

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AGEWELL PHYSICAL THERAPY
& WELLNESS, P.C., CLAIMED
UNALLOWABLE MEDICARE
PART B REIMBURSEMENT
FOR OUTPATIENT
THERAPY SERVICES**



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Office of Inspector General

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EXECUTIVE SUMMARY

AgeWell Physical Therapy & Wellness, P.C., improperly claimed at least \$1.3 million in Medicare reimbursement for outpatient therapy services over a 2-year period.

WHY WE DID THIS REVIEW

Total payments for Medicare Part B outpatient therapy 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. AgeWell Physical Therapy & Wellness, P.C. (AgeWell), was a top provider of outpatient therapy services in New York State.

The objective of this review was to determine whether claims for outpatient therapy services submitted for Medicare reimbursement by AgeWell complied 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

During the period January 1, 2011, through December 31, 2012, AgeWell claimed Medicare reimbursement for 29,542 outpatient occupational and physical therapy claims totaling \$3,133,762. We reviewed a random sample of 100 of those claims.

WHAT WE FOUND

AgeWell claimed Medicare reimbursement for outpatient therapy services that did not comply with Medicare requirements. Of the 100 claims in our random sample, AgeWell properly claimed Medicare reimbursement for 38 claims. However, AgeWell improperly claimed Medicare reimbursement for the remaining 62 claims. Of these 62 claims, 29 contained more than 1 deficiency.

These deficiencies occurred because AgeWell did not have a thorough understanding of Medicare requirements related to claiming outpatient therapy services and did not have adequate policies and procedures to ensure that it billed for services in accordance with Medicare

requirements. On the basis of our sample results, we estimated that AgeWell improperly received at least \$1,377,382 in Medicare reimbursement for outpatient therapy services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that AgeWell:

- refund \$1,377,382 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 Medicare requirements related to claiming outpatient therapy services through such means as attending provider outreach and education seminars.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, AgeWell, through its attorneys, generally disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations.

AgeWell stated that the overwhelming majority of the deficiencies identified in our draft report were based on technical denial decisions related to claims for which it demonstrated compliance with Medicare requirements. AgeWell also provided explanations and additional documentation for certain claims. Specifically, AgeWell provided:

- signed statements from therapists attesting that printed initials on treatment notes represented their signatures (20 claims);
- detailed explanations of why, according to AgeWell, treatment notes supported the number of units billed (10 claims);
- an interpretation of CMS guidance related to plan-of-care requirements and why AgeWell believes it was not required to indicate on plans of care the specific treatments or interventions provided and billed to Medicare (27 claims);
- an interpretation of CMS's "delayed certification standard" and signed statements from physicians indicating that their failures to date their signatures on plans of care or timely certify plans of care were oversights (22 claims); and
- documentation that services were billed by a therapist enrolled in the Medicare program under a correct provider number or under the direction of a therapist whose provider number was used for Medicare billing purposes (13 claims).

In addition, AgeWell stated that it reserves its right to contest our findings through the Medicare appeals process for four claims for outpatient therapy services for which we determined that the services were not medically necessary. AgeWell also stated that we failed to provide documents regarding the statistical validity of the audit, and that we did not conduct an open and transparent audit.

After reviewing AgeWell's comments and additional documentation, we revised our findings related to 11 claims for which AgeWell claimed Medicare reimbursement for therapy services billed under an incorrect provider number. We note that for 3 of these 11 claims, our revisions did not affect our recommended financial disallowance because the claims were unallowable for other reasons. We maintain that our findings and recommendations related to the remaining sampled claims are valid.

We disagree with AgeWell's comments that we failed to produce documents regarding the statistical validity of the audit, and that we did not conduct an open and transparent audit. We provided AgeWell all of the necessary information and data that identified and supported our findings prior to issuing our draft report. This information included our sampling methodology, detailed information identifying all findings in our sample along with an explanation for these findings, and the statistical output from our statistical software.

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INTRODUCTION

WHY WE DID THIS REVIEW

Total payments for Medicare Part B outpatient therapy 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.¹ AgeWell Physical Therapy & Wellness, P.C. (AgeWell), was a top provider of outpatient therapy services in New York State.

OBJECTIVE

Our objective was to determine whether claims for outpatient therapy services submitted for Medicare reimbursement by AgeWell complied 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.

¹ *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), issued December 21, 2010; *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 6, 2013; *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August, 20, 2014.

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.² Further, Medicare Part B pays for outpatient occupational and physical therapy services performed by or under the personal supervision of a therapist in private practice.³ Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁴

Medicare requirements are further clarified in chapter 15 of CMS's *Medicare Benefit Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04). Among these requirements, therapists must maintain a detailed treatment note for each treatment day and each therapy service (*Medicare Benefit Policy Manual*, chapter 15, § 220.3E).

AgeWell Physical Therapy & Wellness, P.C.

AgeWell provides outpatient therapy services at two locations, in Lake Success and Maspeth, New York. During the period January 2011 through December 2012, AgeWell employed approximately 10 full-time therapists who provided outpatient occupational and physical therapy services to Medicare beneficiaries.

HOW WE CONDUCTED THIS REVIEW

During the period January 1, 2011, through December 31, 2012, AgeWell claimed Medicare reimbursement for outpatient therapy services. Our sampling frame consisted of 29,542 outpatient therapy service claims, totaling \$3,133,762, of which we reviewed a 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 Sections 1862(a)(1)(A) and 1835(a)(2)(C) of the Act.

³ 42 CFR §§ 410.59 and 410.60.

⁴ Section 1833(e) of the Act.

FINDINGS

AgeWell claimed Medicare reimbursement for outpatient therapy services that did not comply with Medicare requirements. Of the 100 claims in our random sample, AgeWell properly claimed Medicare reimbursement for 38 claims. AgeWell improperly claimed Medicare reimbursement for the remaining 62 claims. Specifically:

- For 34 claims, AgeWell's treatment notes did not meet Medicare requirements.
- For 29 claims, the plan was missing or did not meet Medicare requirements.
- For 22 claims, outpatient therapy services did not meet Medicare physician certification requirements.
- For four claims, outpatient therapy services were not medically necessary.
- For two claims, the therapist who billed Medicare did not perform or supervise the service.

Of these 62 claims, 29 contained more than 1 deficiency.

These deficiencies occurred because AgeWell did not have a thorough understanding of the Medicare requirements related to claiming outpatient therapy services and did not have adequate policies and procedures to ensure that it billed for services in accordance with Medicare requirements. On the basis of our sample results, we estimated that AgeWell improperly received at least \$1,377,382 in Medicare reimbursement for outpatient therapy services that did not comply with Medicare requirements.

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). If a therapist is not enrolled in Medicare, services performed by the therapist are eligible for Medicare reimbursement only if the therapist is directly supervised by one who is enrolled in Medicare. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the services are performed (*Medicare Benefit Policy Manual*, chapter 15, § 230.4.B). 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 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 34 claims, AgeWell received Medicare reimbursement for services for which the treatment note did not meet Medicare requirements. Specifically:

- **The treatment note did not contain the therapist's signature or professional identification.** For 20 claims, the treatment note did not include the signature or the professional identification of the therapist who performed the service or the presence of a supervising therapist. Without this information, we could not determine identification of the qualified professional who furnished the service.
- **The treatment note did not support the number of units billed.** For 14 claims, the treatment note did not support the number of units billed for some services. For example, for 1 claim, the treatment note indicated 1 unit of a service provided but claimed 2 units of service.

