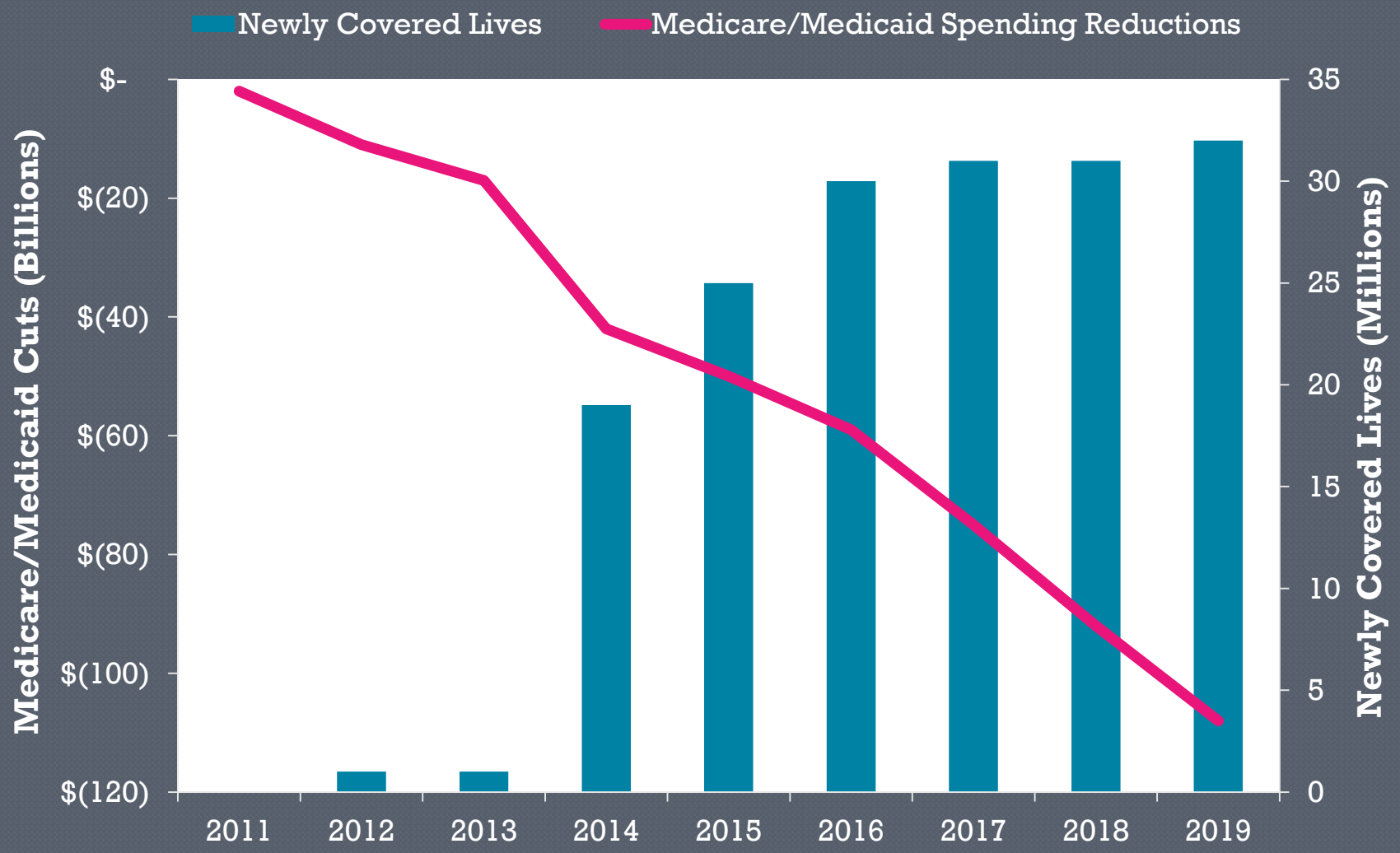
1 **Coverage & Insurance Market Reform**
Make insurance more accessible and affordable for all individuals

2 **Delivery & Payment System Reform**
Pay for quality instead of volume of care

3 **Financing Strategies for Health Reform**
Find sustainable funding to pay for reform provisions

1) The Affordable Care Act is the combination of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

