

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Spectrum Rehabilitation, LLC, improperly claimed at least \$3.1 million in Medicare reimbursement for outpatient occupational and physical therapy services.

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.

Our objective was to determine whether outpatient therapy services provided by Spectrum Rehabilitation, LLC (Spectrum), were paid in accordance with Medicare requirements.

BACKGROUND

Federal regulations provide for the coverage of Medicare Part B outpatient therapy services, including occupational and physical therapy. For outpatient 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 the need for such services must be certified by a physician. Medicare Part B also covers outpatient occupational and physical therapy services performed by or under the personal 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 40,129 Medicare outpatient occupational and physical therapy services, totaling \$4,125,711, provided by Spectrum during the period January 1, 2009, through December 31, 2010. A claim consisted of all payments made for a beneficiary on the same date of service.

WHAT WE FOUND

Spectrum claimed Medicare reimbursement for outpatient occupational and physical therapy services that did not comply with certain Medicare requirements. Of the 100 claims in our random sample, Spectrum properly claimed Medicare reimbursement for 17 claims. However, Spectrum improperly claimed Medicare reimbursement for the remaining 83 claims. Of these 83 claims, 44 contained more than 1 deficiency.

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.

On the basis of our sample results, we estimated that Spectrum improperly received at least \$3,112,501 in Medicare reimbursement for outpatient occupational and physical therapy services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

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.

SPECTRUM COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Spectrum, through its attorneys, disagreed with our first recommendation and agreed with our remaining recommendations. Spectrum indicated that the issues raised in the report were documentation issues and not questions of whether services provided were medically necessary. Spectrum provided detailed explanations as to why the claims questioned in our report were billed and paid in accordance with Medicare reimbursement requirements, as well as additional documentation for certain sample claims.

After reviewing Spectrum's comments and the additional documentation, we have revised our findings for 13 claims. Specifically, we are no longer questioning nine claims that contained services billed under the incorrect provider number, two claims for which there was no plan of care in the beneficiaries' medical records, one claim for which the treatment note did not contain the therapist's signature or professional identification, and one claim for which the date the plan of care was established was not recorded. We have revised the report to reflect these changes; however, for 10 of the 13 claims for which we revised our findings, the revisions did not affect our recommended refund amount because these claims remain unallowable for other reasons.

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INTRODUCTION

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.

OBJECTIVE

Our objective was to determine whether outpatient therapy services provided by Spectrum Rehabilitation, LLC (Spectrum), were paid in accordance 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 end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B provides supplementary medical insurance for medical and other health services, including outpatient therapy services. CMS contracts with Medicare contractors to process and pay Part B claims.

Medicare Outpatient Occupational and Physical Therapy Services

Medicare Part B provides for the coverage of outpatient therapy services, including occupational and physical therapy (sections 1832(a)(2)(C) and 1861(g) and (p) of the Act).

Occupational therapy services are designed to improve the ability of mentally, physically, developmentally, or emotionally impaired patients to perform everyday tasks of living and working, with the goal of reestablishing independent, productive, and satisfying lives. Physical therapy services are designed to evaluate and treat disorders of the musculoskeletal system with the goal of improving mobility, relieving pain, and restoring maximal functional independence.

For Medicare Part B to cover outpatient occupational and physical therapy services, the services must be medically reasonable and necessary, the services must be provided in accordance with a plan of care (plan) established by a physician or qualified therapist and periodically reviewed by a physician, and the need for such services must be certified by a physician.¹ Further, Medicare Part B pays for outpatient occupational and physical therapy services performed by or under the

¹ Sections 1862(a)(1)(A) and 1835(a)(2) of the Act.

personal supervision of a therapist in private practice.² Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.³

These requirements are further clarified in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. 100-04).

Spectrum Rehabilitation, LLC

Spectrum is a provider of outpatient therapy services with four locations throughout southern New Jersey. During the period January 2009 through December 2010, Spectrum employed 12 to 16 full-time therapists who provided outpatient occupational and physical therapy services to Medicare beneficiaries.

Novitas Solutions, Inc. (Novitas),⁴ serves as the Part B Medicare Administrative Contractor for providers in Jurisdiction 12, which includes New Jersey.

HOW WE CONDUCTED THIS REVIEW

Our review covered Spectrum's claims for Medicare outpatient occupational and physical therapy services provided during the period January 1, 2009, through December 31, 2010. We excluded services on seven claims, totaling \$2,048, that the Medicare Administrative Contractor had previously reviewed and questioned. Our revised sampling frame consisted of 40,129 outpatient therapy service claims,⁵ totaling \$4,125,711, of which we reviewed a simple random sample of 100 claims.

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 A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

² 42 CFR §§ 410.59 and 410.60.

³ Section 1833(e) of the Act.

⁴ Formerly Highmark Medicare Services, Inc.

⁵ A claim consisted of all payments made for a beneficiary on the same date of service.

FINDINGS

Spectrum claimed Medicare reimbursement for outpatient occupational and physical therapy services that did not comply with certain Medicare requirements. Of the 100 claims in our random sample, Spectrum properly claimed Medicare reimbursement for 17 claims. However, Spectrum improperly claimed Medicare reimbursement for the remaining 83 claims. Specifically:

- For 45 claims, Medicare physician certification requirements were not met.
- For 36 claims, the treatment notes maintained by Spectrum did not meet Medicare requirements.
- For 35 claims, the therapist who billed Medicare did not perform or supervise the service.
- For 21 claims, the therapy services were not medically necessary.
- For four claims, the plan did not meet Medicare requirements.

Of the 83 claims, 44 contained more than 1 deficiency.

These deficiencies occurred because Spectrum did not have a thorough understanding of the Medicare reimbursement requirements related to outpatient therapy services and did not have adequate policies and procedures in place to ensure that it billed services that met certain Medicare requirements. On the basis of our sample results, we estimated that Spectrum improperly received at least \$3,112,501 in Medicare reimbursement for outpatient occupational and physical therapy services that did not comply with Medicare requirements.

MEDICARE PHYSICIAN CERTIFICATION REQUIREMENTS NOT MET

Payment for outpatient therapy services may be made if a physician certifies: (i) that such services were required because the individual needed outpatient therapy, (ii) a plan for furnishing such services has been established by a physician or by a qualified therapist and periodically reviewed by a physician, and (iii) such services were furnished while the individual was under the care of a physician (section 1835(a)(2)(C) of the Act).

Initial certifications must be obtained as soon as possible after the plan is established and must be signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case (42 CFR §§ 424.24(c)(2) and (3)). Initial certification requirements are satisfied by a physician or non-physician practitioner's certification of the initial plan. For an initial plan to be certified in a timely manner, the physician or non-physician practitioner must certify the initial plan as soon as it is obtained or within 30 days of the initial treatment. For recertification, the plan must be dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less (*Medicare Benefit*

Policy Manual, chapter 15, § 220.1.3.D). Physician certification is documented by a dated signature or verbal order (*Medicare Benefit Policy Manual*, chapter 15 § 220.1.3.B).

