DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

December 14, 2007

Report Number: A-06-07-00061

Mr. Terrence Sablatura
Physical Therapist
108 Shult Drive
Columbus, Texas 78934

Dear Mr. Sablatura:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Texas Physical Therapist's Medicare Claims for Therapy Services Provided During 2002." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Cheryl Blackmon, Audit Manager, at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. Please refer to report number A-06-07-00061 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Tom Lenz, Consortium Administrator
Consortium for Financial Management and Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF TEXAS PHYSICAL THERAPIST'S MEDICARE CLAIMS FOR THERAPY SERVICES PROVIDED DURING 2002

Daniel R. Levinson
Inspector General

December 2007
A-06-07-00061

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Physical therapists provide services according to a physician-approved plan of care designed to improve or restore physical functioning to a patient following disease, injury, or loss of a body part. To aid in a patient's diagnosis and treatment, physical therapists utilize a variety of exercises, rehabilitative procedures, massages, manipulations, and physical agents.

Medicare Part B covers outpatient physical therapy services provided by a qualified therapist in private practice when furnished in the therapist's office or the patient's home. Private practitioners are individuals who work in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice. Regardless of the business structure of the therapy practice, Medicare requires the practice to meet all State and local licensure laws.

Physical therapists must enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. To enroll in Medicare, a physical therapist must complete a form and be qualified to obtain a provider identification number (PIN) that identifies him or her as the person who provided the service on the Medicare claim form. If a physical therapist plans to provide services as part of a group or organization, the group practice must enroll in Medicare. Each individual therapist who plans to reassign his or her benefits to a group or organization must complete and submit a separate form to its Medicare carrier.

Medicare carriers, under contract with the Centers for Medicare & Medicaid Services (CMS) process and pay Part B claims. TrailBlazer Health Enterprises, LLC (TrailBlazer), is the Medicare Part B carrier responsible for paying Part B therapy claims in the state of Texas.

OBJECTIVE

Our objective was to determine whether therapy services provided by a Texas physical therapist during calendar year 2002 met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

None of the 100 sampled claims met Medicare's reimbursement requirements. However, TrailBlazer had already recovered payment for three of the sampled claims because the physical therapy services were provided as the result of a personal injury accident in a retail store, and Medicare should not have been billed for them. We did not consider these three claims to be errors, nor did we include the payments in our overpayment calculation. In total, 688 of the 702 services documented in the remaining 97 claims did not meet one or more of Medicare's reimbursement requirements because:

- The physical therapist inappropriately used his PIN to bill for services provided or supervised by someone else,

- the documentation for therapy services did not meet Medicare requirements,
- therapy services provided were not medically necessary and reasonable,
- plans of care did not meet Medicare requirements,
- Medicare was billed instead of the responsible insurer, and
- cardiac rehabilitation services provided did not meet Medicare requirements.

The physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures to ensure that he billed Medicare only for services that met Medicare requirements. As a result, the physical therapist improperly billed Medicare and received $12,652 for the 688 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $281,325 for calendar year 2002 services that did not meet Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that the physical therapist:

● refund to the Medicare program $281,325 in unallowable payments for therapy services provided in 2002 and

● develop quality control procedures to ensure that therapy services are provided and documented in accordance with Medicare reimbursement requirements.

AUDITEE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In written comments on our draft report, the physical therapist disagreed with our findings. The physical therapist stated that the use of his PIN to bill for services provided or supervised by someone else should not be used as a basis for denying claims. He further stated that the physical therapist consulted with a representative from TrailBlazer regarding the proper use of provider billing numbers and was advised that his billing practices were appropriate.

We followed up with TrailBlazer and could not substantiate the physical therapist's assertions regarding the appropriateness of his billing practices. The medical reviewers denied these claims because the medical records did not support that the services were performed by or under the direct personal supervision of the billing therapist. A review of the medical records shows that the therapists who actually performed the services did not have Medicare-issued individual PINs.

The physical therapist also disagreed that the documentation for therapy services did not meet Medicare requirements, that therapy services provided were not medically necessary and reasonable, and that plans of care did not meet Medicare requirements.