Overall Reform Aims to Expand Coverage and Reduce Spending Over Time



Source: Congressional Budget Office, Score of ACA, March 20, 2010

Payer Activity Related to Bell Curve

- Provider Tier Levels
  - Utilization (units/visit and visits/episode)
  - All prior-approved visits exhausted for all beneficiaries
  - Recent experiences
    - Tricare
    - BCBS in IL – Orthonet being contracted for prior authorization

APTA's Response

Value Proposition
&
Asserting Professional Integrity
Campaign

Tactics to Demonstrate Value Proposition

Identify Best Practices	Adopt Best Practices	Measure Provider Performance	Evaluate Cost Effectiveness
• Use of Performance and Outcome Measures • Contributes to Registry • Create and Revise Clinical Practice Guidelines	• Implement Best Practice / CPGs • Documentation of Performance and Outcomes Measures • Generate Translational Research	• Participate in Quality Reporting • Adopt Health Information Technology • Use of Evidence to Differentiate Performance	• Analyze Relationship between cost and outcome (value) • Conduct cost-effectiveness research

4 Main Campaign Objectives

1) Show APTA as **a leader and partner** in the effort to eliminate fraud and abuse from health care and **strengthen the good reputation of physical therapy** in health care system

2) Educate members, nonmembers, new professionals, and students so they can **avoid pitfalls** that invite more scrutiny and focus on **delivering value and quality** in practice

3) Advocate on behalf of PTs and the profession to **reduce or prevent further burdensome regulation and oversight**, and preserve freedom to practice

4) **Communicate** our efforts and highlight solutions through every channel while showing buy-in from **partner** organizations who are key stakeholders in health care

The Assignment

BUSINESS GOAL

Preserve freedom to practice, reputation of physical therapy profession

POLICY GOALS

Avoid burdensome regulatory action

COMMUNICATIONS GOAL

Demonstrate solution in place, risk addressed. Represent PT interests

Four-Part Program

Define the Problem

Audit and best practices review of compliance efforts by like organizations (for internal purposes)

Commission survey of PT specific issues — highest problem areas, incidence, desired solutions

Forge Credible Solution

Hold Symposium of PT Compliance Task Force with third-party experts to issue a white paper with recommendations on steps for APTA

Design ongoing outreach/updates to ensure high level of continued compliance

Develop suite of PT and consumer tools to educate and empower

Make It Real

Adopt recommendations of task force

Integrate into CE system as pilot

Gather and report results of uptake

Develop messages, materials, and visuals; prepare spokespeople

Pass It On

Determine highest value members and influentials; create stakeholder map

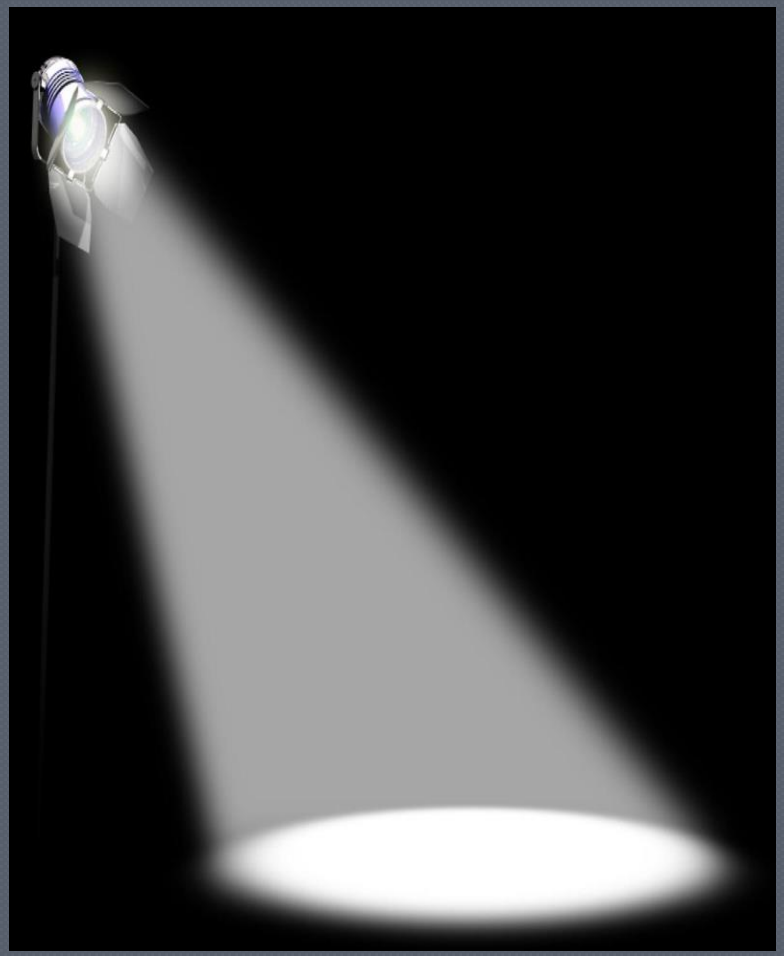
Invite influencers to attend discussion of release of white paper