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). In addition, the signature and professional identity of the person who established the plan and the date it was established must be recorded (*Medicare Benefit Policy Manual*, chapter 15, §§ 220.1.2A and B).

For 29 claims, AgeWell received Medicare reimbursement for services that were not provided in accordance with a plan that met Medicare requirements. Specifically:

- **The services provided were not included in the plan.** For 27 claims, the plan did not include the specific treatment or intervention provided and billed to Medicare. For example, for one claim, electrical stimulation services were provided and claimed, but that specific treatment or intervention was not included in the beneficiary's plan.
- **The plan was missing.** For one claim, the plan was missing.
- **The plan was not dated.** For one claim, the date the plan was established was not recorded. Therefore, we could not determine that the plan was established before treatment began.

MEDICARE PHYSICIAN CERTIFICATION REQUIREMENTS NOT MET

Medicare may make payment for outpatient therapy services if a physician certifies (1) that such services were required because the individual needed outpatient therapy, (2) a plan for furnishing such services has been established by a physician or by a qualified therapist and periodically reviewed by a physician, and (3) 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 nonphysician practitioner's certification of the initial plan. For an initial plan to be certified in a timely manner, the physician or nonphysician 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.B & C). Physician certification is documented by a dated signature or verbal order (*Medicare Benefit Policy Manual*, chapter 15, § 220.1.3.B).

For 22 claims, AgeWell received Medicare reimbursement for services that did not meet physician certification requirements. Specifically:

- **Services were not certified.** For 12 claims, services were not certified (i.e., there was no dated practitioner signature on the plan).
- **Services were not certified in a timely manner.** For 10 claims, services were not certified by a physician or nonphysician practitioner when obtained or within 30 days of the first treatment.⁵

SERVICES NOT MEDICALLY NECESSARY

The Balanced Budget Act of 1997⁶ placed an annual cap on Medicare outpatient 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

⁵ *Medicare Benefit Policy Manual*, chapter 15, § 220.1.3.D, allows providers to submit delayed certifications. Certifications are acceptable without justification for 30 days after they are due. Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/nonphysician practitioner makes a certification accompanied by a reason for the delay. In making these determinations, we allowed services if the plan was certified within 60 days of the first treatment to account for the certification of plans that met delayed certification requirements. Additionally, certifications provided after the 60 days did not include reasons for the delay.

⁶ P.L. No. 105-33 § 4541 (Aug. 5, 1997).

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.

“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).

For four claims, AgeWell received Medicare reimbursement for services that exceeded therapy caps and for which the beneficiaries’ medical records did not support the medical necessity of services reimbursed above these caps.⁸

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. 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 two claims, AgeWell received Medicare reimbursement for outpatient therapy services provided by therapists who were not enrolled in Medicare and did not have a provider identification number.⁹ These services were billed to Medicare using provider identification numbers assigned to other therapists in the practice.

CONCLUSION

On the basis of our sample results, we estimated that AgeWell improperly received at least \$1,377,382 in Medicare reimbursement for outpatient therapy services that did not comply with Medicare requirements.

RECOMMENDATIONS

We recommend that AgeWell:

- refund \$1,377,382 to the Federal Government,

⁸ Medical review staff of National Government Services (NGS), which serves as the Part B Medicare Administrative Contractor for providers in New York State, made these medical necessity determinations.

⁹ We did not disallow claims when a provider had a provider identification number, but the wrong one was used to bill the claim.

- 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 Medicare requirements related to claiming outpatient therapy services through such means as attending provider outreach and education seminars.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, AgeWell, through its attorneys, generally disagreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations.

AgeWell stated that the overwhelming majority of the deficiencies identified in our draft report were based on technical denial decisions related to claims for which it demonstrated compliance with Medicare requirements. AgeWell also provided explanations and additional documentation for certain claims. In addition, AgeWell stated that we failed to provide documents regarding the statistical validity of the audit, and that we did not conduct an open and transparent audit. AgeWell's comments are included as Appendix D. We did not include the additional documentation that AgeWell provided because it was too voluminous and contained personally identifiable information.

After reviewing AgeWell's comments and additional documentation, we revised our findings related to 11 claims for which AgeWell claimed Medicare reimbursement for therapy services billed under an incorrect provider number. We note that for 3 of these 11 claims, our revisions did not affect our recommended financial disallowance because the claims were unallowable for other reasons. We maintain that our findings and recommendations related to the remaining sampled claims are valid.

We disagree with AgeWell's comments that we failed to produce documents regarding the statistical validity of the audit, and that we did not conduct an open and transparent audit. We provided AgeWell all of the necessary information and data that identified and supported our findings prior to issuing our draft report. This information included our sampling methodology, detailed information identifying all findings in our sample along with an explanation for these findings, and the statistical output from our statistical software.

TREATMENT NOTES DID NOT MEET MEDICARE REQUIREMENTS

Auditee Comments

AgeWell stated that Medicare permits providers to submit signature attestation statements to validate missing signatures on treatment notes, and it provided signed statements from therapists attesting that printed initials on treatment notes related to 20 claims represented their signatures. AgeWell also stated that, arguably, a therapist's initials meet CMS signature requirements.

AgeWell also provided detailed explanations of why, according to AgeWell, treatment notes related to 10 claims supported the number of units billed. Specifically, AgeWell stated that the description of exercises associated with the services billed represented language that can be compared to the claim to verify that the claim was coded correctly.

Office of Inspector General Response

We maintain that the 30 claims addressed in AgeWell’s comments 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, the *Medicare Benefit Policy Manual* states that therapists must maintain a treatment note for each treatment day and each therapy service that contains, among other requirements, the “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” (emphasis added). The manual also provides an example of how the signature and professional identification of the qualified professional who furnished or supervised the services should appear on the treatment note (the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law) (*Medicare Benefit Policy Manual*, chapter 15, § 220.3E).

For the 30 claims addressed in AgeWell’s comments, treatment notes did not include the signature or the professional identification of the therapist who performed the service or the presence of the supervising therapist, and the treatment notes did not support the number of timed code treatment minutes billed for some services. Without this information, we could not determine whether the individual who furnished the service was professionally qualified. Further, we have no assurance that AgeWell met Medicare’s minimum time requirements for billing services.¹⁰ For example, one treatment note indicates the type of exercises and the amount of repetitions performed by the beneficiary (e.g. 30 toe raises); however, the treatment note does not indicate the total timed code treatment minutes for the services performed. Finally, signature attestation statements were prepared more than 2 years after the services were provided as a result of our audit to contest specific audit findings. This does not constitute contemporaneous evidence that services were adequately documented in the treatment notes.

PLAN DID NOT MEET MEDICARE REQUIREMENTS

Auditee Comments

AgeWell stated that CMS has advised the provider community that plans of care do not need to identify specific treatments, interventions, procedures, modalities, or techniques for services provided to be in accordance with the Medicare beneficiary’s plan of care. In its comments, AgeWell cited 42 CFR § 410.61 and indicated that the only requirement for the “type” of therapy to be included in the plan is whether the therapy is physical, occupational, or speech-language pathology services. Therefore, according to AgeWell, we have no basis for recommending

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

disallowance for 27 claims for which we determined that the plan of care did not meet Medicare requirements.