Because the physical therapist did not provide us with any additional information, we continue to support the medical reviewers' findings.

The physical therapist's comments are included in their entirety in Appendix C.

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INTRODUCTION

BACKGROUND

Physical Therapy Services

Physical therapists provide services according to a physician-approved plan of care designed to improve or restore physical functioning to a patient following disease, injury, or loss of a body part. To aid in the diagnosis and treatment of a patient, physical therapists utilize a variety of exercises, rehabilitative procedures, massages, manipulations, and physical agents.

Medicare's Coverage of Therapy Services

Medicare Part B covers outpatient physical therapy services provided by a qualified therapist in private practice when furnished in the therapist's office or the patient's home. Private practitioners are individuals who work in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice. Regardless of the business structure of the therapy practice, Medicare requires the practice to meet all State and local licensure laws.

Physical therapists must enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. To enroll in Medicare, a physical therapist must complete a form and be qualified to obtain a provider identification number (PIN) that identifies him or her as the person who provided the service on the Medicare claim form. If a physical therapist plans to provide services as part of a group or organization, the group practice must enroll in Medicare. Each individual therapist who plans to reassign his or her benefits to a group or organization must complete and submit a separate form to its Medicare carrier.

Medicare carriers, under contract with the Centers for Medicare & Medicaid Services (CMS) process and pay Part B claims. TrailBlazer Health Enterprises, LLC (TrailBlazer), is the Medicare carrier responsible for paying Part B therapy claims in the state of Texas.

The Selected Therapist

The selected therapist operated five physical therapy offices in Texas. Six physical therapists, including the selected physical therapist, 1 occupational therapist, and at least 11 physical therapy assistants worked in these offices during this period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether therapy services provided by a Texas physical therapist during calendar year 2002 met Medicare reimbursement requirements.

Scope

Our review covered claims paid by Medicare for physical therapy services provided during calendar year 2002. For this period, the physical therapist received Medicare payments totaling $396,497 for 2,543 claims. In a prior review of multiple therapists in Texas, we contracted with TriCenturion, a program safeguard contractor, to conduct a medical review of 10 claims for services provided in 2002 and paid by Medicare to the selected therapist. The medical reviewers questioned 261 of the 262 services documented in the 10 claims. Therefore, the services and the Medicare payment associated with these claims were removed from the sample for this review. Our audit universe was reduced to 2,533 claims totaling $390,807 in Medicare payments.

We did not assess the physical therapist's overall internal control structure. We limited our internal control review to obtaining an understanding of the policies and procedures the physical therapist used to obtain physician-certified plans of care and to document and bill Medicare for physical therapy services.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- discussed relevant Medicare regulations and guidance with TrailBlazer and CMS officials;
- identified all of the Medicare paid claims for services performed during calendar year 2002 and reduced the total number of claims and the associated Medicare payment amount for the 10 claims previously reviewed by the program safeguard contractor;
- selected a random sample (Appendix A) of 100 claims for medical review;
- obtained copies of the physical therapist's medical records for each claim in our sample; and
- obtained information from TrailBlazer concerning the recovery of payments for 3 of our sampled claims.

We contracted with TriCenturion, a CMS program safeguard contractor, to conduct a medical review of the documentation for the 100 sampled claims. We discussed the medical review results with the physical therapist's legal counsel and business administrator and considered additional information they provided regarding the sampled claims.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

None of the 100 sampled claims met Medicare's reimbursement requirements. However, TrailBlazer had already recovered payment for three of the sampled claims because the physical therapy services were provided as the result of a personal injury accident in a retail store, and Medicare should not have been billed for them. We did not consider these three claims to be errors, nor did we include the payments in our overpayment calculation. In total, the medical reviewers determined that 688 of the 702 services documented in the remaining 97 claims did not meet one or more of Medicare's reimbursement requirements because:

- the physical therapist inappropriately used his PIN to bill for services provided or supervised by someone else,
- the documentation for therapy services did not meet Medicare requirements,
- therapy services provided were not medically necessary and reasonable,
- plans of care did not meet Medicare requirements,
- Medicare was billed instead of the responsible insurer, and
- cardiac rehabilitation services provided did not meet Medicare requirements.

The physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures to ensure that he billed Medicare only for services that met Medicare requirements. As a result, the physical therapist improperly billed Medicare and received $12,652 for the 688 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $281,325 for calendar year 2002 services that did not meet Medicare reimbursement requirements.

Some physical therapy services were denied for more than one reason. Therefore, although the number of unallowable services on the remaining 97 claims totaled 688, the number of reasons the services were unallowable was 1,164. Appendix B shows the number of services, by claim, that were unallowable for one or more reasons.

MEDICARE REIMBURSEMENT REQUIREMENTS NOT MET

Inappropriate Use of Provider Identification Number to Bill Medicare

Federal regulations (42 CFR § 410.60) stated that Medicare Part B pays for therapy services if they are performed by or under the personal supervision of a physical therapist in private practice. All services not performed by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

Medicare requires physical therapists to enroll in the Medicare program to be eligible to render medical services to Medicare beneficiaries and submit claims for the services rendered. For a group practice to bill for services provided by physical therapists who are employees of the group practice, the parties must take the following actions: (1) Each employee must obtain an individual PIN using Form CMS-855I. (2) The group practice must obtain a group PIN using Form CMS-855B. (3) Each employee must complete a Medicare reassignment of benefits (Form CMS-855R) allowing the employee to obtain a performing PIN for the group practice. Additionally, if a provider was a member of a group practice in 2002, the "Medicare Carriers Manual," part IV, section 2010.2, required the claims to identify the individual who performed the service.

The physical therapist, who owned several offices throughout southern Texas, inappropriately used his PIN to bill Medicare for 567 services he did not provide or supervise. Some of the services that were billed under his PIN were actually performed by physical therapy assistants working in separate offices as far as 120 miles away, and the medical records contained no evidence of supervision by the billing therapist. Physical therapists in these offices provided or supervised some of the services, but they did not have Medicare-issued PINs and, therefore, were not identified on the claims.

Documentation Did Not Meet Medicare Requirements

Federal regulations (42 CFR § 486.161(b)) require physical therapists' clinical records to contain sufficient information to clearly identify a patient, justify the treatment, and accurately document the results. The clinical records should include the care and services provided. Further, the "Medicare Claims Processing Manual" (CMS Publication 100-4), chapter 5, section 20.2, states that providers should record in a patient's medical records either the beginning and ending times or total time of the treatment and a note describing the treatment.

For 356 therapy services, the physical therapist did not document the services billed or the documentation was not adequate to support the services billed. For example:

- The amount of service time documented in the medical records did not support the amount of time billed.

- The documentation did not identify or include the signature of the therapist who performed the services.

Services Not Medically Necessary and Reasonable

Section 1862(a)(1)(A) of the Social Security Act allows coverage and payment only for those services that are considered medically necessary and reasonable.

The physical therapist billed for 192 services that were not medically necessary and reasonable. For example:

- The physical therapist billed for aquatic therapy services even though the medical records lacked evidence that the patients had been unable to perform or progress with land-based therapy or had objective loss of joint motion, strength, or mobility.

- The physical therapist provided services that were not ordered by the physician.

- The physical therapist billed for repetitive exercises to maintain gait, strength, or endurance.

Plans of Care Did Not Meet Medicare Requirements

Pursuant to the "Medicare Carriers Manual," part 3, chapter II, section 2210, for Medicare to pay for physical therapy services, the services must relate directly and specifically to an active, written plan of care. Either the physician, after any needed consultation with the qualified physical therapist, or the therapist providing such services may establish the plan of care.

Pursuant to 42 CFR §§ 410.61(c) and (e), the written plan of care must:

- prescribe the type, amount, frequency, and duration of the physical or occupational therapy services to be furnished to an individual;

- indicate the diagnosis and anticipated goals; and

- be dated and signed by the physician who reviews it as often as the individual's condition requires, but at least every 30 days.

The physical therapist billed for 37 services related to plans of care that did not meet Medicare requirements. For example, the physician did not sign and date the plans of care for some services; for other services, the plans of care did not specify the types of services to be provided.