Create partnerships to extend distribution via influential third parties

Arm lobbyists with comprehensive data, third-party validations, and first-person examples

Targeted earned media outreach, re-reach to add credibility

Define the Problem



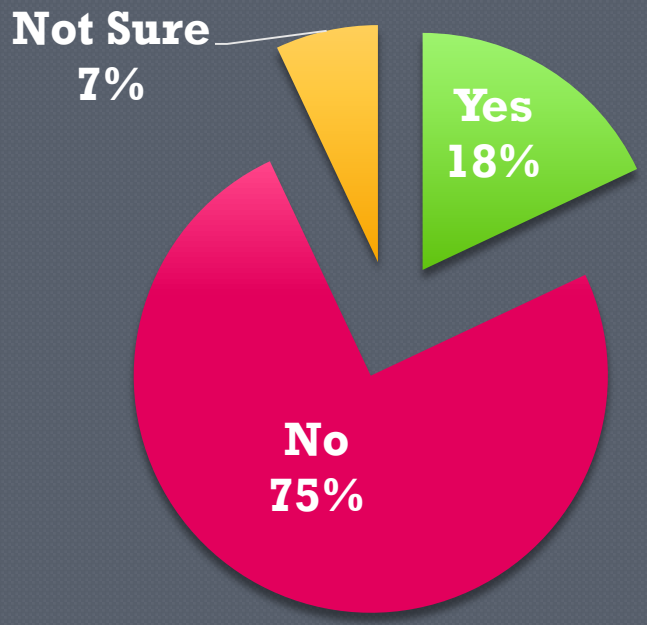
Survey of Physical Therapists. What are the compliance challenges? What would be helpful to address them?

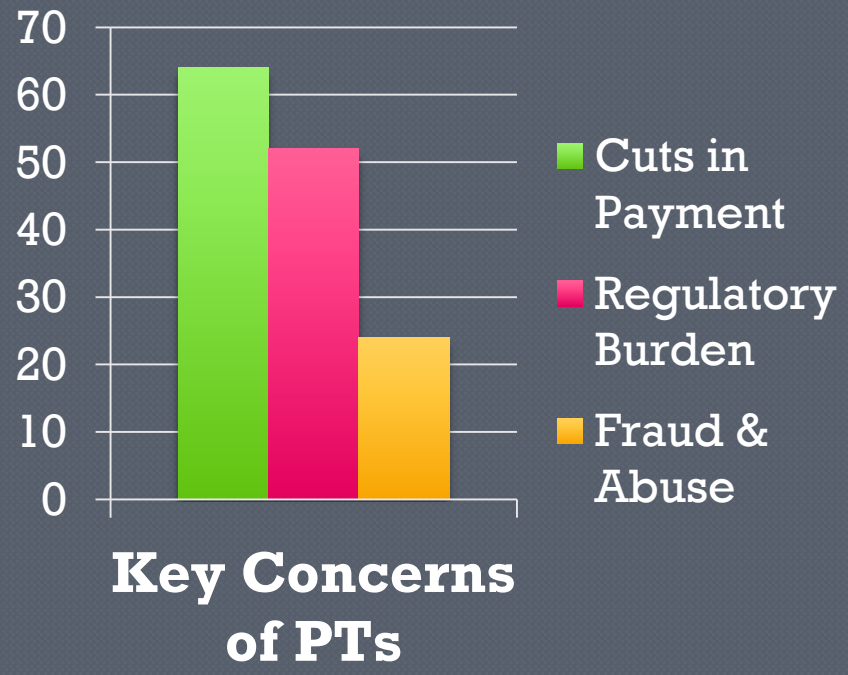
Audit and best practices review of compliance efforts by like organizations (for internal purposes)

Report: *Compliance and Physical Therapy*. Compile a comprehensive database of fraud cases in physical therapy — incidence, geography, trends (for internal purposes)