For 45 claims, Spectrum received Medicare reimbursement for services that did not meet physician certification requirements. Specifically:

- Services were not certified in a timely manner. For 33 claims, services were not certified by a physician or non-physician practitioner when obtained or within 30 days of the first treatment (31 claims) or during the duration of the initial plan or within 90 days of the initial treatment under that plan (2 claims).
- Physician certifications of initial plans were not dated. For 11 claims, certifications were signed by a physician or non-physician practitioner but were not dated.
- Services were not certified. For one claim, services were not certified (i.e., there was no dated physician or non-physician signature on the plan).

TREATMENT NOTES DID NOT MEET MEDICARE REQUIREMENTS

Medicare payments should not be made without the information necessary to determine the amount due the provider (section 1833(e) of the Act). In addition, a provider must furnish to its Medicare Administrative Contractor sufficient information to determine whether payment is due and the amount of payment (42 CFR § 424.5(a)(6)).

Outpatient therapy services are payable when the medical record and information on the provider's claim form consistently and accurately report covered services (*Medicare Benefit Policy Manual*, Chapter 15, § 220.3A). In addition, providers must report the number of units for outpatient rehabilitation services based on the procedures or services provided. For timed procedures, units are reported in 15-minute intervals. For untimed procedures, units are reported based on the number of times the procedure is performed (*Medicare Claims Processing Manual*, chapter 5 § 20.2).

Therapists must maintain a treatment note for each treatment day and each therapy service. The treatment note must document the: (1) date of treatment, (2) identification of each specific service provided and billed, (3) total timed code treatment minutes and total treatment time in minutes, and (4) signature and professional identification of the therapist who furnished or supervised the service (*Medicare Benefit Policy Manual*, chapter 15 § 220.3E).

For 36 claims, Spectrum received Medicare reimbursement for services for which the treatment note was missing or did not meet Medicare requirements.⁶ Specifically:

- Total treatment time not documented. For 31 claims, the total treatment time in minutes for timed procedures was not documented in the treatment note.

⁶ The total exceeds 36 because 1 claim contained services for which the total treatment time was not documented and for which the treatment note did not support the number of units billed.

- No treatment note. For three claims, there was no treatment note for some services.
- Treatment note did not support the number of units billed. For three claims, the treatment note did not support the number of units billed for some services.

SERVICES BILLED UNDER INCORRECT PROVIDER NUMBER

Medicare Part B covers outpatient therapy services performed by or under the personal supervision of a therapist in private practice (42 CFR §§ 410.59(a)(3)(ii) and 410.60(a)(3)(ii)). Each therapist in a private practice must enroll in Medicare and obtain a provider identification number to provide medical services to Medicare beneficiaries and to submit claims for the services provided. If a therapist is not enrolled in Medicare, services performed by the therapist are only eligible for Medicare reimbursement if the therapist is directly supervised by one who is enrolled in Medicare. Direct supervision requires that the supervising private practice therapist be present at the time the services are performed (*Medicare Benefit Policy Manual*, chapter 15 § 230.4). Additionally, claims must include the provider identification number of the individual who performed or supervised the services (*Medicare Claims Processing Manual*, chapter 26 § 10.4).

For 35 claims, Spectrum received Medicare reimbursement for outpatient therapy services provided by therapists that were not enrolled in Medicare and who did not have a provider identification number. These services were billed to Medicare using provider identification numbers assigned to other therapists in the practice. There was no evidence in the case records to indicate that these services were directly supervised by a therapist who was enrolled in Medicare.

SERVICES NOT MEDICALLY NECESSARY

The Balanced Budget Act of 1997 placed an annual cap on Medicare rehabilitation services. Financial limits called “therapy caps” apply to outpatient Part B therapy services.⁷ Exceptions to therapy caps are authorized if services are medically necessary and identified by a “KX modifier” on the claim. The modifier is added to a claim to indicate that the provider attests that services are medically necessary and that justification is documented in the medical record (*Medicare Claims Processing Manual*, chapter 5 §§ 10.2 and 10.3).

No payment may be made under Medicare Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (section 1862(a)(1)(A) of the Act).

⁷ Therapy caps were established for (1) combined physical and speech therapy services and (2) occupational therapy services and were based on therapy services that the beneficiary received. For calendar year 2009, the therapy caps for each were \$1,840 and in calendar year 2010, \$1,860.

For 21 claims, Spectrum received Medicare reimbursement for services that exceeded the therapy caps and for which the beneficiaries' medical record did not support the medical necessity of services above the therapy caps.⁸

PLAN DID NOT MEET MEDICARE REQUIREMENTS

Outpatient rehabilitation services must be provided in accordance with a written plan established before treatment begins. The plan must contain the type, amount, frequency, and duration of the occupational or physical therapy services to be furnished and must indicate the diagnosis and anticipated goals (42 CFR § 410.61).

For four claims, Spectrum received Medicare reimbursement for services that were not provided in accordance with a plan that met Medicare requirements. Specifically, for these four claims, the plan did not include the type of service provided and billed to Medicare.

CONCLUSION

On the basis of our sample results, we estimated that Spectrum improperly received at least \$3,112,501 in Medicare reimbursement for outpatient occupational and physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

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.

SPECTRUM COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Spectrum, through its attorneys, disagreed with our first recommendation and agreed with our remaining recommendations. Spectrum indicated that the issues raised in the report were documentation issues and not questions of whether services provided were medically necessary. Spectrum provided detailed explanations as to why the claims questioned in our report were billed and paid in accordance with Medicare reimbursement requirements, as well as additional documentation for certain sample claims. Spectrum's

⁸ The medical review staff of Novitas made these medical necessity determinations.

comments appear as Appendix D. Exhibits submitted as attachments to the comments are not included because they contain personally identifiable information.

After reviewing Spectrum's comments and the additional documentation, we have revised our findings for 13 claims. Specifically, we are no longer questioning nine claims that contained services billed under the incorrect provider number, two claims for which there was no plan in the beneficiaries' medical records, one claim for which the treatment note did not contain the therapist's signature or professional identification, and one claim for which the date the plan was established was not recorded. We have revised the report to reflect these changes; however, for 10 of the 13 claims for which we revised our findings, the revisions did not affect our recommended refund amount because these claims remain unallowable for other reasons.

MEDICARE PHYSICIAN CERTIFICATION REQUIREMENTS NOT MET

Spectrum Comments

Spectrum stated that 42 CFR § 424.11(d)(3)⁹ allows for delayed certification and recertification statements when there is a legitimate reason. These statements must include an explanation for the delay. Spectrum stated that it uses an aggressive process for obtaining physician certifications within the required timeframes. Specifically, Spectrum indicated that it follows up with providers that fail to return a signed plan by contacting providers up to four times in an attempt to obtain a physician signature. Accordingly, Spectrum stated that its procedures for obtaining a signed plan meet the delayed certification requirements and payment for these claims should not be denied.