Office of Inspector General Response

We maintain that the plan of care associated with the 27 claims addressed in AgeWell's comments did not meet Medicare requirements. According to 42 CFR § 410.61(c) ("Content of the plan"), the plan of care must "prescribe the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals" (emphasis added). For all 27 claims addressed in AgeWell's comments, the plan of care did not include the specific type of treatment or intervention provided and billed to Medicare. A description of the specific type of treatment or intervention is necessary to support that the services provided were appropriate.

MEDICARE PHYSICIAN CERTIFICATION REQUIREMENTS NOT MET

Auditee Comments

AgeWell stated that it met Medicare physician certification requirements for 22 claims and provided an interpretation of CMS's "delayed certification standard" and signed statements from physicians indicating that their failure to date their signatures on plans of care or timely certify plans of care were oversights.¹¹ AgeWell stated that *Medicare Benefit Policy Manual*, chapter 15, § 220.1.3.D, allows for delayed certification and recertification statements when accompanied by a reason for the delay.

Office of Inspector General Response

We maintain that the 22 claims did not meet Medicare physician certification requirements. The signed statements provided by AgeWell were prepared as a result of our audit, and there was no evidence in the beneficiary's medical records explaining why the physicians did not date their signatures on plans of care or timely certify plans of care for services that occurred after 60 days from the time of the first treatment. If the signed statements were in the beneficiaries' medical records prior to our review, even if the statements were prepared more than 2 years after the plans of care were created, we might have accepted these statements as support that physicians certified beneficiaries' plans of care if all other requirements were satisfied. However, the associated beneficiaries' medical records contained no evidence to justify why these "delayed certifications" did not include reasons for the delay (e.g., no evidence that AgeWell contacted a physician on multiple occasions to obtain their signature).

¹¹ Specifically, AgeWell provided letters from 11 physicians explaining that their failure to date their signature was an oversight and from 8 physicians explaining that their failure to timely certify the plan of care was an oversight.

SERVICES BILLED UNDER INCORRECT PROVIDER NUMBER

Auditee Comments

AgeWell provided documentation that services associated with 11 claims were billed by a therapist enrolled in the Medicare program under a correct provider number or under the direction of a therapist whose provider number was used for Medicare billing purposes. For two other claims, AgeWell stated that services were performed under the direct supervision of a therapist whose Medicare provider number was used for billing those services.

Office of Inspector General Response

After reviewing AgeWell's comments and additional documentation, we revised our findings related to 11 claims for which AgeWell claimed Medicare reimbursement for therapy services billed under an incorrect provider number.¹² Regarding the two claims for which AgeWell stated that services were performed under the direct supervision of a therapist whose Medicare provider number was used for billing those services, there was no evidence in the beneficiary's medical records indicating that the supervising therapists referenced in AgeWell's comments were present at the time the services were performed (i.e., directly supervising the therapist).

SERVICES NOT MEDICALLY NECESSARY

Auditee Comments

AgeWell stated that it reserves its right to contest our findings through the Medicare appeals process for four claims for outpatient therapy services for which we determined that the services were not medically necessary.

Office of Inspector General Response

We maintain that the four claims were for services that exceeded therapy caps and for which the beneficiaries' medical records did not support the medical necessity of services reimbursed above these caps. As we noted in our draft report, medical review staff of NGS, which serves as the Part B Medicare Administrative Contractor for providers in New York State, made these determinations.

¹² We note that for 3 of these 11 claims, our revisions did not affect our recommended financial disallowance because the claims were unallowable for other reasons.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 29,542 Medicare outpatient occupational and physical therapy claims, totaling \$3,133,762, that AgeWell provided during the period January 1, 2011, through December 31, 2012.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of AgeWell'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 CMS's National Claims History file, but we did not assess the completeness of the file.

We performed fieldwork at AgeWell's office in Lake Success, New York, from June through July 2013.

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 AgeWell 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 29,542 outpatient therapy services claims, totaling \$3,133,762, for the period January 1, 2011, through December 31, 2012;
- selected a 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 canceled or adjusted;
- obtained and reviewed medical record documentation from AgeWell for each sample item to determine whether the services were provided in accordance with Medicare reimbursement requirements;
- utilized NGS medical review staff to determine whether sampled claims billed with the KX modifier met medical necessity requirements;

- estimated the unallowable Medicare reimbursement paid in the total sampling frame of 29,542 claims; and
- discussed the results of our review with AgeWell officials.

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 provided by AgeWell during the period January 1, 2011, through December 31, 2012.

SAMPLING FRAME

The sampling frame was an Access database containing 29,542 outpatient therapy service claims, totaling \$3,133,762, provided by AgeWell during the period January 1, 2011, through December 31, 2012. The claims data were extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was an outpatient therapy service claim.

SAMPLE DESIGN

We used a simple random sample.

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 AgeWell at the lower limit of the 90-percent confidence interval.

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
29,542	\$3,133,762	100	\$10,996	62	\$5,580

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

Point estimate	\$1,648,472
Lower limit	1,377,382
Upper limit	1,919,561

APPENDIX D: AUDITEE COMMENTS

AGEWELL PHYSICAL THERAPY & WELLNESS, P.C.

**RESPONSE TO THE DRAFT REPORT OF THE U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL**

REPORT NUMBER: A-02-13-01031

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- Exhibit “F” AgeWell Physical Therapy & Wellness, P.C. Compliance Program Guide
- Exhibit “G” AgeWell Physical Therapy & Wellness, P.C. Annual Compliance Training

I. INTRODUCTION

AgeWell Physical Therapy & Wellness, P.C. (“AgeWell”) generally met Medicare requirements for reimbursement for outpatient therapy services. The touchstone for payment for Medicare Part B outpatient therapy services is whether the services are reasonable and necessary for the treatment of injury or to improve a functional limitation.¹ For outpatient physical therapy services, the governing federal regulation makes clear that this standard is met where the physical therapy services are provided under the following conditions: (1) they are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine, (2) they are furnished under a plan of treatment that meets the requirements of 42 C.F.R. § 410.61; and (3) they are furnished by, or under the direct supervision of, a physical therapist in private practice.² Significantly, National Government Services (“NGS”), the Medicare Administrative Contractor for AgeWell, conducted a medical review of the 100 claims audited by the Office of Inspector General (“OIG”), and determined that only 4 claims were allegedly medically unnecessary because the claims exceeded Medicare’s “therapy caps” for outpatient Part B services. Thus, NGS determined that there was a 4 percent error rate for the audited claims based on a medical necessity review of such claims.³

The OIG, however, identified deficiencies in a total of 70 claims as set forth in its draft report. With the exception of the 4 claims noted above, the overwhelming majority of the remaining deficiencies consist of technical denial decisions, made without the benefit of AgeWell’s response to correct the basis for the technical denial or additional information to demonstrate that certain of the OIG’s findings are simply incorrect. For example, the Centers for Medicare & Medicaid Services (“CMS”) expressly permits providers to correct missing or illegible signatures on medical records through the use of a signature attestation statement.⁴ AgeWell is submitting signature attestation statements for all claims identified by the OIG in its draft report as deficient because the treatment note for the date of service in question allegedly did not have a signature or professional identification of the therapist who performed the service. Consistent with CMS’s rules for provider audits, the OIG must reverse course in its final report and find that these claims were properly reimbursable. With respect to other noted deficiencies, AgeWell is supplying additional documentation that demonstrates compliance with Medicare’s rules, such as the delayed certification standard. It is entirely consistent with CMS policy for audited providers to submit additional documentation to demonstrate compliance with initial detected deficiencies. Finally, certain of the OIG’s findings are based upon a misunderstanding of Medicare’s rules for outpatient therapy services.