Medicare Paid for Therapy Services That Had Other Insurance Coverage

Section 1862(b)(2)(A)(ii) of the Social Security Act states that Medicare will not pay for any service for which payment can reasonably be expected from an automobile insurance policy or a liability insurance plan.

Pursuant to 42 CFR § 489.20(g), providers agree to bill other primary payers before Medicare.

The physical therapist billed Medicare for six services involving treatment for injuries sustained in an automobile accident, as stated in the physician's prescription and the physical therapist's evaluation. As such, the physical therapist should have billed the appropriate insurance company as the primary payer and not Medicare.

Cardiac Rehabilitation Services Not Performed As Indicated in the Plans of Care and in a Facility That Met Medicare Requirements

Medicare Part A Newsletter 004-98, issued in August 1998, states that while a cardiac rehabilitation exercise program may be considered a form of physical therapy, it is a specialized program conducted and/or supervised by specially trained personnel who provide services under the direct supervision of a physician. The facility where cardiac rehabilitation programs are conducted must meet the definition of a hospital outpatient department or a physician directed clinic; i.e., a physician is on the premises and available to perform medical duties at all times the facility is open, and each patient is under the care of a hospital or clinic physician.

The physical therapist billed for six cardiac rehabilitation services, but there was no evidence that he performed these services (1) as indicated in the plans of care and (2) in a facility that met Medicare's cardiac rehabilitation program requirements programs.

Therapist Lacked Understanding of Medicare Requirements and Effective Policies and Procedures

The large number of errors identified during the medical review occurred because the therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures to ensure that he billed Medicare only for services that met Medicare requirements.

Effect of Improperly Billed Therapy Services

As a result, the physical therapist improperly billed Medicare and received $12,652 for the 688 services. Using the lower limit of the 90-percent confidence interval, we estimate that the therapist received at least $281,325 for calendar year 2002 services that did not meet Medicare reimbursement requirements.

RECOMMENDATIONS

We recommend that the physical therapist:

- refund to the Medicare program $281,325 in unallowable payments for therapy services provided in 2002 and

- develop quality control procedures to ensure that therapy services are provided and documented in accordance with Medicare reimbursement requirements.

AUDITEE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In written comments on our draft report, the physical therapist disagreed with our findings. The physical therapist stated that the use of his PIN to bill for services provided or supervised by someone else should not be used as a basis for denying claims. He further stated that the physical therapist consulted with a representative from TrailBlazer regarding the proper use of provider billing numbers and was advised that his billing practices were appropriate.

We followed up with TrailBlazer and could not substantiate the physical therapist's assertions regarding the appropriateness of his billing practices. The medical reviewers denied these claims because the medical records did not support that the services were performed by or under the direct personal supervision of the billing therapist. A review of the medical records shows that the therapists who actually performed the services did not have Medicare-issued individual PINs. For a group practice to bill for services provided by physical therapists who are employees of the group practice, the parties must take the following actions: (1) Each employee must obtain an individual PIN using Form CMS-855I. (2) The group practice must obtain a group PIN using Form CMS-855B. (3) Each employee must complete a Medicare reassignment of benefits (Form CMS-855R) and obtain a performing PIN for the group practice.

The physical therapist also disagreed that the documentation for therapy services did not meet Medicare requirements, that therapy services provided were not medically necessary and reasonable, and that plans of care did not meet Medicare requirements. Specifically, he stated: "While not perfect, the records properly show that the claims at issue were generally complete and accurate. Moreover, each of the services were provided pursuant to orders issued by treating physicians. These physicians had determined that therapy services were reasonable and necessary for treatment of the patient's illness and/or injury."

Because the physical therapist did not provide us with any additional information, we continue to support the medical reviewers' findings.

The physical therapist's comments are included in their entirety in Appendix C.

SAMPLE METHODOLOGY AND RESULTS

METHODOLOGY

Population

The population consisted of 2,543 therapy claims paid to a Texas physical therapist with service dates from January 1 through December 31, 2002, less 10 claims that we had reviewed for a previous report (A-06-03-00085). The therapist received $390,807 from Medicare for the 2,533 therapy claims.