Office of Inspector General Response

We maintain that 45 claims did not meet physician certification requirements. Specifically, delayed certification and recertification statements must include an explanation for the delay. For all claims in question, Spectrum believed that it met delayed certification and recertification requirements because it aggressively tried to obtain physician certifications. However, there was no evidence in the beneficiaries' medical records to justify delays (i.e., there was no evidence that Spectrum contacted the providers on multiple occasions to obtain signed plans). Spectrum acknowledged in its comments that it did not maintain evidence of its follow up attempts with providers. Finally, as part of its comments, Spectrum attached physician affidavits that were created 4 years after the dates of service in question; however, these affidavits did not provide evidence that the physicians were involved in the corresponding patients' care when the services were provided or that delayed certification was justified.

⁹ In its comments, Spectrum transposed the subsection and paragraph of this citation. We have included the correct citation.

SERVICES BILLED UNDER INCORRECT PROVIDER NUMBER

Spectrum Comments

Spectrum acknowledged that the services in question were billed under the incorrect provider number and conceded that some of the associated therapists did not possess a Medicare provider number during our audit period; however, Spectrum stated that these services should be still payable. Specifically, Spectrum indicated that claims billed with the provider number of a therapist enrolled in Medicare and not the one that provided the service were the result of clerical errors. In addition, Spectrum stated that the Medicare supervision requirements were met for some of the services in question and indicated that some therapists obtained a Medicare provider number with a retroactive effective date that preceded the dates of service at issue. Finally, Spectrum stated that each of its therapists are now enrolled in Medicare.

Office of Inspector General Response

We have revised our findings to remove the nine claims for which the services were provided or supervised by a therapist who was enrolled in Medicare but billed under another therapist's Medicare provider identification number. However, we maintain that 35 claims with services billed under incorrect provider numbers did not meet Medicare requirements. Specifically, each therapist in a private practice must enroll in Medicare and obtain a provider identification number to provide medical services to Medicare beneficiaries and to submit claims for the services provided. If a therapist is not enrolled in Medicare, services performed by the therapist are only eligible for Medicare reimbursement if the therapist is directly supervised by one who is enrolled in Medicare. Direct supervision requires that the supervising private practice therapist be present at the time the services are performed (*Medicare Benefit Policy Manual*, chapter 15 § 230.4). Additionally, claims must include the provider identification number of the individual who performed or supervised the services (*Medicare Claims Processing Manual*, chapter 26 § 10.4).

For these 35 claims, the services were provided by therapists that were not enrolled in Medicare and did not have a provider identification number. In addition, there was no evidence in the beneficiaries' medical records indicating the supervising therapist was present at the time the services were performed as required. Furthermore, the therapists' affidavits that Spectrum attached as part of its comments were created 4 years after the dates of service in question and did not provide contemporaneous evidence that the supervision requirements were met. Finally, based on information provided by Spectrum during our exit conference, we did not question any services for which the therapist obtained a Medicare provider number with a retroactive effective date that preceded the sampled date of service.

TREATMENT NOTES DID NOT MEET MEDICARE REQUIREMENTS

Spectrum Comments

Spectrum stated that the number of units billed for each claim for which the total treatment time in minutes was not documented was calculated in accordance with the treatment guidelines established in CMS manuals. Therefore, Spectrum contended that the claims at issue were properly reimbursed. Spectrum further stated that, at a minimum, it should be reimbursed one unit of service. For the remaining claims, Spectrum acknowledged that services not supported by treatment notes were billed in error and that one therapist forgot to sign the treatment note.

Office of Inspector General Response

We have revised our findings to remove the one claim for which the treatment note did not contain the signature and professional identification of the therapist that performed the service. However, we maintain that 36 claims did not meet Medicare treatment note requirements. Specifically, Medicare payments should not be made without the information necessary to determine the amount due the provider (section 1833(e) of the Act). In this respect, therapists must maintain a treatment note for each treatment day and each therapy service that contains the: (1) date of treatment, (2) identification of each specific service provided and billed, (3) total timed code treatment minutes and total treatment time in minutes, and (4) signature and professional identification of the therapist who furnished or supervised the service (*Medicare Benefit Policy Manual*, chapter 15 § 220.3E).

For certain claims, the treatment notes did not contain the total timed code treatment minutes or the total treatment time in minutes as required. Without this information, we have no assurance that the minimum time required to bill¹⁰ one unit of service was met.

SERVICES NOT MEDICALLY NECESSARY

Spectrum Comments

Spectrum contends that the medical record for each claim denied for not being medically necessary demonstrated the patient's need for continued skilled therapy beyond the therapy cap (i.e., the service was medically necessary).

Office of Inspector General Response

We maintain that 21 claims did not meet Medicare medical necessity requirements. Specifically, the determination that Spectrum received Medicare reimbursement for services for which the medical record did not support the medical necessity of the services above the therapy cap was made by Novitas' medical review staff. Novitas' medical review staff have extensive knowledge of the Medicare requirements related to medical necessity and, on the basis of their review of the

¹⁰ Providers cannot bill for services performed in less than 8 minutes (*Medicare Claims Processing Manual*, chapter 5 § 20.2C).

medical records, concluded that Spectrum's documentation did not justify services above the therapy cap.

PLAN DID NOT MEET MEDICARE REQUIREMENTS

Spectrum Comments

Spectrum acknowledged that the plan for some questioned claims did not include the type of therapy service provided or the date the plan was established; however, Spectrum provided reasons why it believes the services were billed in accordance with the plan in attachments to its comments.¹¹ Specifically, Spectrum stated in the attachments that, for certain claims, the therapist neglected to select any of the modalities under the section "Skilled Treatment Plan to Address Functional Deficits" on the plan. In addition, Spectrum indicated that one plan did not include a service because the service was only provided in limited instances. Spectrum also stated that another plan included procedure code 97530 (therapeutic activity); therefore, Spectrum contended that we incorrectly found that this service was not provided in accordance with the plan. Finally, for another claim, Spectrum indicated that the therapist failed to record the date the plan was established.

Office of Inspector General Response

We have revised our findings to remove the one claim for which the date the plan was established was not recorded; however, we maintain that four claims contained services that were not provided in accordance with the plan. Outpatient rehabilitation services must be provided in accordance with a written plan established before treatment begins. The plan must contain the type, amount, frequency, and duration of the occupational or physical therapy services to be furnished and must indicate the diagnosis and anticipated goals (42 CFR § 410.61).

The plan that Spectrum indicated included procedure code 97530 was the plan for physical therapy services. We did not question those services. Rather, we questioned the therapeutic activity services provided by the occupational therapist that were not included on the associated beneficiary's occupational therapy plan.

¹¹ We did not include exhibits submitted as attachments to Spectrum's comments in Appendix D because the exhibits contain personally identifiable information.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 40,129 Medicare outpatient occupational and physical therapy services, totaling \$4,125,711, provided by Spectrum during the period January 1, 2009, through December 31, 2010. A claim consisted of all payments made for a beneficiary on the same date of service. These claims were extracted from CMS's National Claims History file.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of Spectrum's policies and procedures for documenting and billing Medicare for outpatient therapy services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We performed fieldwork at Spectrum's office in Northfield, New Jersey, from December 2011 through July 2012.

