Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# A TEXAS PHYSICAL THERAPIST CLAIMED UNALLOWABLE MEDICARE PART B REIMBURSEMENT FOR OUTPATIENT THERAPY SERVICES

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

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## EXECUTIVE SUMMARY

***A Texas physical therapist in private practice improperly claimed at least $70,000 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 2014. Previous Office of Inspector General (OIG) reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, properly documented, and were vulnerable to fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including this therapist in Texas. Our analysis indicated that this selected therapist was among the highest Medicare physical therapy billers in Texas.

The objective of this review was to determine whether claims for outpatient physical therapy services provided by a Texas physical therapist in private practice complied with Medicare requirements.

### BACKGROUND

Federal regulations provide coverage of Medicare Part B outpatient physical therapy services. For these 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 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 14,998 Medicare beneficiary claim days for outpatient physical therapy services, totaling $953,471, provided by a Texas physical therapist from January 1, 2012, through December 31, 2013. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary. We reviewed a random sample of 100 of those beneficiary claim days.

### WHAT WE FOUND

The therapist claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our random sample, the therapist properly claimed Medicare reimbursement on 84 beneficiary

claim days. The therapist improperly claimed Medicare reimbursement on the remaining 16 beneficiary claim days.

These deficiencies occurred because the therapist did not have a thorough understanding of the Medicare reimbursement requirements related to outpatient physical therapy services or mistakenly billed for a service that was not provided.

On the basis of our sample results, we estimated that the therapist improperly received at least $70,748 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

## WHAT WE RECOMMEND

We recommend that the physical therapist:

- refund $70,748 to the Federal Government and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services.

## PHYSICAL THERAPIST'S COMMENTS AND OUR RESPONSE

In written comments on our draft report, the physical therapist agreed with our findings for two of the 16 beneficiary claim days. However, the physical therapist provided an individual response for each of the remaining 14 beneficiary claim days.

After reviewing the physical therapist's comments, we maintain that our findings and recommendations are valid.

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# 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, properly documented, and were vulnerable to fraud, waste, and abuse.[1] As part of a nationwide effort, we selected multiple physical therapists for review, including this therapist in Texas. Our analysis indicated that this selected therapist was among the highest Medicare physical therapy billers in Texas.

## OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by a Texas physical therapist in private 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 end-stage renal 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 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, cold, electricity, and massage are used. These services are provided in a number of different

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[1] *AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-13-01031), issued June 15, 2015; *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August, 20, 2014; *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 6, 2013; *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), issued December 21, 2010.

[2] Section 1832(a)(2)(C) of the Act.

settings; however, the majority of Medicare payments for outpatient 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, 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.[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).

### Texas Physical Therapist

The selected physical therapist operates one physical therapy office located in Texas. During CYs 2012 and 2013, the physical therapy office employed three licensed physical therapists and three physical therapist assistants.

## HOW WE CONDUCTED THIS REVIEW

Our review covered the therapist's claims for Medicare Part B outpatient physical therapy services provided from January 1, 2012, through December 31, 2013. Our sampling frame consisted of 14,998 beneficiary claim days[7] of outpatient physical therapy services, totaling $953,471, of which we reviewed a random sample of 100 beneficiary claim days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary claim days were provided 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.

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[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 to report units of service are called Healthcare Common Procedure Coding System (HCPCS) codes.

[5] 42 CFR § 410.60(c).

[6] Section 1833(e) of the Act.

[7] A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary.

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 therapist claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our random sample, the therapist properly claimed Medicare reimbursement on 84 beneficiary claim days. The therapist improperly claimed Medicare reimbursement on the remaining 16 beneficiary claim days.

Beneficiary claim days by type of error:

- 14 beneficiary claim days had therapy services that were not medically necessary,
- 1 beneficiary claim day did not meet Medicare documentation requirements, and
- 1 beneficiary claim day did not meet Medicare coding requirements.