¹ Section 1862(a)(1)(A) of the Social Security Act (the “Act”), 42 U.S.C. § 1395y(a)(1)(A).

² 42 C.F.R. § 410.60(a).

³ AgeWell’s performance in this respect stands in stark contrast to other physical therapy providers audited by the OIG. See *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August 2014 (finding 44 claims that were allegedly medically unnecessary); and *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 2013 (finding 21 claims that were allegedly medically unnecessary).

⁴ *Medicare Program Integrity Manual*, Ch. 3, § 3.3.2.4.C.

AgeWell's specific responses to the OIG's findings definitively demonstrate that the overwhelming majority of the deficiencies identified in the draft report are based on technical denial decisions for which AgeWell has demonstrated compliance in accordance with the governing CMS rules, regulations, and guidance. In accordance with these rules, regulations, and guidance, and consistent with generally accepted government auditing standards, the OIG must revise its report based on the responses and additional information provided herein.

II. AGEWELL'S RESPONSE TO THE OIG'S GENERAL FINDINGS

AgeWell disagrees with the OIG's findings that AgeWell claimed Medicare reimbursement for outpatient therapy services that did not comply with Medicare requirements. AgeWell is submitting with this response additional documentation that demonstrates compliance with the applicable Medicare requirements at issue for the overwhelming majority of the claims that the OIG found deficient. In other cases, the OIG's findings are based on a misunderstanding of the applicable Medicare requirements compounded by the failure of the OIG to staff the audit with auditors who possess the technical knowledge, skills, and experience necessary to be competent for a review of physical therapy services. AgeWell will generally address the noted deficiencies below. In addition, AgeWell is submitting specific responses to the noted deficiencies for each Sample number in the audit. These specific responses are set forth in Exhibit "A" to this response and are incorporated herein by reference.

A. AgeWell's Treatment Notes Generally Met Medicare Requirements

The OIG identified 34 claims for which it contends the supporting treatment note did not meet Medicare requirements. The OIG identified the following two issues with respect to AgeWell's treatment notes: (1) the treatment note did not contain the therapist's signature or professional identification (20 claims); and (2) the treatment note did not support the number of units billed (14 claims). The purpose of treatment 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."⁵ AgeWell's treatment notes complied with CMS's stated purpose for such notes and, consequently, generally met Medicare's requirements. Tellingly, AgeWell produced treatment notes for every claim audited. As explained below and in AgeWell's specific responses to each claim set forth in Exhibit "A" to this response, 30 of the 34 claims identified by the OIG were properly reimbursable.

1. AgeWell Has Provided Signature Attestation Statements For All 20 Claims Missing A Therapist's Signature

With respect to treatment notes that were missing a therapist's signature, Medicare permits providers to submit a signature attestation statement to authenticate an illegible or

⁵ *Medicare Benefit Policy Manual*, Ch. 15, § 220.3.E.

missing signature on medical documentation.⁶ An attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.⁷ AgeWell has attached to its specific responses set forth in **Exhibit “A”** signature attestation statements, along with the corresponding therapy record, for all 20 of the claims that the OIG recommended disallowance based on the treatment note lacking the therapist’s signature or professional identification. Thus, these claims are allowable based on guidance provided in the *Medicare Program Integrity Manual* allowing for the submission of signature attestation statements to authenticate an illegible or missing signature.

Notably, for all 20 claims at issue the therapist providing the service initialed the treatment note. Arguably, the therapist’s initials meet CMS’s signature requirements. Specifically, the *Medicare Benefit Policy Manual* defines “signature” as “a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, § 3, concerning signatures.”⁸ Chapter 3 of the *Medicare Program Integrity Manual*, in turn, states that a “handwritten signature is a *mark or sign* by an individual on a document signifying knowledge, approval, acceptance or obligation.”⁹ A therapist’s initials constitute such a mark or sign. Thus, the OIG has no basis for recommending that these claims be disallowed even without the benefit of the signature attestation statements provided. Regardless of whether the OIG accepts this argument, in order for the OIG’s audit to comply with CMS’s rules, the submission of the signature attestation statements requires that the OIG reverse its findings with respect to these 20 claims.

2. AgeWell’s Treatment Notes Supported the Number of Units Billed for 10 of the 14 Claims at Issue

The draft report states that the treatment notes did not support the number of units billed for 14 claims. This finding is incorrect and inconsistent with the applicable Medicare rules and regulations regarding the documentation of services. The treatment note must include the “[t]otal timed code treatment minutes and total treatment time in minutes.”¹⁰ The *Medicare Benefit Policy Manual* further states that the documentation of each treatment shall include: “Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in *language that can be compared with the billing on the claim to verify correct coding.*”¹¹

⁶ *Medicare Program Integrity Manual*, Ch. 3, § 3.3.2.4.C. See also Medicare Learning Network, *Complying with Medicare Signature Requirements*, a copy of which is attached hereto as **Exhibit “B”**, at p. 3 (“Q: Am I able to attest to my signature? A: Yes, you may attest that a signature is yours. A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.”) (citing *Medicare Program Integrity Manual*, Ch. 3, § 3.3.2.4.C.).

⁷ *Id.*

⁸ *Medicare Benefit Policy Manual*, Ch. 15, § 220.A.

⁹ *Medicare Program Integrity Manual*, Ch. 3, § 3.3.2.4.A (emphasis added).

¹⁰ *Medicare Benefit Policy Manual*, Ch. 15, § 220.3.E.

¹¹ *Id.* (emphasis added).

With the exception of four claims (Sample Nos. 34, 38, 74, and 100),¹² AgeWell's treatment notes complied with these requirements. For the remaining 10 claims at issue, AgeWell has provided a detailed explanation of the services provided based on the language used in the treatment note and how the services provided support the number of units billed for a particular service. For example, with respect to Sample No. 13, the treatment note supports that 2 units of therapeutic exercise (CPT Code 97110) were provided and appropriately billed.

Specifically, on December 23, 2011, the treatment note reflects that the patient presented for physical therapy in accordance with the plan of care. The total time in minutes recorded at the bottom of the treatment note for December 23, 2011 reflects that the patient performed 65 minutes of time-based physical therapy service. According to CMS's "8 Minute Rule" for timed services, 4 units are properly billed so long as the total number of service minutes is greater than or equal to 53 minutes through 67 minutes.¹³ The following 4 units of service were billed: 1 unit of neuromuscular re-education (CPT Code 97112), 1 unit of therapeutic activity (CPT Code 97530), and 2 units of therapeutic exercise (CPT Code 97110). The following activities recorded on the treatment note constitute the 2 units of therapeutic exercise:

Skilled Treatment/Exercise/Activity	Detailed Explanation
Biodex L4x 10'	Biodex Level 4 for 10 minutes: Therapist set-up and instruction for recumbent seated stepper machine at level 4 resistance for 10 minutes.
UBE 5/5	Upper Body Ergometer (UBE) performed 5 minutes forward followed by 5 minutes in reverse: Therapist UBE patient set-up and instruction.
ADD x 30	Adduction 30 times: A therapist directed specific motion of the hips in which the patient is in a seated position and forcefully attempts to bring the patient's knees together against a resistance. Therapist must instruct the patient upon appropriate position of the pelvis and low back as well as the angle of the hips and knees as this exercise is performed. Therapist must instruct patient regarding length of time and the force with which to maintain each contraction as well as the cadence with which to perform the movement. Patient performed this specific motion with isometric force 30 times.
ABD Blu x 30	Abduction blue 30 times: Therapist directed specific motion of the hips in which the patient is in a seated position and forcefully attempts to separate

¹² For Sample Nos. 38 and 100, although the total treatment minutes are missing from the treatment note, AgeWell respectfully submits that the treatment note justifies the units billed for the reasons set forth in its specific responses at **Exhibit "A"**.