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 therapy services;
- interviewed Spectrum officials to gain an understanding of its policies and procedures related to providing and billing Medicare for outpatient therapy services;
- extracted from CMS's National Claims History file a sampling frame of 40,136 outpatient therapy service claims, totaling \$4,127,759, for the period January 1, 2009, through December 31, 2010;
- excluded services on seven claims, totaling \$2,048, that were previously reviewed and questioned by the Medicare Administrative Contractor;
- determined our revised sampling frame consisted of 40,129 outpatient therapy service claims totaling \$4,125,711;
- selected a simple random sample of 100 outpatient therapy service claims from the sampling frame;
- reviewed data from CMS's Common Working File and other available data for the sampled claims to determine whether the claims had been cancelled or adjusted;

- obtained and reviewed case record documentation from Spectrum for each sample claim to determine whether the services were provided in accordance with Medicare requirements;
- utilized Novitas medical review staff to determine whether sampled claims billed with the KX modifier met medical necessity requirements; and
- estimated the unallowable Medicare reimbursement paid in the total population of 40,129 claims.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part B outpatient therapy service claims paid to Spectrum during the period January 1, 2009, through December 31, 2010.

SAMPLING FRAME

The sampling frame was an Access database containing 40,129 outpatient therapy service claims, totaling \$4,125,711, provided by Spectrum during the period January 1, 2009, through December 31, 2010. We eliminated from the sampling frame services that were previously reviewed and questioned by the Medicare Administrative Contractor. The claims data were extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was an outpatient therapy service claim. A claim consisted of all payments made for a beneficiary on the same date of service.

SAMPLE DESIGN

We used a simple random sample to review Medicare payments made to Spectrum for outpatient therapy services.

SAMPLE SIZE

We selected a sample of 100 outpatient therapy service claims.

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.

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 therapy services made to Spectrum at the lower limit of the 90-percent confidence level.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
40,129	\$4,125,711	100	\$10,124	83	\$8,432

Estimated Value of Unallowable Claims *(Limits Calculated for a 90-Percent Confidence Interval)*

Point Estimate	\$3,383,697
Lower Limit	\$3,112,501
Upper Limit	\$3,654,894

APPENDIX D: SPECTRUM COMMENTS

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March 14, 2013

James Edert
Regional Inspector General for Audit Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

**Re: Spectrum Rehabilitation, LLC
OIG Audit (Report Number A-02-11-01044)**

Dear Mr. Edert:

Please be advised that Wachler & Associates, PC has been retained to represent Spectrum Rehabilitation, LLC ("Spectrum") in the Office of Inspector General ("OIG") Audit Report No. A-02-11-01044.

The overpayment demand in this case would put Spectrum out of business. Spectrum strongly urges the OIG to consider the information included below and, for resolution purposes, allow Spectrum to move forward with a focus towards investing its resources in compliance activities. Overall, the issues raised in the OIG audit were documentation issues, and were not questions of whether the services provided were medically necessary. After the OIG's review of the Spectrum's comments, the provider would appreciate an opportunity to further discuss this matter with the OIG in order to reach a resolution that would allow Spectrum to stay in business and demonstrate their prospective compliance.

We received the December 12, 2012 draft audit report entitled “Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services.” In the report the OIG recommended Spectrum do the following:

- (1) refund \$3,253,022.00 to the Federal Government;
- (2) strengthen its policies and procedures to ensure outpatient therapy services are provided and documented in accordance with Medicare requirements; and
- (3) obtain a better understanding of Medicare reimbursement requirements related to outpatient therapy services. These recommendations were based on six core findings, to which Spectrum provides detailed responses below

Pursuant to the request to provide a statement of concurrence or nonconcurrence to each recommendation we provide the following information:

Spectrum does not concur with recommendation #1

Spectrum provides outpatient rehabilitation services to patients in New Jersey. The audit at issue covers services provided from January 2009 through December 2010. In the audit findings, the OIG reviewed 100 sample claims and alleges that 86 of the 100 sample claims were improperly reimbursed by Medicare. According to the audit, the claims were deficient for at least one of six reasons: (1) physician certification allegedly was not met; (2) the therapist who billed allegedly did not provide the services; (3) the treatment notes allegedly did not meet Medicare requirements; (4) the therapy services allegedly were not medically necessary; (5) the plan of care allegedly did not meet Medicare requirements; and/or (6) the plan of care allegedly did not exist. The findings were then applied to all claims provided between January 2009 and December 2010. As will be demonstrated below, these claims were appropriately billed and paid by Medicare.

I. SPECTRUM PROVIDED APPROPRIATE PHYSICIAN CERTIFICATION AS PART OF THE MEDICAL RECORDS.

The OIG draft report alleges that, for 45 claims, Spectrum did not meet Medicare physician certification requirements. Specifically, for 31 claims, the OIG alleges the physician or non-physician practitioner “must certify the initial plan as soon as it is obtained or within 30 days of the initial treatment” and that in this case, that did not occur. Furthermore, the auditor alleges that for two claims there was no certification within 90 days of the initial treatment under that plan.

However, the assertion that the certification “must” be obtained within 30 days is misguided, and the auditor failed to acknowledge that pursuant to the regulations, “[n]o

specific procedures or forms are required for certification and recertification statements....The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, **or on a special separate form.**¹ CMS specifically allows for what is called “delayed certification” based on the premise that “[i]t is not intended that needed therapy be stopped or denied when certification is delayed.”² Most notably, the Medicare Benefit Provider Manual specifically directs that “the delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient’s care, or treatment did not meet the patient’s need (and therefore, the certification was signed inappropriately).”³ (emphasis added). Finally, the Manual states, “[e]vidence of **diligence** in providing the plan to the physician may be considered by the Medicare contractor during review in the event of a delayed certification.”⁴ (emphasis added).

Furthermore, in the Medicare Benefit Policy Manual, under the definitions for outpatient physical therapy services, it states regarding “dates”:

A DATE may be in any form (written, stamped or electronic). **The date may be added to the record in any manner and at any time, as long as the dates are accurate.** If they are different, refer to both the date a service was performed and the date the entry to the record was made....[I]f the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented.⁵ (emphasis added).

In regards to the acceptance of delayed certification, 42 CFR 424.11(3)(D) provides:

Delayed certification and recertification statements are acceptable when there is a legitimate reason for delay.... Delayed certification and recertification statements must include an explanation of the reason for the delay.

The Medicare Benefit Provider Manual provides further guidance related to delayed certification by explaining that, “[s]ince delayed certification is allowed, the date the certification is signed is important only to determine if it is timely or delayed.”⁶ In one of the examples provided, CMS explains delayed certification as follows:

Payment should not be denied, **even when certified 2 years after treatment,** when there is evidence that a physician approved needed treatment, such as an

¹ 42 CFR 424.11(b)

² Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3(D).

³ *Id.*

⁴ Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3(B).

⁵ Medicare Benefit Policy Manual, Chapter 15, Section 220(A).