These deficiencies occurred because the therapist did not have a thorough understanding of the Medicare reimbursement requirements related to outpatient physical therapy services or mistakenly billed for a service that was not provided. On the basis of our sample results, we estimated that the therapist improperly received at least $70,748 in Medicare reimbursement for outpatient physical therapy services that did not comply with Medicare requirements.

### SERVICES NOT MEDICALLY NECESSARY

For services to be payable, a beneficiary must need physical therapy services (*Medicare Benefit Policy Manual*, chapter 15, § 220). For a service to be covered, the service must be reasonable and necessary (section 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 14 beneficiary claim days, the therapist received Medicare reimbursement for which the beneficiaries' medical record 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 the skills of a physical therapist (11 beneficiary claim days).

[8] The total errors listed in the bullet points exceed 14 because some beneficiary claim days contained more than 1 error.

- Given the patient's diagnoses, complexities, severities, and interaction of current active condition(s), the care was not appropriate (11 beneficiary claim days).

- The amount, frequency, and duration of services were not reasonable (9 beneficiary claim days).

- Services were not specific and/or an effective treatment for the patient's condition (8 beneficiary claim days).

- There was no expectation for significant improvement within a reasonable and predictable period of time (6 beneficiary claim days).

For example, the therapist received payment for physical therapy provided on August 23, 2012, to a 76-year-old Medicare beneficiary. The medical review contractor determined that the therapy service did not meet Medicare coverage requirements because the medical records showed that the beneficiary did not have any range of motion problems that required skilled therapy or therapy beyond the implementation of a home exercise program. In addition, the therapist did not provide active, hands-on therapy exercises and saw the beneficiary on 2 consecutive days, which is not standard care for the beneficiary's condition.

## DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS

Medicare documentation requirements state that outpatient physical therapy services must be made in accordance with a written plan established before treatment begins (42 CFR § 410.60). 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). Goals should be measurable and pertain to identified functional impairments. 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, § 220.1.2).

Therapists must also maintain a treatment note for each treatment day and each therapy service (*Medicare Benefit Policy Manual*, chapter 15, § 220.3B). 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 1 beneficiary claim day, the therapist received Medicare reimbursement for services that were not provided in accordance with Medicare documentation requirements. Specifically, the treatment notes did not meet Medicare requirements because the physical therapist's initial evaluation of the 76-year-old beneficiary did not provide enough information to determine whether the services were appropriate and medically necessary. There was no evaluation of pain status, and the documentation lacked a complete assessment of functional status, posture, etc. There were no functional goals set, and the goals stated were not specific or measurable (objectively quantifiable).

## CODING DID NOT MEET MEDICARE REQUIREMENTS

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). Providers must report the number of units for outpatient rehabilitation services based on the procedures or services provided (*Medicare Claims Processing Manual* (Pub. No. 100-04), chapter 5, § 20.2A).

For 1 beneficiary claim day, the therapist received Medicare reimbursement that did not meet Medicare coding requirements. Specifically, the therapist billed and received payment for four HCPCS codes for physical therapy provided on November 20, 2013, to a 74-year-old Medicare beneficiary. However, the treatment notes stated that the beneficiary was "not feeling well," and it appears that exercises under HCPCS code 97110 were not performed that day; thus, payment for this code was not supported.

## CONCLUSION

On the basis of our sample results, we estimated that the therapist improperly received at least $70,748 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

## RECOMMENDATIONS

We recommend that the physical therapist:

- refund $70,748 to the Federal Government and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services.

## PHYSICAL THERAPIST'S COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the physical therapist agreed with our findings for two of the 16 beneficiary claim days. However, the physical therapist provided an individual response for each of the remaining 14 beneficiary claim days. The physical therapist's comments are included as Appendix D.

After reviewing the physical therapist's comments, we maintain that our findings and recommendations are valid.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered the therapist's claims for Medicare outpatient physical therapy services provided from January 1, 2012, through December 31, 2013. Our sampling frame consisted of 14,998 beneficiary claim days of outpatient physical therapy services, totaling $953,471, of which we reviewed a sample of 100 beneficiary claim days. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary. These claims were extracted from CMS's National Claims History file.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the therapist'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, but we did not assess the completeness of the file.