¹³ *Medicare Claims Processing Manual*, Ch. 5, § 20.2.C (Counting Minutes for Timed Codes in 15 Minutes). This rule is known as the "8 Minute Rule" and provides as follows with respect to units and the corresponding number of minutes:

- Units Number of Minutes**
- 1 unit: ≥ 8 minutes through 22 minutes.
 - 2 units: ≥ 23 minutes through 37 minutes.
 - 3 units: ≥ 38 minutes through 52 minutes.
 - 4 units: ≥ 53 minutes through 67 minutes.

Skilled Treatment/Exercise/Activity	Detailed Explanation
	patient's knees together against a medium heavy resistance. Therapist must instruct the patient upon appropriate position of the pelvis and low back as well as the angle of the hips and knees as this exercise is performed. Therapist must instruct patient regarding length of time and extent of movement with each contraction as well as the cadence with which to perform the movements. Patient performed this specific movement 30 times.
II Bars 4#HF, Abd, Ext 30x	Parallel bars 4# hip flexion, abduction, extension 30 repetitions: Therapist directed specific motions of the hip joint (3 separate and distinct motions). Standing left leg, then right leg, with upper extremity support on fixed surface, lifting the leg with 4 pound weight off the floor, moving the hip joint in forward and up to highest degree, laterally and back/behind planes of movement to strengthen corresponding hip muscles using body weight and 4 pounds against gravity as resistance. Each movement requires specific instructions regarding proper form so that appropriate and effective muscle recruitment is achieved. Each leg and each motion performs exercise 30 repetitions (times.)
Toe Raises 30x	Toe Raises 30 times: Therapist directed, instructed and cued specific motion of the ankle which the patient performs in the standing position with bilateral upper extremity support of varying amounts of load bearing depending upon the patient's ability. The patient drops both heels off the edge of a step to place the heel cord on a stretch at an intensity directed by the therapist and then bears down on his upper extremities and presses the balls of his feet into the standing surface to raise the heels off the surface and then holds that position as directed by the therapist. The patient repeats this process 20 times at a cadence directed by the therapist.
GS Str 3 x 30 "	Gastrocnemius Stretch 3 times 30 seconds: Therapist set up and directed specific ankle and knee stretch where the patient stands on one leg on the edge of a solid surface and drops his heel an amount directed by the therapist while maintaining a specific position at the knees for a period of time of 30 seconds and at an instructed intensity. Patient performs this 3 times on each leg separately. This stretch requires 3 minutes of time with the therapist.
Crossovers 3 laps	Crossovers 3 laps: Patient performed a specific exercise which involves him sidestepping and crossing one foot in front of the other. Therapist provides ongoing instruction and cueing and guarding for safety and to prevent falls. The patient performs this for approximately 60 feet. Patient performs this exercise 3 times. This requires 5 minutes of time with the therapist.
TS on TB	Total stretch on total back: Patient stands on semi-vertical treatment table leaning body against table surface. Patient stands on one leg at a time while therapist supports other leg and moves leg stretching all muscles in all planes within patient's flexibility and pain tolerance, holding each stretch 30 seconds and doing each stretch 2 to 3 times. Patient then stands on other leg while therapist stretches patient's other leg. Therapist performs these stretches on both hip and knee joints. This is done to maximize patient's flexibility and movement. This requires 7 minutes of time with the therapist.

These exercises represent a total of 270 prescribed movements that were instructed, cued and completed during a timeframe consistent with billing for 2 units of therapeutic exercise (23 minutes through 37 minutes). In addition, the therapist set up and instructed the patient on the upper body ergometer and the recumbent seated stepper machine as well as performed bilateral ankle stretches, gait/coordination activities and performed stretching to the patient's bilateral lower extremity hip and knee joints. Accordingly, the claim for 2 units of therapeutic exercise

submitted for Sample No. 13 was properly reimbursable. AgeWell has provided similar detailed explanations for the additional 9 claims at issue in its specific responses attached as Exhibit "A".

It appears that these claims were disallowed because the reviewing auditor lacked the subject matter expertise to assess the physical therapy treatment notes. The failure to use auditors with such knowledge violates sections 3.72 and 6.45 of the *Government Auditing Standards* issued by the U.S. Government Accountability Office. Section 3.72 expressly provides as follows:

The staff assigned to conduct an audit in accordance with [generally accepted government auditing standards] should collectively possess the *technical knowledge, skills, and experience necessary* to be competent for the type of work being performed *before* beginning work on that audit.¹⁴

Similarly, Section 6.45 requires that audit management assign "sufficient staff and specialists with adequate collective professional competence to perform the audit."¹⁵ Here, the OIG's apparent failure to staff the audit with specialists familiar with physical therapy and the descriptions used for physical therapy services constitutes a violation of generally accepted government auditing standards. Notwithstanding this violation of generally accepted government auditing standards, the OIG can correct this finding before issuing its final report. For all of the foregoing reasons and the reasons set forth in AgeWell's specific responses, the OIG must revise its final report to correct that AgeWell's treatment notes generally met Medicare's requirements, and support the services billed for 30 of the 34 claims identified as deficient in the OIG's draft report.

B. AgeWell's Plans of Care Complied with Medicare Requirements

The OIG contends that AgeWell received reimbursement for services that were not provided in accordance with a plan of care that met Medicare requirements for 29 claims. For 27 of these claims, the OIG takes the position that the plan of care did not include the specific treatment or intervention provided and billed to Medicare.¹⁶ The OIG's position is not supported by the authority cited in the draft report. Specifically, the OIG cites to the applicable federal regulation which provides, in pertinent part, that the plan "prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated

¹⁴ *Government Auditing Standards*, Ch. 3, § 3.72 (emphasis added). During the abbreviated Exit Conference between AgeWell and the OIG, one auditor candidly admitted that he lacked the expertise to determine if the minutes recorded supported the units billed solely based on the description of services provided.

¹⁵ *Government Auditing Standards*, Ch. 6, § 6.45.

¹⁶ AgeWell submits that the other 2 claims at issue were properly reimbursable. For Sample No. 18, AgeWell is submitting a signature attestation statement for the missing therapist's signature on the plan of care. For Sample No. 41, AgeWell disagrees that the plan of care did not cover the date of service at issue as explained in AgeWell's specific responses set forth in Exhibit "A".

goals.”¹⁷ The “type” of therapy that must be included on the plan of care is whether the therapy is physical therapy, occupational therapy, or speech-language pathology services.¹⁸ Here, all of AgeWell’s plans of care expressly state that they are “physical therapy” plans of care or “occupational therapy” plans of care. Thus, there is no basis for recommending disallowance for these 27 claims based on the governing federal regulation.