Sample Unit

The sample unit was a paid Medicare claim for therapy services.

Sample Design

We used a simple random sample design.

Sample Size

We used a sample size of 100 therapy claims paid to the Texas physical therapist.

Estimation Methodology

We used the Office of Audit Services RAT-STATS statistical software package to estimate the amount of unallowable program payments based on the dollar value of the sampled claims determined to be paid in error. We reported the estimate of unallowable program payments using the difference estimator at the lower limit of the 90-percent two-sided confidence interval.

SAMPLE RESULTS

The results of our review are as follows:

Sample Size	Value of Sample	Number of Claims With Unallowable Payments	Unallowable Payments
100	$12,964	97	$12,652

VARIABLE PROJECTIONS

The results of our estimations of unallowable Medicare payments are as follows:

Point estimate: $320,475

90-percent confidence interval:

Lower limit: $281,325

Upper limit: $359,625

Summary of Medical Review Determinations

Of the 100 sampled claims, TrailBlazer had already recovered payment for 3 claims. In total, 688 of the 702 services documented in the remaining 97 claims in calendar year 2002 were denied for one or more reasons. Therefore, although the number of unallowable services on the 97 claims TriCenturion reviewed totaled 688, the number of reasons the services were unallowable was far higher.

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE					
CLAIM NUMBER	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	INAPPROPRIATE USE OF PROVIDER IDENTIFICATION NUMBER	DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS	SERVICES WERE NOT MEDICALLY NECESSARY AND REASONABLE	PLANS OF CARE DID NOT MEET MEDICARE REQUIREMENTS	OTHER INSURANCE COVERAGE	UNALLOWABLE CARDIAC REHABILITATION SERVICES
1	8	$185.01	0	$0.00	8	$185.01	8	7		4		
2	5	74.12	0	0.00	5	74.12	5	2	5			
3	3	5.22	0	0.00	3	5.22	3	2	3			
4	6	87.58	0	0.00	6	87.58	6		2			
5	3	24.57	0	0.00	3	24.57	3		3			
6	5	118.36	0	0.00	5	118.36	1	4	1			
7	4	67.20	0	0.00	4	67.20	4	4	4	4		
8	6	79.63	0	0.00	6	79.63	6		6	6		
9	8	130.30	0	0.00	8	130.30	8	3	2			
10	8	161.64	0	0.00	8	161.64	8	3	3			
11	6	91.23	0	0.00	6	91.23	6	5				
12	6	72.46	0	0.00	6	72.46	6					
13	6	69.91	2	23.61	4	46.30	4					
14	6	79.63	0	0.00	6	79.63	6	1				
15	6	76.83	0	0.00	6	76.83	6	1				
16	11	266.14	0	0.00	11	266.14	11					
17	6	69.96	0	0.00	6	69.96	6	2				
18	12	237.52	0	0.00	12	237.52	12	12				
19	19	435.03	0	0.00	19	435.03	19	17	16			
20	6	83.94	0	0.00	6	83.94	6	2	3	3		
21	6	100.42	0	0.00	6	100.42	4	5				
22	8	132.77	0	0.00	8	132.77	8	4				
23	8	128.01	0	0.00	8	128.01	8	4				
24	2	39.58	0	0.00	2	39.58	2	2				
25	6	112.02	0	0.00	6	112.02	6	1				
26	8	120.78	0	0.00	8	120.78	8	4				
27	9	166.51	0	0.00	9	166.51	9	8				
28	8	146.73	0	0.00	8	146.73	8	7				
29	3	74.22	0	0.00	3	74.22	3					
30	14	282.11	1	50.61	13	231.50	5	11	2			