⁶ Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3(A).

order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, certifications for intervals before or after the service in question, or physician/NPP services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.”⁷ (emphasis added)

Finally, regarding the acceptance of delayed certification, CMS states:

...[d]elayed certifications should include any evidence the provider or supplier considers necessary to justify the delay. For example, a **certification may be delayed because the physician did not sign it**, or the original was lost. In the case of a long delayed certification (over 6 months), the provider or supplier may choose to submit with the delayed certification some other documentation (e.g., an **order**, progress notes, telephone contact, **requests for certification** or **signed statement of a physician/NPP**) indicating need for care and that the patient was under the care of a physician at the time of the treatment. Such documentation may be requested by the contractor for delayed certifications if it is required for review.⁸

As it pertains to Spectrum, each and every claim at issue received physician certification. For 33 claims, the OIG alleges that certification or recertification was not timely obtained. CMS specifically lists “requests for certification” as an example of evidence to show delayed certification. In addition, the Medicare Benefit Policy Manual does not require certification to be obtained on any specific form, and allows for certification to be entered on a special form. It is the practice of Spectrum to provide a completed plan of care to the referring physician. When sending the plan of care, Spectrum also sends a form entitled “Certification and Recertification Evaluation and Treatment Prescription” (“certification form”), which provides a detailed treatment plan for the patient. As established by Medicare manual provisions, the physician’s dated signature on either of these forms would meet the certification requirements.

Spectrum utilizes an aggressive process for obtaining physician certification, as evidenced by the affidavit of Spectrum’s Administrator, attached hereto as **Exhibit A**. The Administrator receives the plan of care from a therapist within 24 hours of the evaluation of the patient and promptly faxes the certification form and plan of care to the ordering physician. If this is not returned within five days, the Administrator faxes a second written request. If the plan of care is still not returned within ten business days of the original fax, the certification form and plan of care is refaxed a third time to the physician. If after 15 days it is not signed, then a Spectrum staff member or the physical therapist will hand deliver the plan of care and request a signature, if possible, and if not

⁷ Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3(D).

⁸ *Id.*

Office of Inspector General Note—The exhibits have been redacted because they contain personally identifiable information.

possible, it will be faxed for a fourth time. If the plan of care is not signed within 30 days then it is again faxed with the statement, "Medicare requires your signature within 30 days of initiation of this POC. If you do not wish to certify this poc or do not feel these services are medically necessary, please contact [Spectrum's owner] at [phone number]."

In addition, Spectrum has obtained physician statements, attached hereto as **Exhibits B1-B27**, evidencing that the physician was involved in the patient's care at the time of the physical therapy services, and was aware of and agreed to the services being provided.⁹ The physician statements also makes clear that any delay is not on the part of Spectrum, and in fact Spectrum diligently follows up on the certification forms. Furthermore, for the 11 claims alleged by the OIG to contain only a physician signature but not a date on the certifications, the physician statement supports that the physician approved the patient's plan of care despite the physician's failure to date the plan of care.

Clearly, Spectrum is extremely diligent in attempting to obtain the physician's signature within the 30 day timeframe, but when Spectrum was not able to meet this requirement, the provider has demonstrated that a reasonably delayed certification exists. As noted in the Medicare Manual, "the delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately)", neither of which exists here.¹⁰

Attached hereto as Exhibit C is a claim by claim analysis of the 45 sample claims which were denied due to certification issues.

II. SERVICES BILLED UNDER INCORRECT PROVIDER NUMBER SHOULD STILL BE PAYABLE.

The OIG also alleges that for 44 claims Spectrum received Medicare reimbursement for therapy services that did not include the provider identification number of the therapist who performed or supervised the services. Specifically, the OIG alleges that for 35 of these claims the services were provided by therapists that were not enrolled in Medicare and who did not have provider identification numbers, and the services performed by these therapists were billed using provider identification numbers assigned to other therapists at Spectrum. For the remaining nine claims, the OIG alleges that the therapist who performed the service had a provider identification number, but the identification number on the claim was not the number assigned to the therapist who performed or supervised the service.

⁹ Exhibit B corresponds to the comments put forth in Exhibit C.

¹⁰ Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3(D).

A. For 9 sample claims, Spectrum’s submission of claims under the incorrect provider number should be viewed as a clerical error.

There were 9 claims in which the therapist who provided the service was enrolled in Medicare and had a provider identification number. However, due to a clerical error, these claims were billed under another therapist’s provider identification number by an independent third party biller.

Medicare recognizes that clerical errors occur, including incorrect data items such as the provider number, and that such errors should be reopened. The Code of Federal Regulations specifically states that “a contractor must process clerical errors...as reopenings...”¹¹ Clerical error is defined to include, “human or mechanical errors on the part of the party or the contractor such as— (i) Mathematical or computational mistakes; (ii) Inaccurate data entry; or (3) Denials of claims as duplicates.”¹²

Regarding clerical errors, the Medicare Claims Processing Manual provides:

We believe it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, Section 405.927 and Section 405.980(a)(3) require that clerical errors be processed as reopening rather than appeals. CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors; or
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.
- **Incorrect data items, such as provider number, use of a modifier or date of service.**¹³ (emphasis added).

The following list contains the 9 sample claims at issue here and the therapist who performed the services for each beneficiary:¹⁴

¹¹ 42 CFR 405.980(a)(3).

¹² *Id.*

¹³ Medicare Claims Processing Manual, Chapter 34, Section 10.4.

¹⁴ Refer to **Exhibit D** for a list containing the therapist’s full name.

Sample #	Providing PT
5	J.B.
10	J.B.
26	J.B.
30	P.S.
40	J.B.
45	P.S.
65	J.B.
95	J.B.
98	P.S.

J.B. and P.S. have been enrolled in Medicare with provider identification numbers since 2003. Therefore, the OIG's allegations regarding these 9 claims should be viewed as a clerical error, and it should not be required that reimbursement for these claims be refunded.

B. For two claims, the therapist obtained a Medicare provider identification number with a retroactive effective date that preceded the dates of service at issue.

Spectrum should be given credit for those claims where the individual physical therapist did in fact have an effective provider identification number during the date of service. For these claims, the physical therapists who provided the service had not, at the time of performing the service, received their acknowledgement from CMS that their Medicare enrollment application had been approved. It was not until months after the therapists performed the services on the dates at issue that the therapists were informed of their approved enrollment status and granted a Medicare identification number. Importantly, the therapists' Medicare identification numbers had effective enrollment dates that preceded the dates of service at issue. Therefore, the therapists did not require the supervision of another therapist in order for the services at issue to be billed to Medicare. These claims are attached hereto as **Exhibit E** with detailed information regarding the dates of service and the dates of the physical therapists' enrollment in the Medicare program.

C. For three claims, the services provided met the Medicare supervision requirements.

For Sample #74, the services performed by therapist on April 12, 2010 met the supervision requirements in accordance with Medicare Benefit Policy Manual, Chapter 15, Section 230.4(B). As demonstrated in the attached affidavits, attached hereto as **Exhibit F**, the services were performed by the physical therapist while a therapist

enrolled in the Medicare program was present in the same office suite, therefore meeting the direct supervision requirement.