Our audit work included contacting the physical therapist and obtaining pertinent support documentation.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations and guidance;
- extracted from CMS's National Claims History file a sampling frame of 15,114 beneficiary claim days, totaling $961,435, from January 1, 2012, through December 31, 2013;
- selected a random sample of 100 beneficiary claim days from the sampling frame (Appendixes B and C);
- removed 116 Railroad Retirement Board claim days from the sampling frame, resulting in a sampling frame of 14,998 beneficiary claim days, totaling $953,471, from January 1, 2012, through December 31, 2013;
- reviewed available data for the sampled beneficiary claim days to determine whether the claims had been cancelled or adjusted;
- obtained and reviewed medical record documentation from the therapist for each sample beneficiary claim day to determine whether the services were provided in accordance with Medicare requirements;
- used an independent medical review contractor to determine whether the 100 sample beneficiary claim days met medical necessity requirements;

- used the results of the sample review to calculate the estimated unallowable Medicare reimbursement paid to the therapist (Appendix C); and

- discussed the results of our review with the auditee.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of all Medicare Part B outpatient therapy service claims paid to the therapist from January 1, 2012, through December 31, 2013.

### SAMPLING FRAME

The original sampling frame used to select the sample was an Access database containing 15,114 Medicare Part B beneficiary claim days for outpatient therapy service claims, totaling $961,435, provided by the therapist from January 1, 2012, through December 31, 2013. The claims data were extracted from the CMS National Claims History file.

After selecting the statistical sample, 116 Railroad Retirement Board (RRB) claims were identified in the frame, including one claim in the sample. These claims were fully accounted for by treating the single RRB claim in the sample as a nonerror. Nevertheless, to reduce any confusion about the interpretation of the estimate, the 116 RRB claims were also removed from the frame. Given this latter step, the statistical estimates were calculated using a frame size of 14,998, totaling $953,471, rather than the original 15,114.

### SAMPLE UNIT

The sample unit was an outpatient therapy service beneficiary claim day and included all Medicare Part B services provided on a specific date of service for each beneficiary. The claims were limited to payment amounts greater than or equal to $25.

### SAMPLE DESIGN

We used a simple random sample.

### SAMPLE SIZE

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

### SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, 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 OIG/OAS statistical software to appraise the sample results. We estimated the total amount of inappropriate Medicare payments for unallowable outpatient therapy services made to the therapist at the lower limit of the 90-percent confidence interval.

## APPENDIX C: SAMPLE RESULTS AND ESTIMATES

### SAMPLE RESULTS

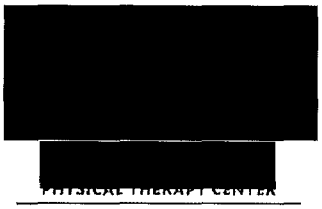
| Beneficiary Claim Days in Frame | Value of Frame | Sample Size | Value of Sample | Number of Unallowable Beneficiary Claim Days | Value of Unallowable Beneficiary Claim Days |
|---|---|---|---|---|---|
| 14,998 | $953,471 | 100 | $6,440 | 16 | $789 |

### ESTIMATES

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

| | |
|---|---|
| Point estimate | $118,325 |
| Lower limit | 70,748 |
| Upper limit | 165,903 |

# APPENDIX D: PHYSICAL THERAPIST'S COMMENTS



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|---|---|
| Patricia Wheeler<br>Regional IG for Audit Services<br>Office of Audit Services, Region VI<br>1100 Commerce St., Room 632<br>Dallas, TX 75242 | Paul Chesser<br>Audit Manager<br>Office of Audit Services, Region VI<br>1100 Commerce St., Room 632<br>Dallas, TX 75242<br>*via email to Paul.Chesser@oig.hhs.gov* |

RE: A-06014-00065

Dear Ms. Wheeler and Mr. Chesser:

This responds to your letter of December 29, 2015, which states that (1) the OIG has issued a draft report in the above referenced case, (2) written comments are requested within 30 days.

