

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**A KANSAS PHYSICAL THERAPY
PRACTICE CLAIMED
UNALLOWABLE MEDICARE PART B
REIMBURSEMENT FOR
SOME OUTPATIENT
PHYSICAL THERAPY SERVICES**

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



Brian P. Ritchie
Assistant Inspector General
for Audit Services

August 2016
A-07-14-01146

Office of Inspector General

<http://oig.hhs.gov/>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

A Kansas physical therapy practice improperly claimed at least \$134,000 in Medicare reimbursement for physical therapy services for calendar years 2012 and 2013.

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about \$1.9 billion in calendar year (CY) 2014. Previous Office of Inspector General reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, or properly documented, and that were vulnerable for fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including a therapy practice located in the State of Kansas. Our analysis indicated that this selected therapy practice was among the highest Medicare therapy billers in the State of Kansas.

Our objective was to determine whether claims for outpatient physical therapy services provided by a Kansas physical therapy practice (the Therapy Practice) complied with Medicare requirements.

BACKGROUND

Federal regulations provide coverage of Medicare Part B outpatient physical therapy services. For these 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 they must have a physician's certification of the need for such services. Medicare Part B also covers outpatient physical therapy services performed by, or under the direct supervision of, a therapist in private practice. Federal law precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

HOW WE CONDUCTED THIS REVIEW

Our review covered 8,706 Medicare beneficiary days for outpatient physical therapy services totaling \$673,499, provided by the Therapy Practice during CYs 2012 and 2013. A beneficiary day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the Therapy Practice received a payment from Medicare. We reviewed a random sample of 100 of those beneficiary days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary days were allowable in accordance with Medicare requirements.

WHAT WE FOUND

The Therapy Practice claimed Medicare reimbursement for some outpatient physical therapy services that did not meet Medicare reimbursement requirements. Of the 100 beneficiary days in

our random sample, the Therapy Practice properly claimed Medicare reimbursement on 71 beneficiary days. The Therapy Practice improperly claimed Medicare reimbursement on the remaining 29 beneficiary days.

These deficiencies occurred because the Therapy Practice did not have adequate policies and procedures in place to ensure that it billed for services that complied with Medicare requirements.

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least \$134,967 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that the Therapy Practice:

- refund \$134,967 to the Federal Government and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Therapy Practice disagreed with 22 of the 31 beneficiary days that our draft report identified as not meeting Medicare reimbursement requirements. The Therapy Practice's comments included attachments that detailed specific reasons for its disagreement with these findings. The Therapy practice stated that it would not contest our findings regarding the remaining nine beneficiary days and added that it would continue to improve its efforts to properly document all care provided to its patients.

After reviewing the Therapy Practice's written comments and attachments, we forwarded that material, along with the independent medical review contractor's determinations for the 22 beneficiary days with which the Therapy Practice disagreed, to Wisconsin Physicians Service Insurance Corporation, a Medicare contractor, for review. After completing its review, the Medicare contractor's medical review staff determined that 2 of the 22 beneficiary days met Medicare requirements. Accordingly, we revised our findings to disallow 29 instead of 31 beneficiary days. Thus, we maintain that our findings and recommendations related to the 29 sampled beneficiary days are valid.

TABLE OF CONTENTS

| | |
|--|----|
| INTRODUCTION | 1 |
| Why We Did This Review | 1 |
| Objective | 1 |
| Background | 1 |
| The Medicare Program | 1 |
| Medicare Outpatient Physical Therapy Services | 1 |
| Kansas Physical Therapy Practice | 2 |
| How We Conducted This Review..... | 2 |
| FINDINGS | 3 |
| Services Not Medically Necessary | 3 |
| Incorrect Healthcare Common Procedure Coding System Code Billed to Medicare..... | 4 |
| CONCLUSION..... | 4 |
| RECOMMENDATIONS | 5 |
| AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE..... | 5 |
| Auditee Comments..... | 5 |
| Office of Inspector General Response | 5 |
| APPENDIXES | |
| A: Audit Scope and Methodology | 6 |
| B: Statistical Sampling Methodology | 8 |
| C: Sample Results and Estimates..... | 9 |
| D: Auditee Comments..... | 10 |

INTRODUCTION

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about \$1.9 billion in calendar year (CY) 2014. Previous Office of Inspector General (OIG) reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, or properly documented, and that were vulnerable for fraud, waste, and abuse.¹ As part of a nationwide effort, we selected multiple physical therapists for review, including a therapy practice located in the State of Kansas. Our analysis indicated that this selected therapy practice was among the highest Medicare therapy billers in the State of Kansas.

OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by a Kansas physical therapy practice (the Therapy Practice) 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 permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B covers services considered medically necessary to treat a disease or condition, including outpatient physical therapy services. CMS contracts with Medicare contractors to process and pay Part B claims.

Medicare Outpatient Physical Therapy Services

Medicare Part B provides coverage for outpatient physical therapy services.² Physical therapists evaluate and treat disorders of the musculoskeletal system. The goal of physical therapy is to restore maximal functional independence to each individual patient by providing services that aim to restore function, improve mobility, and relieve pain. Modalities such as exercise, heat,

¹ *Age Well Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-13-01031), issued Jun. 15, 2015; *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued Aug. 20, 2014; *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued Jun. 10, 2013; *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), issued Dec. 21, 2010.

² Section 1832(a)(2)(C) of the Act.

cold, electricity, and massage are used. These services are provided in a number of different settings; however, the majority of Medicare payments for outpatient physical therapy services are made to physical therapists practicing in an office setting.

For Medicare Part B to cover outpatient physical therapy services, the services must be medically reasonable and necessary, be provided in accordance with a plan of care established by a physician or qualified therapist and periodically reviewed by a physician, and have a physician's certification of the need for such services.³ Further, Medicare Part B pays for outpatient physical therapy services billed using standardized codes.⁴ Services furnished by physical therapists in private practice must be performed by, or under the direct supervision of, a qualified physical therapist.⁵ Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁶ These requirements are further described in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04).

Kansas Physical Therapy Practice

The Therapy Practice operates two physical therapy offices located in Kansas. During CYs 2012 and 2013, the Therapy Practice employed four licensed physical therapists and one physical therapist assistant.

HOW WE CONDUCTED THIS REVIEW

Our review covered the Therapy Practice's claims for Medicare Part B outpatient physical therapy services provided during CYs 2012 and 2013. Our sampling frame consisted of 8,706 beneficiary days⁷ of outpatient physical therapy services, totaling \$673,499, of which we reviewed a random sample of 100 beneficiary days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary days were allowable in accordance with Medicare requirements.

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.

³ Sections 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) of the Act; 42 CFR §§ 410.60 and 410.61.

⁴ Standardized codes used by providers are called Healthcare Common Procedure Coding System (HCPCS) codes to report units of service.

⁵ 42 CFR § 410.60(c).

⁶ Section 1833(e) of the Act.

⁷ A beneficiary day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the therapist received a payment from Medicare.

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.

FINDINGS

The Therapy Practice claimed Medicare reimbursement for some outpatient physical therapy services that did not meet Medicare reimbursement requirements. Of the 100 beneficiary days in our random sample, the Therapy Practice properly claimed Medicare reimbursement on 71 beneficiary days. The Therapy Practice improperly claimed Medicare reimbursement on the remaining 29 beneficiary days:

- 28 beneficiary days had therapy services that were not medically necessary that resulted in overpayments and
- 1 beneficiary day had an incorrect HCPCS code billed to Medicare that resulted in an underpayment.

These deficiencies occurred because the Therapy Practice did not have adequate policies and procedures in place to ensure that it billed for services that complied with Medicare requirements.

On the basis of our sample results, we estimated that the Therapy Practice improperly received at least \$134,967 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

SERVICES NOT MEDICALLY NECESSARY

In order for services to be payable, a beneficiary must have the need for physical therapy services (*Medicare Benefit Policy Manual*, chapter 15, § 220). In order for a service to be covered, the service must be reasonable and necessary (§ 1862(a)(1)(A) of the Act and *Medicare Benefit Policy Manual*, chapter 15, § 220).