For Samples #21 and #94, the services were performed by an occupational therapist on February 18, 2009 and January 16, 2010, respectively. The procedure codes performed on these dates of service met the supervision requirements in accordance with Medicare Benefit Policy Manual, Chapter 15, Section 230.4(B). As demonstrated in the attached affidavits, attached hereto as **Exhibit G**, the services were performed by the occupational therapist at an assisted living facility while an occupational therapist enrolled in the Medicare program was also present at the facility, therefore meeting the direct supervision requirement.

In addition, Spectrum believes that Sample #67 involves a scenario identical to that just described. However, after the audit took place, Spectrum has been unable to locate the relevant portion of the record needed to defend the claim for Sample #67.

D. Each physical therapist at Spectrum is now currently enrolled in the Medicare program with effective provider identification numbers.

Despite having not been enrolled in Medicare on the dates of service, each physical therapist met the Medicare requirements for being a qualified physical therapist. As required by 42 C.F.R. §484.4, each physical therapist in question was licensed to practice physical therapy by the state of New Jersey and graduated after successful completion of an approved physical therapy program. In addition to meeting the definition of a qualified therapist, no therapist would have been otherwise excluded from the Medicare program as defined by Section 1128 of the Social Security Act.

Today, with the exception of two therapists who are no longer employed by Spectrum, every physical therapist at Spectrum who provided services during the audit period is currently enrolled in Medicare and has an effective provider identification number. The supporting affidavits, attached hereto as **Exhibit H**, provide the OIG with the enrollment application dates, effective enrollment dates and current provider identification numbers for the physical therapists at issue in the audit.

Although Spectrum concedes that the therapists for the sample claims at issue under this section did not possess Medicare provider identification numbers during the audited time period, Spectrum requests the OIG to accept that each therapist met the requirements for enrollment, subsequently enrolled in Medicare, and obtained and continue to have an active provider identification number. Denial of reimbursement in this matter, which to date has been resolved, would create an unduly harsh impact on the provider. For

purposes of resolution, Spectrum requests that these claims be given credit because the physical therapists at issue were qualified, not excluded and ultimately credentialed in the Medicare program. Further, we would ask the OIG to consider Spectrum's remedial actions of enrolling each therapist in the Medicare program.

E. For two claims, the therapists who provided the services qualified for Medicare enrollment but are no longer employed by Spectrum.

Two claims, Sample #12 and Sample #63, involved services provided by physical therapists not currently employed by Spectrum. Similar to the section above, and supported by affidavits of the therapists, attached hereto as **Exhibit I**, the therapists for these two claims met the Medicare requirements of a qualified physical therapist and were not otherwise excluded from Medicare during the audited time frame. However, these therapists left their positions at Spectrum prior to initiating the Medicare enrollment process. Moreover, the neither of the two therapists ever became an enrolled Medicare provider because their subsequent employers do not require enrollment. Therefore, as with the claims in the above section, Spectrum requests that reimbursement not be denied for the two claims at issue here.

III. TREATMENT NOTES SUPPORT MEDICARE REIMBURSEMENT

The OIG alleges that for 37 claims Spectrum received Medicare reimbursement for services for which the treatment note did not meet Medicare requirements. Specifically, the OIG alleges: the total treatment time in minutes for times procedures was not document in the treatment note (31 claims); there was no treatment note for some services (3 claims); the treatment note did not support the number of units billed for some services (3 claims); and the treatment note did not include the signature or the professional identity of the therapist who performed the service (1 claim).

A. OIG alleges total treatment time in minutes was not documented

i. At a minimum, each claim billed by Spectrum should be reimbursed for one unit

For 31 claims, the OIG alleges that the total treatment time in minutes for timed procedures was not documented in the treatment note.

Regarding treatment note documentation, Medicare Benefit Policy Manual states, "*the format shall not be dictated by contractors and may vary depending on the practice of*

*the responsible clinician and/or the clinical setting.*¹⁵ (emphasis added). The Manual also states that “the purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim.”¹⁶

The Manual also confirms that, “the billing and the total time code treatment minutes must be consistent.”¹⁷ Based on this, Spectrum, consistent with the billings, recorded their treatment time in the same units which equal minutes as found in the Medicare Claims Processing Manual, Chapter 5, Section 20.2, where one unit is 8 to 22 minutes.

Despite the total treatment time in minutes not being documented in the treatment note for each claim, it should be recognized that, out of the 100 sample claims reviewed, there was not a single disallowance by the OIG where Spectrum was found to have billed more units than were supported by the documented treatment minutes. This clearly demonstrates Spectrum’s understanding of the rules for billing units based treatment minutes. Although Spectrum contends that the number of units billed for the services in question were consistent with the time spent performing each modality, Spectrum understands that documenting the total treatment time in minutes is an important piece of information for verifying the number of units billed for each claim. As will be explained in greater detail under recommendation #2, Spectrum has made a number of key changes to its policy for treatment note documentation and has provided additional training and education to its therapists to ensure the total treatment time in minutes is properly and consistently recorded.

The number of units billed for each claim was calculated in accordance with the treatment minute guidelines established in CMS manuals. Therefore, Spectrum contends that the claims at issue were properly reimbursed. However, at minimum, Spectrum requests that the OIG credit Spectrum with one unit for each claim at issue. As demonstrated by the signed statement of Spectrum’s owner, attached hereto as **Exhibit J**, it is the practice of Spectrum to never bill for any modality performed for less than 8 minutes. Since one unit is to be billed for a service rendered between 8 and 22 minutes, each claim at issue warrants credit for at least one unit because Spectrum does not bill any procedure code that has not been performed for at least 8 minutes.

ii. Spectrum should be reimbursed for claims billed for two and three units

¹⁵ Medicare Benefit Policy Manual, Chapter 15, Section 220.3E,

¹⁶ *Id.*

¹⁷ *Id.*

As evidenced by **Exhibit J**, Spectrum also clearly understands the treatment minute requirements for billing two and three units for a service provided on a particular date of service. This is further evidenced by the auditor not finding any discrepancies between the number of units and total treatment time in minutes recorded in the treatment notes. Therefore, Spectrum was properly reimbursed for the services provided for two and three units.

B. OIG alleges no treatment note

For three claims, the OIG alleges that there was no treatment note for some services. The services at issue include: (1) two units of 97530 for Sample #63 on May 18, 2010; (2) one unit of 97124 for Sample #67 on July 1, 2009; and (3) one unit of 97530 for Sample #83 on August 5, 2009.

In regards to Sample #63, the two units of 97530 billed on May 18, 2010 were due to a billing error. The treatment notes clearly document that the only procedure codes performed on this date of service were 15 minutes of 97112 and 15 minutes of 97110. The total daily treatment time in minutes and total daily units correctly reflect this recording; total daily treatment time was listed as 30 minutes and total daily units were listed as 2 units. The treatment notes make no record of procedure code 97530 being billed and, therefore, the billing company erred by not billing in accordance with the treatment notes, which is the practice of the independent billing company.

