

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

<https://oig.hhs.gov>

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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

Athletic Physical Therapy improperly claimed at least \$267,000 in Medicare reimbursement for outpatient physical therapy services over a 21-month period.

WHY WE DID THIS REVIEW

In recent years, Medicare Part B payments for outpatient physical therapy have increased annually, with private-practice physical therapists generating payments of about \$1.9 billion in calendar year 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 to fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including physical therapists associated with Athletic Physical Therapy (Athletic), a private practice located in California. Our analysis indicated that one of Athletic's physical therapists was among the highest Medicare therapy billers in California.

Our objective was to determine whether claims for outpatient physical therapy services provided by Athletic complied with Medicare requirements.

BACKGROUND

Federal law and regulations provide for 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 personal supervision of a therapist in private practice. Federal law precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

HOW WE CONDUCTED THIS REVIEW

Our review covered 12,259 Medicare beneficiary days for outpatient physical therapy services, totaling \$1.1 million, provided by Athletic from January 1, 2013, through September 30, 2014. A beneficiary day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary for which Athletic received a payment from Medicare. We reviewed a random sample of 100 of those beneficiary days.

WHAT WE FOUND

Claims for outpatient physical therapy services provided by Athletic did not comply with Medicare requirements. Specifically, of the 100 beneficiary days in our random sample, Athletic properly claimed Medicare reimbursement for 68 beneficiary days. However, Athletic improperly claimed Medicare reimbursement for the remaining 32 beneficiary days, which had therapy services that were not medically necessary.

These deficiencies occurred because Athletic did not have adequate policies and procedures to ensure that claims for outpatient physical therapy services complied with Medicare requirements. On the basis of our sample results, we estimated that Athletic improperly received at least \$267,794 in Medicare reimbursement for outpatient physical therapy services that did not comply with Medicare requirements.

WHAT WE RECOMMEND

We recommend that Athletic:

- refund \$267,794 to the Federal Government and
- strengthen its policies and procedures to ensure that claims for outpatient physical therapy services comply with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, Athletic disagreed with our first recommendation and agreed with our second recommendation. Of the 33 beneficiary days that we found did not comply with Medicare requirements (as stated in our draft report), Athletic disagreed that 31 beneficiary days were noncompliant and provided specific comments for each of the 33 beneficiary days. For two beneficiary days, Athletic stated that it had made clerical errors and provided us with additional medical documentation not previously provided to the independent medical review contractor.

After reviewing Athletic's comments, we forwarded the additional medical documentation to the independent medical review contractor. On the basis of the contractor's conclusions, we revised our findings to state that Athletic improperly claimed Medicare reimbursement for 32 (instead of 33) beneficiary days that had therapy services that were not medically necessary. We also revised our recommended refund amount accordingly. We continue to stand by the determinations for the 32 beneficiary days.

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INTRODUCTION

WHY WE DID THIS REVIEW

In recent years, Medicare Part B payments for outpatient physical therapy 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, or properly documented and that were vulnerable to fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including physical therapists associated with Athletic Physical Therapy (Athletic), a private practice located in California. Our analysis indicated that one of Athletic's physical therapists was among the highest Medicare therapy billers in California. (Appendix A lists related OIG reports on outpatient physical therapy services.)

OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by Athletic 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 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.¹ 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. Treatments such as exercise, heat, cold, electricity, and massage are used. These services are provided in many different 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

¹ The Act § 1832(a)(2)(C).

physician or qualified therapist, and periodically reviewed by a physician, and the need for such services must be certified by a physician.² Further, Medicare Part B pays for outpatient physical therapy services billed using standardized codes.³ Services furnished by physical therapists in private practice must be performed by or under the direct supervision of a qualified physical therapist.⁴ Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁵ These requirements are further described in CMS's *Medicare Benefit Policy Manual* (Benefit Manual), Pub. No. 100-02, chapter 15.