**Findings in general**

$ 1 beneficiary claim day that did not meet Medicare coding requirements,
$ 1 beneficiary claim day that did not meet Medicare documentation requirements, and
$ 14 beneficiary claim days had therapy services that were not medically necessary.

This makes a total of 16 "unallowable beneficiary claim days" out of 100 claim days in the sample, with a value of $789.00.

**One Claim Day Not Meeting Medicare Coding Requirements.** This refers to a service rendered on 11/20/13, as reflected in Medical Professional Reviewer Report "AS14-002352." That report states that "the record supports some of the PT services provided...met Medicare coverage criteria," that "PT services on 11/20/13 were medically necessary" and that codes 97124, 97035 and G0283 were medically necessary. At issue is 97110 which describes "Therapeutic exercises to develop strength and endurance, range of motion, and flexibility (15 minutes)". The report notes that the patient was not feeling well and the exercises were not performed on such day. We are not contesting this finding.

**One Claim Day Noting Meet Medicare Documentation Requirements.** The Audit Report states that treatment notes for a 76-year-old patient did not provide enough information to determine whether the services were appropriate and medically necessary. This appears to refer to a service rendered on 5/16/12, as reflected in Medical Professional Reviewer Report "AS14-001950." We are not contesting this finding.

**Claim Days Had Therapy Services That Were Not Medically Necessary.** There are 14 records subject to this criticism, and will be responded to using the identifiers "Sample (X)" and "AS14-00XXX."

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

Criticism summary: The treatment provided 11/7/12 was not medically necessary because (1) patient was independent with HEP, (2) no additions or modifications to HEP and (3) pain reduction with ice does not require a PT.

Response: the patient had 25 visits and was discharged 11/9/12, two days after the questioned date. [redacted] PT used HIVAMAT for pain reduction on this patient (acronym for Histological Variable Manual Technique) which does require the use of a physical therapist. There is some confusion as to how to bill for HIVAMAT with 97140 being somewhat of a consensus - which is what was billed on that DOS.

6. **Sample 24/AS14-001957D** - 10/22/12

Criticism summary: This concerns the same patient as Sample 23. The treatment provided 10/22/12 was not medically necessary for essentially the same reasons.

Response: the reviewer is in no position to say that "by this time it was clear that the Hivamat treatment was not providing significant relief..." The progress notes from 10/15 through 10/26 are similar, this date seems to have been selected randomly for denial.

7. **Sample 43/AS140001976D** - 5/23/12

Criticism summary: The treatment provided 5/3/12 was not medically necessary because the physician's initial order did not list long term goals.

Response: the patient had 13 visits and was discharged 6/20/12. If the treatment on 5/3 was not medically necessary due to the physician's deficient initial order, then none would have been. This date seems to have been selected randomly for denial. The American Association of Hip and Knee Surgeons recognizes that much of the therapy after hip replacement is walking with general stretching and thigh muscle strengthening, which is reflected in the physician's order for "generalized muscle strengthening, emphasis on abductor strengthening and gain training with assistive devices.

8. **Sample 62/AS14-002329D** - 9/4/12

Criticism summary: the treatment provided 9/4/12 was not medically necessary because (1) no Plan of Care signed, (2) no objective measures to demonstrate therapy effective and (3) patient did not participate in active therapy.

Response: the patient had 4 visits and was discharged 9/21/12. The patient performed exercises on 2 out of 4 dates of service (participating in active therapy); pain and muscle spasm relief in 4 visits is hard to do (initial evaluation 8/24/12 notes "severe and acute R neck and upper trapezius pain at rest and with movement."). [redacted] PT has a signed POC from [redacted] Hospital Outpatient Department dated 8/23/12.