Similar to Sample #63 above, the one unit of 97530 billed on August 5, 2010 for Sample #83 was due to a billing error. The treatment note clearly documents that the only procedure codes performed on this date of service were 15 minutes of 97116 and 30 minutes of 97110. The total daily treatment time in minutes and total daily units correctly reflect this recording; total daily treatment time was listed as 45 minutes and total daily units were listed as 3 units. The treatment notes make no record of procedure code 97530 being billed. Therefore, Sample #83 was also a claim in which the billing company erred by not billing in accordance with the treatment notes.

As for Sample #67, the relevant portions of the medical record needed in order to defend the allegations for this claim have been unable to be located since the audit took place.

C. OIG alleges treatment note did not support the number of units billed

The OIG alleges that, for three claims, the treatment note did not support the number of units billed for some services. The three claims at issue here are Sample #12, Sample #38 and Sample #81.

For Sample #12, the OIG alleges that the treatment note only supports one of the two units billed for procedure code 97110 on May 14, 2009. The treatment note for this date of service clearly shows that the physical therapist documented only one unit of 97110. Furthermore, the total treatment time and total units performed on May 14, 2009 correctly correspond with the single unit of 97110 being performed, as documented in the treatment note. Therefore, billing an additional unit of 97110 was an error by the billing company because the billing company failed to bill what was recorded on the treatment note, which is practice of the independent billing company.

The OIG alleges that, for Sample #38, the treatment note only supports one of two units billed for procedure code 97530 on November 22, 2010. The treatment note for this date of services shows that the therapist performed 15 minutes of 97530 and 25 minutes of 97001. The treatment note also documents total daily treatment time in minutes as 40 and total daily units as 3. These totals correctly reflect the intention of Spectrum to bill two units of 97001 and only one unit of 97530.

Sample #81 was also the result of a billing error by the billing company. The OIG alleges that the treatment note only supports one of two units billed for procedure code 97110 on April 6, 2010. The treatment note for this date of services shows that the therapist performed 15 minutes of 97110 and 23 minutes of 97530. The treatment note also documents total daily treatment time in minutes as 38 and total daily units as 3. These totals correctly reflect the intention of Spectrum to bill two units of 97530 and only one unit of 97110.

D. OIG alleges treatment note did not contain PT's signature.

This allegation pertains to the treatment note for Sample #46 on the September 28, 2009 date of service. The physical therapist that performed the service on this date was also the physical therapist who established the plan of care and who performed therapy services for the beneficiary on each date of service covered under the plan of care. The medical record for Sample #46 demonstrates that the physical therapist signed each and every other treatment note for dates of service under the plan of care time frame. However, on September 28, 2009, the physical therapist simply forgot to sign the treatment note. The signed statement of the physical therapist, attached hereto as **Exhibit K**, establishes that the therapist performed the services on the date in question. This human error should not prevent reimbursement for the services provided.

IV. SPECTRUM PROVIDED MEDICALLY NECESSARY SERVICES

In the draft audit, the auditor alleges that, for 21 claims, Spectrum received reimbursement for services that exceeded the therapy caps and that the medical record did not support the medical necessity above the therapy caps. However, as evidenced in the medical records and attested to by the attached expert reports, each of these claims did meet Medicare medical necessity requirements.

Section 220.3 of the Medicare Benefits Provider Manual, Chapter 15, states that:

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

Section 10.3(a) of the Medicare Benefit Policy Manual, Chapter 5, explains that,

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines.

In this case, the auditor denied the claims alleging only that the medical record did not support the medical necessity of services above the cap. As will be explained in greater detail in the expert reports for each claim at issue, attached hereto as **Exhibit L**, the medical records provided to the auditor met the Medicare guidelines for medical necessity. The services provided were reasonable and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in the physical function or health status of the beneficiary. The condition of the patient and the complexity of treatment carried out required services that could have only been safely and effectively performed by a therapist. The services in question could not have been safely carried out by nonskilled personnel. There was an expectation that each patient's condition would improve significantly within a reasonable period of time, and the amount, frequency and duration of the services provided were reasonable for meeting such expectations. The medically necessary services qualified for exceptions to the therapy caps, and each claim was billed utilizing the KX modifier. The patients' conditions were justified by the medical record documentation, which demonstrated each patient's need for continued skilled therapy beyond the therapy cap in order to achieve

their prior functional status or maximum expected functional status within a reasonable time and, in fact, each patient at issue achieved such status.

V. THE PLANS OF CARE MET MEDICARE REQUIREMENTS

The OIG denied five claims alleging that the services were not provided in accordance with a plan that met Medicare requirements. Specifically, for four claims, the OIG alleged that the plan did not include the type of service provided and billed to Medicare, and for one claim, the date the plan was established was never recorded.

For the four claims in which the OIG alleged the plan did not include the type of service provided and billed to Medicare, **Exhibit M** puts forth the specific reasoning as to why the services were billed in accordance with the plan. However, the relevant portions of the medical record needed in order to defend the allegations for Sample #67 have been unable to be located since the audit took place.

For the one claim in which the plan of care was alleged to not include an establishment date, the plan of care in question was established on April 17, 2009 for Sample #3. It is the practice of Spectrum to establish the plan of care the same day as the therapist performs the initial evaluation (i.e., the plan of care establishment date is also the start of care date). The plan of care in question includes the start of care date as April 17, 2009. In addition the treatment notes demonstrate that the therapist performed the initial evaluation on April 17, 2009, and the progress notes for April 17, 2009 specifically refer the reader to the initial assessment contained in the plan of care in great detail. The Medicare Benefit Policy Manual states, “[t]he date may be added to the record in any manner and at any time, as long as the dates are accurate.”¹⁸ Here, the start of care date contained on the plan of care should be accepted as the date the plan of care was established. This minor oversight on the part of the therapist in only documenting the start of care date and failing to record the date the plan of care was established is evidenced by the physical therapist affidavit, attached hereto as **Exhibit N**.

VI. PLANS OF CARE WERE INCLUDED IN THE MEDICAL RECORDS

For two claims, the OIG alleges that the medical records did not include a plan of care. The two sample claims in question do in fact have a plan of care, attached hereto as **Exhibit O**, and therefore the reimbursement should not be denied for these claims.

Based on the Spectrum’s comments under recommendation #1, and in consideration of Spectrum’s commitment to compliance, Spectrum requests the OIG to consider a

¹⁸ Medicare Benefit Provider Manual, Chapter 15, Section 220(A).

substantial and meaningful reduction in the recommended refund amount, allowing the provider to survive and continue its compliance activities set forth below.