Athletic Physical Therapy

Athletic operates four physical therapy offices in Southern California. These offices are located in the following cities: Encino, Simi Valley, Westlake Village, and Los Angeles. From January 1, 2013, through September 30, 2014 (audit period), Athletic's professional staff consisted of 19 physical therapists, 1 physical therapy assistant, and 27 physical therapy aides.

Athletic's claims are processed and paid by Noridian Healthcare Solutions, LLC, the Part B Medicare administrative contractor (MAC) for providers in Jurisdiction E, which includes California. Previously, the MAC was Palmetto GBA, LLC.

HOW WE CONDUCTED THIS REVIEW

Our review covered Athletic's claims for Medicare Part B outpatient physical therapy services provided during the audit period. Our sampling frame consisted of 12,259 beneficiary days,⁶ totaling \$1,122,774, 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 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.

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

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

³ Standardized codes used by providers are called Healthcare Common Procedure Coding System codes to report units of service.

⁴ 42 CFR § 410.60(c).

⁵ The Act § 1833(e).

⁶ A beneficiary day consisted of all outpatient physical therapy services provided on a specific date of service for a specific beneficiary for which Athletic received a payment from Medicare.

FINDINGS

Claims for outpatient physical therapy services provided by Athletic did not comply with Medicare requirements. Specifically, of the 100 beneficiary days in our random sample, Athletic properly claimed Medicare reimbursement for 68 beneficiary days. However, Athletic improperly claimed Medicare reimbursement for the remaining 32 beneficiary days, which had therapy services that were not medically necessary.

These deficiencies occurred because Athletic did not have adequate policies and procedures to ensure that claims for outpatient physical therapy services complied with Medicare requirements. On the basis of our sample results, we estimated that Athletic improperly received at least \$267,794 in Medicare reimbursement for outpatient physical therapy services that did not comply with Medicare requirements.

FEDERAL REQUIREMENTS

For services to be payable, a beneficiary must have the need for physical therapy services (Benefit Manual, chapter 15, § 220). For services to be covered, they must be reasonable and necessary (the Act § 1862(a)(1)(A) and Benefit Manual, chapter 15, § 220).

Services are reasonable and necessary if it is determined that services were safe and effective, were 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). Medicare requires that outpatient physical therapy services be provided in accordance with a written plan established before treatment begins (42 CFR § 410.60).

SERVICES WERE NOT MEDICALLY NECESSARY

For 32 beneficiary days, Athletic received Medicare reimbursement for therapy services for which the beneficiaries' medical records did not support the medical necessity of the services. The results of the medical review indicated that these services did not meet one or more Medicare requirements:⁷

- Given the beneficiary's diagnoses, complexities, severities, and interaction of current active conditions, the care was not appropriate (30 beneficiary days).
- The amount, frequency, and duration of services were not reasonable (29 beneficiary days).
- Services were not specific, were not an effective treatment for the beneficiary's condition, or both (12 beneficiary days).

⁷ The total number of deficiencies exceeds 32 because some beneficiary days contained more than 1 deficiency.

- There was no expectation of significant improvement within a reasonable and predictable period of time (10 beneficiary days).
- Services did not require the skills of a physical therapist (9 beneficiary days).
- Services were not provided under and in accordance with a physician's signed plan of care (1 beneficiary day).

For example, Athletic received payment for physical therapy provided on April 25, 2014, to a 78-year-old Medicare beneficiary. The independent medical review contractor determined that the therapy service did not meet Medicare coverage requirements because the medical records showed that the beneficiary had reached a plateau with the treatments that were being provided (indicating that (1) given the beneficiary's diagnoses, complexities, severities, and interaction of current active conditions, the care was not appropriate and (2) the amount, frequency, and duration of services were not reasonable). The medical review contractor concluded that an independent home exercise program would have met the beneficiary's needs.