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE					
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31	8	172.42	0	0.00	8	172.42	8	8	8	8		
32	9	223.03	0	0.00	9	223.03	5	8	9			
33	6	95.66	0	0.00	6	95.66	6	2				
34	8	158.32	0	0.00	8	158.32	2	8	8			
35	6	118.76	0	0.00	6	118.76	3	6				
36	2	39.58	0	0.00	2	39.58	2	2	2			2
37	6	74.97	0	0.00	6	74.97	6	2	1			
38	9	143.31	0	0.00	9	143.31	9	6				
39	6	100.42	0	0.00	6	100.42	6	2				
40	6	118.74	0	0.00	6	118.74	6		6			
41	6	112.02	0	0.00	6	112.02	2	1			6	
42	20	409.94	0	0.00	20	409.94	3	12	8			
43	6	114.82	0	0.00	6	114.82	6					
44	6	136.45	0	0.00	6	136.45	6	2				
45	6	77.16	0	0.00	6	77.16	6	1				
46	4	53.55	0	0.00	4	53.55	4	1				
47	8	135.24	0	0.00	8	135.24	8	4	4			
48	6	95.66	0	0.00	6	95.66	6	2				
49	6	77.16	0	0.00	6	77.16	6	1				
50	7	120.15	0	0.00	7	120.15	6	3				
51	6	126.48	0	0.00	6	126.48	6	1				
52	12	258.63	0	0.00	12	258.63	4		12	12		
53	3	73.93	0	0.00	3	73.93	3					
54	5	83.37	0	0.00	5	83.37	5					
55	6	79.63	0	0.00	6	79.63	6	1				
56	6	81.20	0	0.00	6	81.20	6	3				
57	14	317.63	0	0.00	14	317.63	13	1	1			
58	3	55. 00	0	0.00	3	55.00	3	2				
59	5	116.66	2	66.03	3	50.63	2	1				
60	4	86.21	0	0.00	4	86.21	4		4			
61	6	94.35	0	0.00	6	94.35	6	3	3			
62	17	384.05	2	60.76	15	323.29		15				
63	6	73.36	0	0.00	6	73.36	6	1				
64	6	64.56	0	0.00	6	64.56	6					
65	3	24.57	1	8.19	2	16.38	2					
66	20	395.85	0	0.00	20	395.85	16	8				

	ORIGINAL MEDICARE PAYMENT TO PROVIDER		ALLOWABLE		UNALLOWABLE		REASON FOR DISALLOWANCE					
CLAIM NUMBER	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	INAPPROPRIATE USE OF PROVIDER IDENTIFICATION NUMBER	DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS	SERVICES WERE NOT MEDICALLY NECESSARY AND REASONABLE	PLANS OF CARE DID NOT MEET MEDICARE REQUIREMENTS	OTHER INSURANCE COVERAGE	UNALLOWABLE CARDIAC REHABILITATION SERVICES
67	12	258.63	0	0.00	12	258.63	12	12	12			
68	6	83.94	0	0.00	6	83.94	6	5				
69	6	95.66	0	0.00	6	95.66	6	2				
70	7	166.66	0	0.00	7	166.66	7	5				
71	6	105.63	0	0.00	6	105.63	6	3				
72	1	50.61	0	0.00	1	50.61	1					
73	6	55. 02	0	0.00	6	55. 02	6					
74	6	80.59	0	0.00	6	80.59	5	1				
75	10	178.97	1	8.19	9	170.78	8	4	2			
76	4	109.99	0	0.00	4	109.99	3	3	4			4
77	2	72.21	0	0.00	2	72.21	2	1				
78	3	64.80	0	0.00	3	64.80	2	3				
79	16	347.51	0	0.00	16	347.51	13	15				
80	1	19.79	0	0.00	1	19.79		1				
81	9	159.40	0	0.00	9	159.40	9	9				
82	6	76.16	0	0.00	6	76.16	6	1				
83	8	158.77	0	0.00	8	158.77	8	4				
84	16	344.84	4	86.21	12	258.63	12					
85	11	182.91	0	0.00	11	182.91	1	8	11			
86	9	156.60	0	0.00	9	156.60	3	6				
87	6	110.67	0	0.00	6	110.67	6	3	3			
88	3	56.68	0	0.00	3	56.68	1	2	1			
89	3	73.93	0	0.00	3	73.93	3					
90	8	121. 03	0	0.00	8	121. 03	8	4				
91	3	34.98	0	0.00	3	34.98	3					
92	20	460.11	0	0.00	20	460.11	20	19	20			
93	9	143.31	1	8.19	8	135.12	2	6				
94	8	172.42	0	0.00	8	172.42	4	8	8			
95	4	59.88	0	0.00	4	59.88	4	2				
96	15	318. 01	0	0.00	15	318. 01	8	11	15			
97	3	31.80	0	0.00	3	31.80	3					
Total	**702**	**$12,963.78**	**14**	**$311.79**	**688**	**$12,651.99**	**567**	**356**	**192**	**37**	_	_