Services are reasonable and necessary if it is determined that services were safe and effective, of appropriate duration and frequency within accepted standards of medical practice for the particular diagnosis or treatment, and met the patient's medical needs (*Medicare Program Integrity Manual*, chapter 3, § 3.6.2.2).

For 28 beneficiary days, the Therapy Practice received Medicare reimbursement for which the beneficiaries' medical records did not support the medical necessity of services. The results of the medical review indicated that these services did not meet one or more Medicare requirements:⁸

- Services did not require skills of a physical therapist (6 beneficiary days).

⁸ The total errors listed in the bullets below exceed 28 because some of the beneficiary days contained more than one error.

- Services were not specific and/or an effective treatment for the patient’s condition (10 beneficiary days).
- There was no expectation of significant improvement within a reasonable and predictable period of time (8 beneficiary days).
- The amount, frequency, and duration of services were not reasonable (27 beneficiary days).
- Given the patient’s diagnoses, complexities, severities, and interaction of current active condition(s), the care was not appropriate (28 beneficiary days).

For example, the Therapy Practice received payment for the 23rd therapy session provided to a 73-year-old Medicare beneficiary. The medical review contractor determined that the therapy did not meet Medicare coverage requirements because the medical records showed that the patient could function independently with a home exercise program and was able to walk up and down a flight of stairs safely. Specifically, the contractor concluded that the skills of a therapist were no longer needed and improvements would be expected to occur naturally if the patient continued the home exercise program. Thus, the excessive amount of treatment was not medically reasonable or necessary.

INCORRECT HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODE BILLED TO MEDICARE

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).

For one beneficiary day, the Therapy Practice billed Medicare with an incorrect HCPCS code that resulted in an underpayment to the Therapy Practice. Specifically, the Therapy Practice billed Medicare for performing a manual therapy technique (HCPCS code 97140) when it should have billed a HCPCS code for applying a compression wrap (HCPCS code 29581). Because the reimbursement amount was higher for applying the compression wrap than it was for performing the manual therapy technique, we determined the amount of underpayment by subtracting the reimbursement amount for HCPCS code 29581 from the reimbursement amount for HCPCS code 97140.

CONCLUSION

On the basis of our sample results for which we netted the overpayment and underpayment amounts, we estimated that the Therapy Practice improperly received at least \$134,967 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

We recommend that the Therapy Practice:

- refund \$134,967 to the Federal Government and
- strengthen its policies and procedures to ensure that outpatient physical therapy services are billed in accordance with Medicare requirements.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Auditee Comments

In written comments on our draft report, the Therapy Practice disagreed with 22 of the 31 beneficiary days that our draft report identified as not meeting Medicare reimbursement requirements. The Therapy Practice's comments included attachments that consisted of detailed support from the Therapy Practice's staff and the results of a medical review that the Therapy Practice obtained. The Therapy practice stated that it would not contest our findings regarding the remaining nine beneficiary days.

The Therapy Practice also stated that it "intends to properly document all care provided to its patients and will continue to improve its efforts in this regard...." The Therapy Practice added that it had upgraded its medical record system to further enhance its compliance efforts.

The Therapy Practice's comments, excluding attachments that we have removed from this final report because they contain personally identifiable information, appear as Appendix D. We have also redacted personally identifiable information within Appendix D itself. We are separately providing the Therapy Practice's comments and attachments in their entirety to CMS.

Office of Inspector General Response

After reviewing the Therapy Practice's written comments and attachments, we forwarded that material, along with the independent medical review contractor's determinations for the 22 beneficiary days with which the Therapy Practice disagreed, to Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, for review. After completing its review, WPS's medical review staff determined that 2 of the 22 beneficiary days met Medicare requirements. Accordingly, we revised our findings to disallow 29 instead of 31 beneficiary days. Thus, we maintain that our findings and recommendations related to the 29 sampled beneficiary days are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the Therapy Practice's claims for Medicare outpatient physical therapy services provided during CYs 2012 and 2013. Our sampling frame consisted of 8,706 beneficiary days⁹ of outpatient physical therapy services, totaling \$673,499, of which we reviewed a sample of 100 beneficiary days. These claims were extracted from CMS's National Claims History (NCH) file.