CONCLUSION

Athletic did not have adequate policies and procedures to ensure that claims for outpatient physical therapy services complied with Medicare requirements. On the basis of our sample results, we estimated that Athletic improperly received at least \$267,794 in Medicare reimbursement for outpatient physical therapy services that did not comply with Medicare requirements.

RECOMMENDATIONS

We recommend that Athletic:

- refund \$267,794 to the Federal Government and
- strengthen its policies and procedures to ensure that claims for outpatient physical therapy services comply with Medicare requirements.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Athletic disagreed with our first recommendation and agreed with our second recommendation. Of the 33 beneficiary days that we found did not comply with Medicare requirements (as stated in our draft report), Athletic disagreed that 31 beneficiary days were noncompliant and provided specific comments for each of the 33 beneficiary days. For two beneficiary days, Athletic stated that it had made clerical errors and provided us with additional medical documentation not previously provided to the independent medical review contractor.

A portion of Athletic's full comments are included as Appendix E. We did not include the detailed comments on each of the 33 beneficiary days and the additional documentation because

they were too voluminous and contained personally identifiable information. We are separately providing Athletic's comments in their entirety to CMS.

After reviewing Athletic's comments, we forwarded the additional medical documentation to the independent medical review contractor. On the basis of the contractor's conclusions, we revised our findings to state that Athletic improperly claimed Medicare reimbursement for 32 (instead of 33) beneficiary days that had therapy services that were not medically necessary. We also revised our recommended refund amount accordingly. We continue to stand by the determinations for the 32 beneficiary days.

DUE PROCESS, MEDICAL REVIEW CONTRACTOR, AND BENEFICIARY ENTITLEMENT TO BENEFITS

Auditee Comments

Athletic stated that our audit did not provide due process. Athletic also stated that without due process, it feared that its property would be unjustly taken, resulting in irreparable harm.

Athletic commented that our use of an independent medical review contractor created bias. Athletic also commented that the contractor lacked subject matter expertise to assess the physical therapy documentation and that the failure to use medical reviewers with such basic competence violated government auditing standards issued by the Government Accountability Office.

Athletic stated that beneficiaries have a legal right to use their Medicare benefits and that its patients are legally entitled to receive skilled physical therapy services to help them live a better life with less pain. Athletic commented that it has a legal right to be paid under the CMS provider agreement.

Office of Inspector General Response

Our audit did not violate Athletic's due process rights. We conducted this audit in accordance with generally accepted government auditing standards. On the basis of a multifactor risk analysis of Medicare Part B claims for physical therapy services, we determined which providers to audit. Our analysis indicated that one of Athletic's physical therapists was among the highest Medicare physical therapy billers in California. Due process is available to all Medicare providers through the normal appeals process.

We obtained an independent medical review of the sampled beneficiary days for medical necessity, documentation, and coding requirements, and our report reflects the results of that review. The independent contractor had no affiliation with the U.S. Department of Health and Human Services (HHS), OIG, the beneficiaries, or the provider involved in this audit. The independent contractor's reviewers were board certified in Physical Medicine and Rehabilitation and qualified to determine the medical necessity of the beneficiary days.

Our audit did not harm beneficiary rights. Although beneficiaries may use their Medicare benefits to receive medical services, it is our responsibility to ensure that services furnished by

providers that receive Medicare reimbursement are medically necessary and comply with all Medicare requirements.

FINDINGS

Auditee Comments

Athletic stated that our findings related to 31 of the 33 beneficiary days were based only on opinion, not on fact or law. Athletic also stated that our proposed denial of these beneficiary days on the basis of medical necessity was not factually supported and directly contradicted the documentation that it provided. Athletic noted examples of what it stated were facts related to these beneficiary days, such as certification of the plans of care by the treating physicians.

Athletic commented that our findings related to 2 of the 33 beneficiary days were caused by simple clerical errors. For these two beneficiary days, Athletic provided us with additional medical documentation not previously provided to the independent medical review contractor.