LILES | PARKER PLLC
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SUBJECT
Columbus Physical Therapy

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August 31, 2007

SENT BY REGULAR MAIL AND
BY FACSIMILE TO: (225) 389-0469

Mr. Gordon L. Sato
Regional Inspector General
Office of Inspector General
Office of Audit Services
Department of Health and Human Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Audit Report A-06-07-00061: Mr. Terrence Sablatura, d/b/a Columbus Physical Therapy and Rehabilitation Services.

Dear Mr. Sato:

Thank you for the opportunity to review your draft report entitled "Review of Texas Physical Therapist's Medicare Claims for Therapy Services Provided During 2002." Our Firm represents Mr. Terrence Sablatura, d/b/a Columbus Physical Therapy and Rehabilitation Services (Columbus) and has been asked to comment regarding the findings outlined in your report.

As set out in the draft report, the Department of Health and Human Services, Office of Inspector General, Office of Audit Services (HHS-OIG-OAS) contracted with TriCenturion, a Program Safeguard Contractor (PSC) to review 100 sampled Medicare claims, none of which allegedly met Medicare's reimbursement requirements. Your office then extrapolated the alleged damages and now seeks to recover $281,325.00 in connection with therapy services provided by our client in 2002. We respectfully disagree with TriCenturion's findings and with your statistical extrapolation of the alleged damages assessed in this case.

TriCenturion has denied most of the claims at issue, at least in part, on the basis that our client failed to correctly use provider identification numbers when billing for physical therapy services. As the record will reflect, Columbus consulted with a representative of TrailBlazer Health Enterprises (TrailBlazer) regarding the proper use of provider billing numbers and was advised that its billing practices were appropriate. Years later, TriCenturion has now alleged that Columbus' use of provider numbers do

not meet Medicare billing requirements. Remarkably, HHS-OIG-OAS now seeks to penalize Columbus despite the fact that its actions were based on clear, unambiguous advice given by TrailBlazer. In light of TrailBlazer's actions, fundamental fairness dictates that this administrative basis for denial be dropped. Consistent with 42 U.S.C. 1395gg(b)(1)(B), Columbus was without fault with respect to the payment of any excess over the correct amount due from the government.

TriCenturion has also argued that a number of Columbus' claims lacked proper documentation, were not medically necessary and appropriate, and / or lacked suitable plans of care. We disagree. While not perfect, the records properly show that the claims at issue were generally complete and accurate. Moreover, each of the services were provided pursuant to orders issued by treating physicians. These physicians had determined that therapy services were reasonable and necessary for the treatment of the patient's illness and / or injury.

Over the years, our client has consistently provided superb skilled therapy care to Texas' senior citizens and others in rural areas of the state. As the evidence will show, each of the services provided were properly administered by licensed, qualified therapists in accordance with the orders of each patient's treating physician. Rural Texas physicians rely on our client to provide excellent therapeutic support for their patients. In consideration of the totality of the circumstances in this case, these claims should be paid.

With regard to HHS-OIG-OAS's recommendations, Columbus has strengthened its compliance safeguards and remains committed in its efforts to better ensure that therapy claims meet Medicare's reimbursement requirements. Nevertheless, Columbus respectfully contends that the claims currently at issue should not have been denied. As such, Columbus fully intends to appeal the denial of these claims and the government's flawed statistical extrapolation of damages.

Should you have any questions, please feel free to contact me. I can be reached at (202) 298-8750.

Regards,

Liles Parker, PLLC

Robert W. Liles