In addition, there is no basis for recommending disallowance based on guidance from CMS. In its draft report, the OIG cites as one example a claim in which electrical stimulation services were provided and claimed, but that *specific treatment or intervention* was not included in the beneficiary’s plan. The OIG’s position is directly undermined by guidance from CMS in which CMS states that clinicians *may* include specific treatment interventions in a plan at the clinician’s option:

It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these *optional* elements: short term goals, goals and duration for the current episode of care, *specific treatment interventions, procedures, modalities or techniques* and the amount of each.¹⁹

In other words, CMS has advised the provider community that plans of care do not need to identify specific treatment, interventions, procedures, modalities or techniques for the service provided to be in accordance with the plan of care. In fact, the only express requirement is that the plan of care specify the type of therapy planned, *e.g.*, physical therapy, occupational therapy, or speech-language pathology.²⁰ Moreover, if the OIG fails to reverse these findings, its report will violate generally accepted government auditing standards related to internal controls for performance audits.²¹ Consequently, the OIG must reverse all of these noted deficiencies as a basis for recommending disallowance of the claims based on the applicable federal regulation, CMS’s guidance and generally accepted government auditing standards.

C. AgeWell Complied with Medicare’s Physician Certification Requirements

The OIG found that AgeWell received reimbursement for services that did not meet physician certification requirements for 22 claims. For 12 of these 22 claims, the OIG found that

¹⁷ 42 C.F.R. § 410.61.

¹⁸ See Affidavit of Nancy J. Beckley, MS, MBA, CHC (“Beckley Aff.”), which is attached hereto as Exhibit “C”. Ms. Beckley is an expert in rehabilitation compliance, including the rules, regulations, and guidance issued by CMS for the documentation of outpatient therapy services. Beckley Aff. at ¶¶ 1-4. Ms. Beckley explains in detail in her affidavit why the OIG’s interpretation that plans of care must include the specific treatment or intervention is incorrect. Beckley Aff. at ¶¶ 10-21.

¹⁹ *Medicare Benefit Policy Manual*, Ch. 15, § 220.1.2.B (emphasis added).

²⁰ *Id.*; see also Beckley Aff. at ¶¶ 10-21.

²¹ *Government Auditing Standards*, Ch. 6, § 6.21 (providing that a deficiency in internal controls exists in performance audits when the design of a control does not allow the auditor to correct noncompliance with provisions of law). Here, the OIG’s interpretation of the requirements for plans of care does not comply with controlling law.

the physician certified the plan of care but failed to date the physician's signature. For the remaining 10 of the 22 claims, the OIG found that the plan of care was not certified in a timely manner. These findings must be reversed because AgeWell is submitting documentation that demonstrates that all 22 of these claims have met CMS's delayed certification standard.²²

The *Medicare Benefit Policy Manual* expressly provides that "[d]elayed certification and recertification requirements shall be deemed satisfied where, **at any later date**, a physician/NPP makes a certification accompanied by a reason for the delay."²³ The *Medicare Benefit Policy Manual* further explains as follows with respect to delayed certifications:

Delayed 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.²⁴

Thus, CMS recognizes that a certification may be delayed because a physician simply fails to certify a plan of care notwithstanding a provider's attempts to obtain such certification. In addition, CMS states that the determinative factor in deciding whether the standard is met is documentation indicating the patient's need for care and that the patient was under the care of a physician at the time physical therapy was provided. Moreover, the length of time in which it takes to have the plan of care certified does not provide a basis for recommending the denial of any service provided to a patient pursuant to the plan of care subsequently certified by the prescribing physician. In fact, such a decision would fly in the face of the *Medicare Benefit Policy Manual's* clear instructions:

²² During the Entrance Conference, the OIG completely ignored the delayed certification standard. See Entrance Conference Agenda at p. 2, a copy of which is attached hereto as **Exhibit "D"**. The OIG's failure to acknowledge the delayed certification standard in explaining the criteria upon which claims would be reviewed calls into question whether the OIG adequately planned the audit to address the OIG's stated objective. The failure to adequately plan the audit violates the field work standards for performance audits. *Government Auditing Standards*, Ch. 6, § 6.06. The Entrance Conference Agenda criteria further violated generally accepted government auditing standards related to identifying audit criteria by failing to address the delayed certification standard at all. *Government Auditing Standards*, Ch. 6, § 6.37.

²³ *Medicare Benefit Policy Manual*, Ch. 15, § 220.1.3.D (emphasis added).

²⁴ *Id.* Significantly, the OIG again misinterprets CMS guidance on this issue as evidenced by footnote 5 of its draft report, which suggests that a reason for the delay *must* be provided with a late certification. CMS advises providers that a reason for the delay *should* be provided, but is not required to meet the standard. It appears that the OIG – based on the lack of technical knowledge to assess the delayed certification standard – is promoting form over substance. The OIG must reverse course. If not, its report will violate several applicable generally accepted government auditing standards, including sections 6.28, 6.37, and 6.45 of the *Government Auditing Standards*.

EXAMPLE: 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 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.²⁵

In evaluating whether the delayed certification standard is met, CMS instructs its contractors that “[t]he 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).”²⁶ Thus, there is a strong presumption in favor of accepting delayed certifications for plans of care when evidence is presented that the physician who subsequently certifies the plan of care was the physician involved in treating the patient at the time physical therapy was provided.

For the 12 claims denied because the physician failed to date his or her signature, AgeWell has obtained letters from 11 physicians explaining that the failure to date the physician’s signature was an oversight.²⁷ For the 10 claims denied because the physician failed to certify the plan of care within 30 days, AgeWell has obtained letters from 8 physicians similarly explaining that the failure to timely certify the plan of care was an oversight.²⁸ These letters are attached to AgeWell’s specific responses set forth in **Exhibit “A”**. These physicians further certify that the services provided as outlined in the applicable plans of care were medically necessary and furnished while the patients at issue were under their care. The letters from the physicians, along with the applicable prescription, plan of care, and additional documentation provided, demonstrate that AgeWell has met the delayed certification standard for these claims.

CMS recognizes that obtaining certifications on plans of care within 30 days can be challenging. In recognition of these challenges, CMS provides that “[i]t is not intended that needed therapy be stopped or denied when certification is delayed.”²⁹ Significantly, CMS states that denial for payment based on the absence of a certification is “a technical denial.”³⁰ **“If an appropriate certification is later produced, the denial shall be overturned.”**³¹ Thus, the OIG

²⁵ *Medicare Benefit Policy Manual*, Ch. 15, § 220.1.3.D (emphasis added).

²⁶ *Id.*

²⁷ The 11 letters apply to all 12 claims because Sample Nos. 34 and 83 involve the same patient.

²⁸ For the 2 claims at issue for which AgeWell did not obtain a letter from the patient’s physician, the existing medical record demonstrates that the delayed certification standard was met.

²⁹ *Medicare Benefit Policy Manual*, Ch. 15, § 220.1.3.D.

³⁰ *Medicare Benefit Policy Manual*, Ch. 15, § 220.1.3.E.