Office of Inspector General Response

The independent medical review contractor examined all of the medical records and documentation that Athletic submitted, including the plans of care, and carefully considered this information to determine whether claims for outpatient physical therapy services provided by Athletic complied with Medicare requirements.

We also forwarded the additional medical documentation to the independent medical review contractor. On the basis of the contractor's conclusions, we revised our findings to state that Athletic improperly claimed Medicare reimbursement for 32 beneficiary days that had therapy services that were not medically necessary. We continue to stand by those determinations.

EXTRAPOLATION

Auditee Comments

Athletic stated that our statistical method for extrapolation to determine the refund amount was questionable and requested the opportunity to discuss our extrapolation methodology. Athletic also stated that it believed we grossly miscalculated the refund amount.

Office of Inspector General Response

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare.⁸ For our audit, we properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant Medicare requirements in evaluating the sample,

⁸ See *Momentum EMS, Inc. v. Sebelius*, 2014 WL 199061 at *9 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. Accordingly, we stand behind our statistical estimates.

We discussed with Athletic the results of our review, including our statistical estimates, before issuing our draft report. Also, Appendix C describes our statistical sampling methodology.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Northern California Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-09-14-02040</u>	11/1/2016
<i>A Kansas Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-07-14-01146</u>	8/22/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07054</u>	6/30/2016
<i>A South Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Physical Therapy Services</i>	<u>A-06-14-00064</u>	6/14/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07055</u>	4/22/2016
<i>A Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-06-14-00065</u>	3/17/2016
<i>Boulevard Health Care Program, Inc., Improperly Claimed Medicare Reimbursement for Outpatient Physical Therapy Services</i>	<u>A-02-14-01004</u>	10/29/2015
<i>AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-02-13-01031</u>	6/15/2015
<i>An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-05-13-00010</u>	8/20/2014
<i>Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-02-11-01044</u>	6/10/2013
<i>Questionable Billing for Medicare Outpatient Therapy Services</i>	<u>OEI-04-09-00540</u>	12/21/2010

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered Athletic's claims for Medicare Part B outpatient physical therapy services provided during the audit period. Our sampling frame consisted of 12,259 beneficiary days,⁹ totaling \$1,122,774, of which we reviewed a random sample of 100 beneficiary days.

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

We conducted our audit from April 2015 through June 2016 and performed fieldwork at Athletic's office in Westlake Village, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations and guidance;
- interviewed Noridian Healthcare Solutions, LLC, officials to obtain an understanding of the Medicare requirements related to outpatient therapy services;
- interviewed Athletic officials to gain an understanding of Athletic's policies and procedures related to providing and billing Medicare for outpatient therapy services;
- obtained a database of claims from CMS's NCH file containing the claims for outpatient therapy services provided by Athletic during the audit period;
- performed data analysis on the NCH file to identify our sampling frame of 12,259 beneficiary days, totaling \$1,122,774 (Appendix C);
- selected a random sample of 100 beneficiary days from the sampling frame (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted;

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

- obtained medical record documentation from Athletic for the 100 sampled beneficiary days and provided the medical records to an independent medical review contractor, who determined whether each outpatient therapy service was allowable in accordance with Medicare requirements;
- used the results of the sample review to calculate the estimated total unallowable Medicare reimbursement paid to Athletic for services provided during the audit period (Appendix D); and
- discussed the results of our review with Athletic officials.

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 C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part B claims for outpatient physical therapy services that Athletic provided during the audit period.

SAMPLING FRAME

The sampling frame was a Microsoft Access database containing 12,259 beneficiary days for Medicare Part B outpatient therapy services, totaling \$1,122,774, provided by Athletic during the audit period.

To identify our sampling frame, we excluded claims that had been reviewed, were currently under review, or were excluded from review by the Recovery Audit Contractor. From the lines of service associated with the remaining claims, we excluded each line of service for which payment was \$0. From the remaining lines of service, we grouped the information by beneficiary Health Insurance Claim number and date of service to identify the beneficiary days and excluded each beneficiary day for which payment was less than \$25.