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

We performed our audit, which included on-site fieldwork at the Therapy Practice's office, from July 2014 through October 2015.

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 physical therapy services;
- extracted from CMS's NCH file a sampling frame of 8,706 outpatient physical therapy service beneficiary days, totaling \$673,499, during CYs 2012 and 2013;
- selected a random sample of 100 outpatient physical therapy service beneficiary days from the sampling frame (Appendixes B and C);
- obtained medical records and other documentation from the Therapy Practice for the 100 sampled beneficiary days and provided them to an independent medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- forwarded the Therapy Practice's written comments on our draft report and the attachments to those comments, along with the independent medical review contractor's

⁹ A beneficiary day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary, for which the therapist received a payment from Medicare.

determinations for the 22 beneficiary days on which the Therapy Practice disagreed with our findings, to WPS for further medical review;

- used the results of the sample review (including the adjustments for the claims allowed by the WPS medical reviewers) to calculate the estimated unallowable Medicare reimbursement paid to the therapist (Appendix C); and
- discussed the results of our review with the auditee on November 4, 2015.

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 physical therapy service claims paid to the Therapy Practice during CYs 2012 and 2013.

SAMPLING FRAME

The sampling frame was an Access database containing 8,706 outpatient physical therapy service beneficiary days, totaling \$673,499, provided by the Therapy Practice during CYs 2012 and 2013. The claims data were extracted from CMS's NCH file. A beneficiary day consisted of all outpatient physical therapy services provided on a specific date of service for a specific beneficiary for which the therapist received a payment from Medicare. The beneficiary days were limited to payment amounts that were at least \$50.

SAMPLE UNIT

The sample unit was an outpatient physical therapy service beneficiary day.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 outpatient physical therapy service beneficiary days.

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. We then created a list of the 100 sampled items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the total amount of Medicare payments for unallowable outpatient physical therapy services made to the therapist at the lower limit of the 90-percent confidence interval (Appendix D).

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

| Beneficiary Days in Frame | Value of Frame | Sample Size | Value of Sample | Number of Unallowable Beneficiary Days | Value of Unallowable Beneficiary Days |
|----------------------------------|-----------------------|--------------------|------------------------|---|--|
| 8,706 | \$ 673,499 | 100 | \$8,095 | 29 | \$2,139 |

ESTIMATES

Estimated Value of Unallowable Beneficiary Days
(Limits Calculated for a 90-Percent Confidence Interval)

| | |
|-----------------------|------------|
| Point Estimate | \$ 186,180 |
| Lower Limit | 134,967 |
| Upper Limit | 247,380 |



Kevin Little

Partner
(404) 921-4040email: kevin@hamillittle.com
blog: www.healthcarelaw-blog.com
web: www.hamillittle.com

March 15, 2016

By Electronic Mail (Chris.Bresette@oig.hhs.gov) and Federal Express

Chris Bresette, Audit Manager
Office of Inspector General, Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-14-01146

| |
|----------|
| REDACTED |
|----------|

10

Dear Chris:

I represent

| |
|----------|
| REDACTED |
|----------|

.

| |
|------|
| RDCT |
|------|

 executed Appointment of Representative is attached. This letter and supporting exhibits respond to the December 9, 2015, correspondence of Patrick Cogley of OIG and the above-referenced OIG report (the "Report") regarding

| |
|------|
| RDCT |
|------|

. We appreciate your allowing

| |
|------|
| RDCT |
|------|

 additional time to respond to the Report.

This letter and exhibits are submitted in response to the OIG's request for concurrence and non-concurrence with the Report. On behalf of

| |
|------|
| RDCT |
|------|

 I respectfully request your consideration of the following information and the supporting exhibits provided herewith, which demonstrate relevant grounds for non-concurrence and disagreement with specific elements of the Report and the audit's medical review findings and determinations. Exhibits to this letter include electronic spreadsheets contained on secure files. (I will provide you with the password via separate email.) For your convenience, hard copies of this letter and exhibits will follow by Federal Express.