Survey Sampling

Approx 1 in 6 PTs Witnessed Fraud & Abuse In Past 12 Months





- Survey of 571 member and 300 non-member PTs

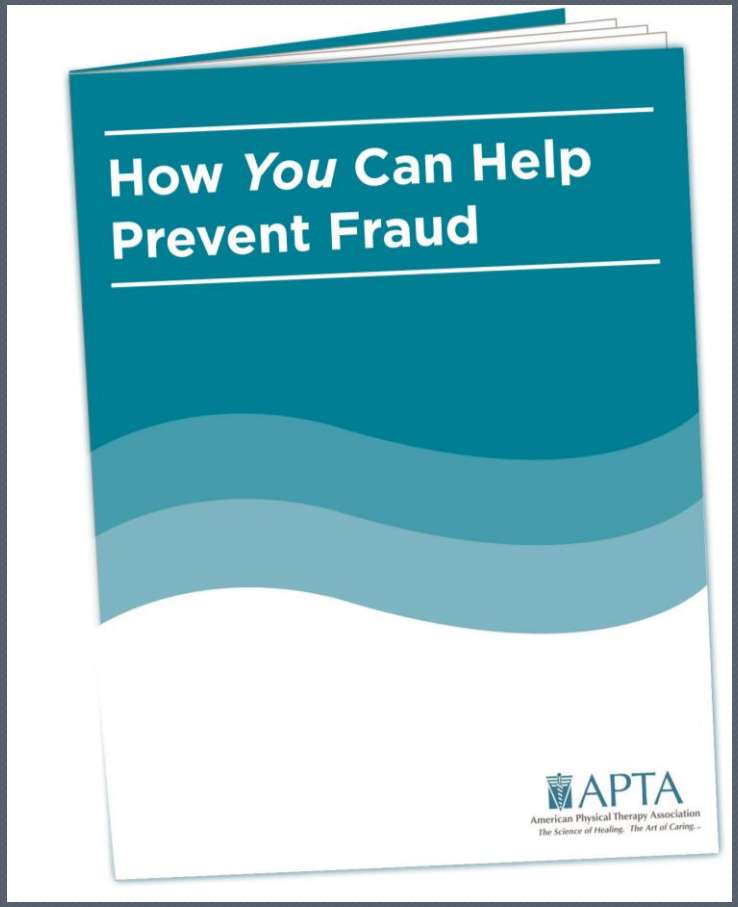
Forge Credible Solutions: Strike Force Recommendations

Medicare Program Integrity	Medicaid Program Integrity	Private Insurance	Enforcement
Centers for Medicare & Medicaid Services (CMS) John Spiegel, Director, Medicare Program Integrity Group, CMS Center for Program Integrity Shantanu Agrawal, M.D., Medical Director, CMS Center for Program Integrity **Office of the Inspector General** Ann Maxwell, Regional Inspector General for Evaluation and Inspections, Region V (Chicago)	**State Medicaid Agency (Massachusetts)** Joan Senatore, Chief Compliance Officer, Executive Office of Health & Human Services **State Inspector General (Wisconsin)** Alan White, Inspector General, Wisconsin Department of Health Services **Centers for Medicare & Medicaid Services (CMS)** Angela Brice-Smith, Director, Medicaid Program Integrity Group, CMS Center for Program Integrity	**National Association of Insurance Commissioners** Sandy Praeger, Kansas Insurance Commissioner and Former NAIC President **BlueCross BlueShield** Byron Hollis, Managing Director, National Anti-Fraud Department	**Office of the Inspector General** John Hagg, Director of Medicaid Audits Michael Henry, Deputy Regional Inspector General, OIG, San Francisco **Department of Justice** Thomas Devlin, Chief Deputy Attorney General, Health Care Section, Office of Attorney General, Pennsylvania Margaret L. Hutchinson, Chief, Civil Division, U.S. Attorney, Philadelphia **State Inspector General (New Jersey)** Mark Anderson, Director, Medicaid Fraud Division, N.J. State Comptroller

Make It Real: Materials

Drive awareness through a suite of materials designed to educate and empower, incorporating Strike Force recommendations

- Educational fact sheets for PTs on the new recommendations
- Five questions for consumers to ask to help prevent fraud
- 1-800 number information for consumers and PTs
- Whistleblower rights and responsibilities for PTs
- Case studies of whistleblowers to humanize the issue