Spectrum concurs with recommendation #2

Over the past year, Spectrum has made numerous changes and updates to its policies and procedures that demonstrate the provider's commitment and dedication of ensuring its billing and documentation practices meet Medicare guidelines. Each year, Spectrum holds an annual meeting in which mandatory attendance of all Spectrum employees is required. Prior to the meeting, each employee is required to sign the meeting sign-in log, attached hereto as **Exhibit P**. The goal of this meeting is to ensure all Spectrum employees are educated and trained on the new and existing standards of proper care and billing, using CMS manuals as its guide. In addition, prior to the OIG audit, Spectrum provided each employ \$500 to be used towards continuing education. Today, Spectrum mandates that, as part of the employee's education stipend, at least one seminar the employee attends is focused on Medicare documentation requirements and policies. As part of its compliance plan, Spectrum has instituted a number of additions to the specific compliance categories alleged by the OIG as not meeting Medicare requirements, including the following examples:

I. Timely physician certification

Spectrum fully comprehends the importance of receiving timely certification by physicians to ensure the established plan of care coincides with the patient's diagnosis and treatment needs. In addition to Spectrum's prior practice of persistent attempts to receive physician certification within 30 days from the start of care, Spectrum now dedicates part of its time and resources to educating its physician/NPP referral sources on Medicare certification requirements. Spectrum has come to the realization that taking a more proactive approach in helping physicians/NPPs understand the importance of timely certification will provide greater cooperation and transparency between Spectrum and its physician referral sources in obtaining the necessary certification to ensure patients receive the most effective and medically necessary therapy treatment.

II. Therapist enrollment in the Medicare program and billing under the correct provider identification number

As explained in Spectrum's response to the OIG's first recommendation, all therapists employed by Spectrum during the audit period became enrolled in the Medicare program. Today, it is Spectrum's practice to enroll all newly hired therapists in the Medicare program, as well as maintain its current staff certification through the revalidation process, as required by CMS.

Once the Medicare enrollment application process for new therapists has commenced, any and all billing for services performed by that therapist is held until the therapist's enrollment has been approved. Thereafter, Spectrum submits the billing for those services under the providing therapist's provider identification number. Furthermore, as part of its initiative to follow Medicare billing guidelines, Spectrum's billing company has been further instructed to bill each service under the correct provider identification number. In addition, when services are provided to a patient by a physical therapist assistant (PTA), Spectrum requires the supervising therapist to sign or cosign the treatment note for the services performed by the PTA on that particular date of service. Thereafter, the billing company is to bill the procedure codes performed by the PTA under the supervising therapist's provider identification number.

III. Treatment note documentation

Spectrum has revised its treatment/progress notes to include sections for documenting "time in" and "time out" for the services performed on any given date of service. By instituting these new sections into the treatment note, the therapists and billing professional can consistently and accurately calculate the total number of minutes spent providing therapy services that day, and allow for the proper recording of the total treatment time in minutes. Spectrum requires total treatment time in minutes to be recorded on the note, which is then used to correctly document the total number of units performed on the particular date of service. An example of Spectrum's revised treatment/progress note is attached to this response for the OIG's reference (see **Exhibit Q**). Spectrum has also provided the OIG with its Daily Flow Sheet, attached hereto as **Exhibit R**, which was added to Spectrum's documentation system to provide for a more detailed visual of each therapy session. As the OIG will find, the Daily Flow Sheet also contains a section for documenting time in/time out to provide the therapist, reviewer and biller with the total number of minutes performed for that therapy session.

In regards to billing for services exceeding therapy cap, Spectrum has and will continue to educate its therapists on providing sufficient detail to enable the therapist, reviewer and Medicare contractors to make an easy determination that the services in question were in fact medically necessary. Each therapist will also continue to be instructed as to the appropriateness of adding the KX modifier to the applicable claim.

IV. Thorough review of documentation

Spectrum has also increased its procedures for reviewing billing documentation prior to sending the material to the billing company. Spectrum's billing is sent to the billing company every Tuesday. Each and every therapist is required to submit their billing slips to Spectrum's owner for final review by Monday morning. Thereafter, Spectrum's owner

conducts a thorough review to ensure that the billing slips contain all required information needed to meet CMS guidelines (e.g., total treatment time in minutes, therapist signature, etc.).

Spectrum has also hired a physical therapist to perform chart reviews for proper documentation. Upon discharge, the therapist reviews the patient's chart to ensure each and every chart meets CMS documentation guidelines. If any discrepancy is found in the chart, the reviewing therapist will consult with the documenting therapist to determine the accuracy of the information recorded. If it is determined that the record contains an error or omission, an addendum to the record is established. The addendum contains any corrections made, along with the dated signature of the therapist who originally recorded the treatment and/or billing information.

Finally, Spectrum plans to conduct its billing in-house. During the audit period, Spectrum utilized an independent third party biller. Spectrum is certain that this shift in billing responsibilities will result in fewer billing errors, and that an accurate billing system would be best served by Spectrum's new compliance policies and procedures than it would by using the services of its independent billing company.

As demonstrated above, Spectrum has made, and will continue to make, significant improvements to its compliance plan in order for the provider's billing and treatment documentation to conform to CMS guidelines. **In addition, Spectrum offers to have an independent billing expert, approved by the OIG, conduct a quarterly audit of Spectrum's billing and documentation procedures. Once each audit has been completed, Spectrum offers to share these results with the OIG to ensure Spectrum's practices are in compliance with Medicare reimbursement requirements.**

Spectrum concurs with recommendation #3

Since August 2012, Spectrum's owners have attended multiple seminars in order to obtain a better understanding of the Medicare reimbursement requirements. These seminars include:

1. *CMS Guide to Manual Medical Review of Therapy Services*, August 7, 2012.
2. *Preparing for Functional Reporting*, December 12, 2012.
3. *Novitas presents: Medicare Part B Physical and Occupational Therapy Billing*, January 28, 2013.

In addition, Spectrum's owners are currently registered for a seminar, entitled *Documentation for Function*, presented by Cross Country Education on April 24, 2013. Spectrum's owners, therapist and other staff will continue to attend additional provider outreach and education seminars to obtain a better understanding of Medicare reimbursement requirements. Spectrum will continue to implement the information obtained from these programs into its standards of care and practice to ensure that its patients receive the highest quality of care and that all of Spectrum's billing and treatment documentation complies with Medicare reimbursement requirements and guidelines.

Conclusion

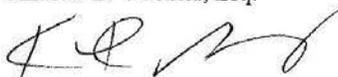
Since 2003, Spectrum has provided quality physical therapy services to a great number of patients. In doing so, Spectrum utilizes the skills and experience of ten physical therapists, four occupational therapists, one speech therapist and four therapist assistants to deliver effective results to patients needing various methods of therapy treatment. Such a substantial refund of alleged improper payments, as initially recommended by the OIG, would certainly cause Spectrum to go out of business, resulting in numerous patients not receiving the quality of care they deserve and have come to expect from their physical therapy provider. The allegations contained in this audit center around inadequate documentation, rather than the level of care provided by Spectrum. Therefore, Spectrum requests that the OIG accept its resolution of efficiently utilizing Spectrum's resources by putting these resources into compliance. Spectrum has already made and will continue to make the necessary ongoing revisions to its compliance plan so that its policies and procedures appropriately align with Medicare reimbursement guidelines. Finally, Spectrum is offering to work closely with the OIG by implementing the above referenced compliance activities and submitting quarterly reviews to the OIG for the OIG's review and consideration, thereby ensuring Spectrum's billing system achieves an acceptable level of quality and accuracy approved by the OIG.

Respectfully Submitted,

WACHLER & ASSOCIATES, P.C.



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