9. **Sample 63/AS14-002330D** - 8/23/12

Criticism summary: the patient was seen two days in a row which is not standard of care

for frequency of visits. Records do not demonstrate specific exercises.

Response: the patient had 10 visits and was discharged 9/6/12. The records show that treatments were provided to the wrist, and that his elbow (diagnosis with lateral epicondylitis for last 5-6 years) was better.

**10. Sample 65/AS14-002332D** - 10/22/12

Criticism summary: evidently the criticism is that there was no therapist intervention of specific exercises targeted to the area of complaint.

Response: the patient had 20 visits and was discharged 11/2/12. On 10/22, [redacted] PT billed 97035 (ultrasound), 97124 (therapeutic massage therapy) and G0283(electrical stimulation) - no exercises were billed for.

**11. Sample 70/AS14-002337D** - 2/8/13

Criticism summary: (1) POC not certified by physician, (2) no regular evaluations to determine progress, (3) minimal information about response to therapy.

Response: the patient had 7 visits and was discharged 3/7/13. Patient passed away as noted in discharge note. Extensive measurements were noted throughout, documentation shows progress. There is a signed physician's prescription dated 1/3/13 from [redacted] MD.

**12. Sample 79/AS14-002346D** - 10/2/13

Criticism summary: (1) patient received 18 treatments which in total were not medically necessary, (2) amount, frequency and duration were not reasonable, (3) services not specific and effective for patient's condition, (4) no examination documented 10/2.

Response: the criticisms are a "shotgun" approach that is difficult to pinpoint specific issues and difficult to make a response. Is the reviewer disallowing one DOS or all? How were the services not effective? Why were treatments not medically necessary when patient still had pain at the end of treatment - some conditions do not improve as expected. The patient was doing active exercises on many dates of service including the date in question. The referring physician diagnosed the patient lumbar degenerative disc disease and sciatica (see initial evaluation). Reviewer cites no specific authority for lack of coverage where patient progresses as slowly and as difficultly as this one evidently did.

**13. Sample 83/AS14-002350D**

Criticism summary: patient received 20 treatments when a course of PT for such condition "would typically include up to 10 visits over 8 weeks." The specific date complained of was 11/22/13.

Response: the patient had 20 visits and was discharged 12/11/13. Reviewer states that - traction, e-stim, and massage do not require skills of a PT. However where would the patient go

to receive such treatments (other than perhaps massage) than to someone besides as PT? This patient was gradually getting better and eventually discharged pain free. Reviewer cites no authority to discharge patient earlier but still in pain.

**14. Sample 99/AS14-002366D** - 9/27/13

Criticism summary: (1) the amount, frequency and duration of services were not reasonable, (2) treatment through 9/10 was reasonable, but 9/27 was excessive.

Response: the patient had 18 visits and was discharger 10/7/13. There were two other visits past the date in question. Reviewer states that the primary diagnosis of debility would not be expected to require the number of visits provided, but cites no Medicare or other authority for the correct number of visits to cure debility and is making an arbitrary judgment call thereby. The referring physician authorized 10 additional visits on 9/10/13 (after the first 10), so the reviewer is second-guessing the patient's attending physician.

**Additional Beneficiary Claim Days/Plan of Care Issues**

Finally, while there are Medicare Professional Reviewer Reports for 19 claim days, the Audit report itself only takes exception to 14 beneficiary claim days, leaving a total of 5 reviewer reports whose specific criticisms are not addressed in this response:

1. Sample 28/AS14-001961D 2/17/12
2. Sample 35/AS14-001968D 3/5/12
3. Sample 47/AS14-001960D 3/27/13
4. Sample 56/AS14-002323D 6/17/13
5. Sample 86/AS14-002353D 12/3/13

In all of these the apparent issue was whether or not [redacted] PT had a signed Plan of Care - which they do. It appears these claim days were omitted from the results on this basis, but further elaboration can be provide on request.

Regards,

[redacted]