³¹ *Id.* (emphasis added).

must overturn all of these technical denials in accordance with CMS policies that govern this audit because the letters submitted with this response constitute *independent* certifications of the plans of care at issue that meet the delayed certification standard requirements.

D. Services Billed Under Incorrect Provider Number.

The draft report provides that the OIG identified 13 claims in which AgeWell received Medicare reimbursement for outpatient therapy services provided by therapists who were not enrolled in Medicare and did not have a provider identification number. The OIG's findings are incorrect with respect to 11 of the 13 claims. Specifically, the following therapists obtained their National Provider Identifier ("NPI") and Provider Transaction Access Number ("PTAN") numbers as of the effective dates set forth in the table below.

Therapist	NPI Enumeration Date	PTAN Effective Date
R.C.	12-28-2011	12-27-2011
M.P.	7-17-2006	9-01-2012
L.M.P.	8-03-2012	9-01-2012

Documentation confirming the foregoing NPI enumeration dates and PTAN effective dates is attached to AgeWell's specific responses set forth in **Exhibit "A"**. A simple comparison of this information against the dates of service at issue proves that the services were provided by therapists who were enrolled with Medicare and who had a valid NPI.

With respect to the two remaining claims at issue (Sample Nos. 25 and 57), these services were performed under the direct supervision of the therapist whose NPI number was used for billing the services. If a therapist is not enrolled in Medicare, services performed by the therapist are 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.³² Here, AgeWell is providing documentation contemporaneous with the provision of services on the dates of service in question that demonstrates the direct supervision standard was met. For example, with respect to Sample No. 25, AgeWell is submitting with its specific responses documentation that the supervising therapist re-evaluated the patient on the same day as the date of service at issue.

For all of the foregoing reasons and the reasons set forth in AgeWell's specific responses, the OIG must revise its final report to correctly report that AgeWell did not receive Medicare reimbursement for outpatient therapy services provided by therapists who were not enrolled in Medicare and did not have a provider identification number.

³² Medicare Benefit Policy Manual, Ch. 15, § 230.4.B.

E. All Services Provided By AgeWell Were Medically Necessary

NGS conducted a medical review of the 100 claims audited by the OIG and concluded that 4 claims were allegedly medically unnecessary because the progress note for the date of service at issue did not include justification for the KX modifier billed. AgeWell disagrees with these findings for all 4 claims at issue. However, the OIG lacks the technical knowledge to assess AgeWell's response to demonstrate that these claims were medically necessary. In addition, based on our review of other OIG audit reports of physical therapy providers, the OIG does not even consider any responses submitted in connection with medical necessity issues. Instead, the OIG rejects any response out of hand with the perfunctory response that the "medical review staff have extensive knowledge of the Medicare requirements related to medical necessity and, on the basis of their review of the medical records, concluded that [the physical therapy provider's] documentation did not justify services above the therapy cap."³³ Given the OIG's failure to consider any responses on medical necessity issues, AgeWell will not provide a detailed response for each claim at issue. Instead, AgeWell reserves its right to contest these findings through the Medicare appeals process.³⁴

III. AGEWELL'S RESPONSE TO SPECIFIC RECOMMENDATIONS

A. AgeWell Does Not Concur With The OIG's Recommendation That \$1,661,132 Should Be Returned To The Federal Government

As demonstrated above and in AgeWell's specific responses, there are arguably 8 claims that failed to meet Medicare requirements for reimbursement.³⁵ The total amount deficiencies in the 100 claims sampled. **These claims total \$658.03.** The OIG's calculated overpayment is simply unsupported based on a straight-forward application of CMS's rules, regulations, and guidance for the reimbursement of outpatient therapy services in light of the additional information provided with this response.

Moreover, the OIG's use of statistical sampling to extrapolate an overpayment is fundamentally unfair in this case for three reasons. First, there is no sustained or high level of payment error based on the review of the 100 sample claims. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") mandates that *before* using

³³ See, e.g., *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August 2014, at p. 13; and *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 2013, at pp. 9-10.

³⁴ The OIG's failure to be technically proficient and competent to review these therapy claims will result in further overburdening the Medicare appeals process. Thus, this audit exacerbates a growing problem. We encourage the OIG to revise its audit process so it can become part of a solution on a broader scale that benefits beneficiaries, HHS programs, and providers.

³⁵ These 8 claims are for the following Sample Nos.: 31, 34, 38, 43, 62, 74, 85, and 100. Of these 8 claims, 4 claims were denied based on the medical review conducted by NGS. AgeWell disagrees with NGS's findings for these 4 claims, but understands that there is no information it can submit at this stage for the OIG to reverse course on these 4 claims given the OIG's lack of expertise to assess such claims and apparent refusal to have NGS revisit them.

extrapolation to determine overpayment amounts to be recovered by recoupment, these must be a determination of sustained or high level of payment error.³⁶ As explained herein, AgeWell has provided evidence that supports the total amount of claims with deficiencies is, at most, 8 claims. That translates into an error rate of 8%. Moreover, at the Exit Conference, one of the OIG auditors candidly admitted that there is no uniform agreement within the government on what constitutes a high level of payment error.³⁷ Consequently, AgeWell respectfully submits that the OIG should recommend that CMS recoup only the amount of the overpayment based on the actual claims reviewed without the use of extrapolation.

Second, there is no documentation that educational intervention has failed to correct any payment errors. This is the second basis under the MMA that would justify the use of statistical sampling to extrapolate an overpayment.³⁸ Here, not only has there been no such educational intervention, prior audits by NGS demonstrated that AgeWell generally complied with Medicare requirements. Specifically, AgeWell has undergone the following audits conducted by NGS – the very entity that OIG relied upon for its expertise to conduct a medical review of the sample claims:

Audit Date	Provider	Error Rate	Overpayment
June 2008	J.D.	2.6%	\$95.12
June 2008	M.H.	20.6%	\$696.53
June 2009	J.D.	0.00%	\$0.00
June 2009	M.H.	0.00%	\$0.00

Copies of these NGS audit summaries are attached here to as **Exhibit “E”**. These audit reports demonstrate that AgeWell historically has performed well on government audits, and there is no documented educational intervention that would justify using an extrapolation in this audit.

Finally, the OIG failed to produce documents so AgeWell could assess the statistical validity of the audit or otherwise assess if the audit was, in fact, conducted in accordance with generally accepted government auditing standards. Specifically, in response to AgeWell’s Freedom of Information Act (“FOIA”) request seeking, *inter alia*, OIG’s work papers in connection with the audit, OIG refused to produce any such documents. It is well-settled that one way to challenge the validity of an extrapolated overpayment derived from statistical sampling is to verify the statistical validity of the extrapolation.³⁹ Here, the OIG conducted the audit from an unfair playing field by refusing to conduct an open and transparent audit.

³⁶ 42 U.S.C. § 1395ddd(f)(3)(A).

³⁷ In *Miniet v. Sebelius*, No. 10-24127-CIV, 2012 WL 2930746 (S.D. Fla. July 18, 2012), the district court found that a 100% error rate constituted a sustained or high level of payment error as contemplated by the MMA. This decision is not helpful in assessing whether a sustained or high level of payment error was found in this audit because both the OIG and AgeWell agree that the error rate was not 100%. In fact, based on NGS’s medical review, the error rate was 4%.

³⁸ 42 U.S.C. § 1395ddd(f)(3)(B).