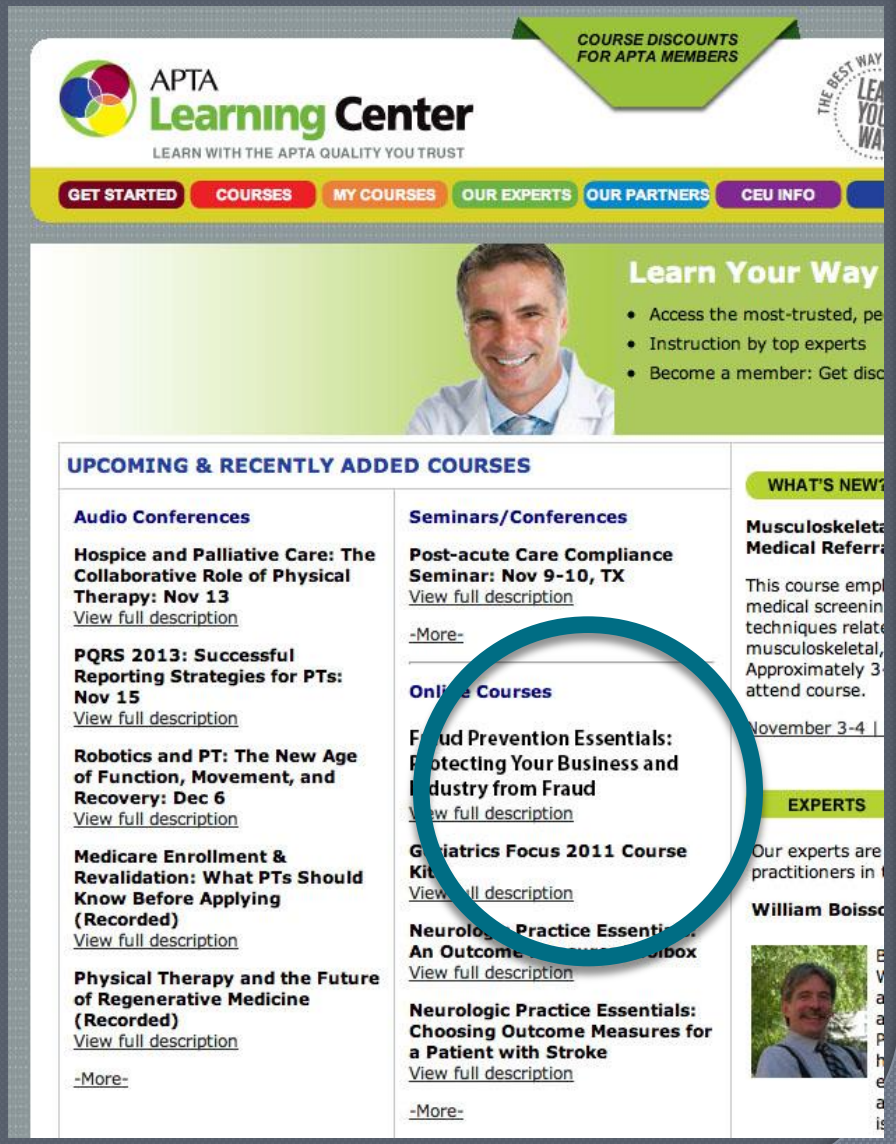
Make It Real: CE

Develop CE to incentivize participation, substantive learning

- CE module on the new findings
- Promotional materials for the new CE module

Design calendar of activities to ensure high level of continued compliance

- APTA meeting sessions
- Newsletter article content
- Targeted internal advertising



Pass It On: Proclaim Results

Announce initial results in early 2014 with high-profile keynote speaker talking about the importance of anti-fraud efforts.

Monitor and report on uptake and participation

Develop quarterly reports on the Initiative progress to provide to Congress, HHS, others, and to share progress

Accomplishments to Date

- Identified most common types of fraud
- Developed a draft of the CE Module: **"Navigating the Regulatory Environment: Ensuring Compliance While Promoting Professional Integrity"**
- Invited expert faculty/completed audio-roundtable recording
- Identified Key Stakeholders/Influencers with which to partner
- Surveyed 571 members and 300 non-members on practice challenges.

On Deck

- Complete White Paper
- Complete CE Module/Submit for state approvals
- Develop government relations & member tools:
  -Fact Sheets, Infographics, FAQs
- Media Outreach and Pitch
- Publish feature articles in APTA publications
- Develop partnerships with influential third parties to extend distribution of campaign message

Thank You

Comments and Suggestions