10

Office of Inspector General Note: The deleted text has been redacted because it is personally identifiable information.

The following exhibits are provided:

- Exhibit 1 – OIG Audit Spreadsheet: Not Contested Audit Findings
- Exhibit 2 – 22 Audit Findings at Issue: Physical Therapist Medical Necessity Support
- Exhibit 2A – Detailed Physical Therapy Support
- Exhibit 3 – Independent Medical Review Findings

The Report recommends that [RDCT] be required to refund \$ 147,447. We have carefully reviewed the Report's audit findings as to specific 31 patients whose care, according to the audit, failed medical review or coding standards for the service provided. The total sample payment for the 31 patients is \$2,473.96. Without waiving any objections or arguments as to the billing with respect to any patients, we respectfully contend that the exhibits submitted herewith demonstrate conclusively that 22 of the 31 patients meet all applicable medical necessity criteria. We disagree with your medical expert that 22 patients contained in Exhibit 2 do not meet medical necessity requirements.

The original audit findings provided written testimony from a physician who largely did not agree with physical therapy services after an eight week period. [RDCT]'s first task was to review the records again from the physical therapy standpoint and provide you with more detail about the individual patient. Each [RDCT] therapist reviewed the documentation personally and provided additional comments in support of the claim. Exhibit 2A provides individual therapy comments for your consideration.

[RDCT] also obtained the services of [REDACTED] MD to provide a critical and independent medical review. Dr. [REDACTED] is a physician who understands the standard of medical care within the relevant community and provides an independent clinical perspective in support of 22 of the 31 remaining patients at issue. Exhibit 3 provides an independent medical review findings in support of [RDCT]'s patient services identified in Exhibit 2.

Exhibit 1 contains those patient line items of which **RDCT** will not contest your findings and total \$ 640.29. Exhibit 2 contains those patients reviewed by the physical therapy providers and independent medical review that we believe meet medical necessity requirements and ask that those line items contained in Exhibit 2 be reduced \$1,833.67 from your sample overpayment calculations and RATS-Stats findings.

RDCT contends that a reduction of \$ 1,833.67 from your original sample audit exists, reducing any overpayment extrapolation an estimated 74%. **RDCT**'s summary findings for your overpayment request are:

| RDCT 100 Sample Audit | |
|------------------------------|--------------------|
| 69 | Claims Allowed |
| 31 | Claims Not Allowed |
| 22 | Contested |
| 9 | Not Contested |

RDCT contests 22 of the 31 claims you originally did not allow. We believe that the sample overpayment should be reduced as follows:

| Revised Sample Overpayment | |
|-------------------------------------|------------|
| Failed Medical Review Sum | \$2,473.96 |
| Advanced PT Overpayment | \$640.29 |
| Sample Overpayment Reduction | \$1,833.67 |
| Percent Sample Reduction | 74% |

As a healthcare provider **RDCT** is devoted in its efforts to individual patient care. While **RDCT** of course intends to properly document all care provided to its patients and will continue to improve its efforts in this regard, it is my hope that the OIG will weigh the inherent difficulties involved in the process of documentation to support care of chronically ill patients. What constitutes compliant medical record documentation

continues to be subject to some difference of reasonable opinion and, in some instances, vagueness in applicable requirements. [REDACTED] would also like to note that the audit time-frame included a different medical record system that, to further enhance its compliance efforts, has since been upgraded. A medical condition, reason, symptom or complaint(s) existed for all patients in your sample. [REDACTED] understands that all providers should at all times be vigilant and adequately support and document medical services provided.

This submission is with reservation of [REDACTED]'s full Medicare appeal rights as to the claims at issue. My client remains open to a fair resolution of this matter, however. We look forward to your comments to this rebuttal. Please do not hesitate to contact me should you wish to discuss or have any questions or concerns.

Sincerely,

/s/ Kevin S. Little

Kevin S. Little

Encl.

cc (by email):

REDACTED