³⁹ See, e.g., *Schuldts Chiropractic Wellness Center v. Sebelius*, No. 8:13CV4, 2014 WL 247972, at *3 (D. Neb. Jan. 22, 2014).

Consequently, AgeWell was denied the opportunity to assess the statistical sampling conducted by the OIG. Furthermore, without the requested documents, it is difficult to assess whether the audit complied with generally accepted government auditing standards.

For all of the foregoing reasons, the OIG should refrain from using statistical sampling to extrapolate an overpayment in this case, and recommend that AgeWell return \$658.03 to the federal government.⁴⁰

B. AgeWell Concur With The OIG's Recommendation That It Strengthen Its Policies And Procedures To Ensure That Outpatient Therapy Services Are Provided And Documented In Accordance With Medicare Requirements; AgeWell Does Not Concur That Its Then-Existing Policies And Procedures Were Inadequate To Ensure That Outpatient Therapy Services Were Provided And Documented In Accordance With Medicare Requirements

AgeWell concurs with the OIG's recommendation that AgeWell strengthen its policies and procedures to ensure that AgeWell complies with all Medicare requirements with respect to outpatient therapy services. Towards this end, AgeWell developed and adopted a Compliance Program and a Compliance Code of Conduct in September of 2013. The Code of Conduct was based upon AgeWell's mission statement and guiding ethics. The Compliance Program was formalized in AgeWell's Compliance Program Guide, which was introduced and reviewed with all employees who signed attestation statements in support of and adherence to AgeWell's Compliance Program and Code of Conduct. A copy of AgeWell's Compliance Program Guide is attached hereto as Exhibit "F".

AgeWell's Compliance Program includes an educational and training component. For example, when the program was introduced, all clinical employees were required to complete five courses, and all non-clinical employees completed a fraud and abuse course as part of the annual compliance education and training requirements. All courses required a test and passing score in order to obtain course completion status. Moving forward, compliance training is scheduled on an annual basis, and additional informal training and updates take place as necessary.

AgeWell's Compliance Program also includes a monitoring and auditing component. Specifically, AgeWell conducts routine monitoring of therapy documentation, including physician certifications and verification that the therapy cap and threshold have been established to ensure compliance with Medicare documentation requirements. The monitoring program also includes sanctions checks and license verifications. In addition, the audit program provides for routine, ongoing quality chart reviews by AgeWell's designated compliance officer as well as an

⁴⁰ There is precedent for the OIG to refrain from calculating an extrapolated overpayment through the use of statistical sampling. Specifically, the OIG did not extrapolate an overpayment in the audit of Tyler Prosthetics, Inc. because the provider generally complied with Medicare requirements. *Tyler Prosthetics, Inc. Generally Met Medicare Documentation Requirements for Lower Limb Prosthetic Claims* (A-06-13-00049), issued August 2014. The same rationale applies here and warrants recommending an overpayment refund based only on claims for which the OIG will recommend disallowance.

annual, external audit to ensure compliance with Medicare documentation, coding and certification requirements.

During the first external audit, eleven charts were randomly selected of recently discharged Medicare patients. The focus of the review was overall compliance with Medicare documentation requirements, including requirements related to patient evaluation and the plan of care, daily treatment notes, progress reports, and discharge reports. Medicare's functional limitation reporting requirements, effective July 1, 2013, were also reviewed during this audit to provide additional feedback to AgeWell. The chart review was based upon fifty compliance elements. The average score for the selected charts was forty-six. In summary, the external review demonstrated AgeWell's understanding and compliance with Medicare documentation requirements.

AgeWell does not concur with the OIG's recommendation to the extent the OIG believes that AgeWell's then-existing policies and procedures resulted in any deficiencies identified by the OIG in its draft audit. In this regard, the OIG's recommendation violates one of the fundamental standards of performance audits: "Performance audits are defined as audits that prove findings or conclusions based on an evaluation of *sufficient, appropriate evidence* against criteria."⁴¹ Here, with the exception of one person, the OIG failed to interview any of AgeWell's clinical staff that provides physical therapy services to determine if AgeWell's existing policies and procedures were sufficient for purposes of meeting Medicare documentation requirements. The failure to adequately assess the knowledge of AgeWell's clinical staff violates the foregoing generally accepted government auditing standard because the OIG did not obtain sufficient or appropriate evidence to reach any conclusion with respect to the adequacy of AgeWell's then-existing policies and procedures. The OIG only interviewed one AgeWell official who provides physical therapy. This official explained AgeWell's treatment protocols, documentation of treatment, and his understanding of how this documentation meets Medicare's requirements. There is simply no basis for any conclusion with respect to AgeWell's then-existing policies and procedures especially in light of the majority of deficiencies identified by the OIG that need to be reversed based on the additional information provided in this response.

C. AgeWell Concurs With The OIG's Recommendation That AgeWell's Staff Should Attend Provider Outreach And Education Seminars

AgeWell agrees that its staff could benefit from taking educational classes to further develop their understanding of Medicare's requirements for outpatient therapy services. As part of AgeWell's formal Compliance Program, AgeWell requires that all employees undergo an annual compliance training that contains information regarding Medicare documentation and billing requirements.⁴² Pursuant to the requirements of AgeWell's Compliance Program, in December 2013, all AgeWell clinical employees completed the following courses:

- Compliance Training & Education: Fraud & Abuse;

⁴¹ *Government Auditing Standards*, Ch. 2, § 2.10 (emphasis added).

⁴² AgeWell Compliance Program Guide, Exhibit "F", at p. 25

- Medicare Cap, Threshold & ABN;
- Medicare 8 Minute Rule;
- Medicare Billing Risks; and
- Medicare - The Daily Note.

Descriptions of these course and their objectives are attached hereto as **Exhibit "G"**. In addition, as previously set forth, all AgeWell non-clinical employees completed the "Compliance Training & Education: Fraud & Abuse" course. AgeWell is committed to continuing this educational component of its Compliance Program. Currently, AgeWell's annual training for 2014 is scheduled to take place in December.

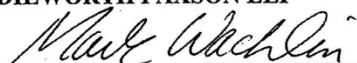
IV. CONCLUSION

AgeWell Physical Therapy & Wellness has been providing quality and compassionate care for over 10 years. AgeWell intentionally focused its physical therapy practice on the "Greatest Generation" as the patient population that it wanted to treat. AgeWell provides high quality physical therapy services to its senior patients that meaningfully improves their lives.

The fundamental mission of the Office of Inspector General is to protect not only the integrity of the HHS programs but also the health and welfare of beneficiaries served by those programs. Absent making the necessary corrections to its draft report, including by correcting its overpayment recommendation, this report will evidence one indisputable fact – the OIG has failed in its mission to protect the health and welfare of the Medicare beneficiaries treated by AgeWell. The OIG will also have failed the Medicare program. Without the provision of medically necessary outpatient therapy, Medicare beneficiaries will be forced to turn to other options, including in-patient hospital stays. Treating beneficiaries in hospital settings will exponentially increase the costs borne by the Medicare program.

AgeWell Physical Therapy & Wellness respectfully requests that the OIG revise its draft report based on the additional information and specific responses provided herein. Such revisions require, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, that the OIG recommend an overpayment refund only for the audited claims determined to still be deficient, not an extrapolated overpayment calculated using statistical sampling.

Dated: November 4, 2014

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