SAMPLE UNIT

The sample unit was a beneficiary day. A beneficiary day consisted of all outpatient therapy services provided on a specific date of service for a specific beneficiary for which Athletic received a payment from Medicare. The beneficiary days 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 beneficiary 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 UNITS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to calculate our estimates. We estimated the total unallowable Federal reimbursement paid to Athletic for services provided during the audit period. The lower limit was calculated using a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

No. of Beneficiary Days in Sampling Frame	Value of Beneficiary Days in Sampling Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary Days	Value of Unallowable Beneficiary Days
12,259	\$1,122,774	100	\$9,595	32	\$2,900

Table 2: Estimated Value of Unallowable Beneficiary Days
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$355,501
Lower limit	267,794
Upper limit	443,208

APPENDIX E: AUDITEE COMMENTS

Athletic Physical Therapy, Inc

Report Number: A-09-15-02015

Response to the Draft Report of the US
Department of Health and Human Services;
Office of the Inspector General

September 15, 2016

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Introduction

The overpayment demand in this case would put Athletic Physical Therapy, Inc. out of business. Athletic Physical Therapy strongly urges the Office of the Inspector General (OIG) to consider the information included below and, for resolution purposes, allow Athletic Physical Therapy to move forward with a focus towards investing its resources into patient care activities. Overall, the issues raised in the OIG audit were a majority of personal opinion of the OIG reviewer rather than legal fact. After the OIG's review of the Athletic Physical Therapy's comments, the provider would appreciate an opportunity to further discuss this matter with the OIG in order to reach a resolution that would allow Athletic Physical Therapy to stay in business and demonstrate their prospective compliance.

Athletic Physical Therapy received the September 15, 2015 letter indicating the OIG's intention to perform an audit to determine whether outpatient services were allowable in accordance with Medicare reimbursement requirements.

Athletic Physical Therapy received the July 16, 2016 draft audit report entitled "Athletic Physical Therapy Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services." In the report the OIG recommended Athletic Physical Therapy do the following:

1. refund \$277,598 to the Federal Government and
2. strengthen its policies and procedures to ensure that claims for outpatient physical comply with Medicare requirements.

In response to the recommendations by the OIG:

OIG Lack of Due Process

The 5th Amendment to the United States Constitution acts as a safeguard from arbitrary denial of life, liberty or property by the Government outside of the sanction of the law. Athletic Physical Therapy is not being afforded their Constitutional right to Due Process.

Without Due Process, Athletic Physical Therapy fears its property will be unjustly taken resulting in irreparable harm. Specifically, if the OIG, Medicare Administrative Contractor (MAC), or Center for Medicare Services (CMS) decides to withhold money from rightfully due Medicare payments, Athletic Physical Therapy, its employees, and all of the medical care it provides to the community will cease to exist.

Athletic Physical Therapy has full confidence that once it is allowed to be heard fully, an impartial judge will conclude that the vast majority of the alleged claims should be dismissed. Athletic Physical Therapy maintains that it has met every requirement as stated in the CMS

Benefits Manual Chapter 15 and that in its clinical judgment, it has performed exemplary physical therapy services within the standard of care.

There should also be the presumption of innocence before property is taken and the burden of proof should be placed squarely on the shoulders of the OIG, MAC or CMS.

Medical Reviewer Conflict of Interest and Lack of Subject Matter Expertise

The very fact that the OIG contracts medical reviewers creates bias. How long will a medical reviewer remain working if he/she finds no deficiencies? As a medical provider, Athletic Physical Therapy is thrilled to see individuals and corporations criminally charged and prosecuted for medical fraud. But in this case, the OIG reviewer has gone too far.

Of the 100 sample records audited by the OIG, only 2 were actually deficient, and those deficiencies were due to clerical error. That is 2% of the total sample. The OIG should therefore immediately reverse course in its final report and find that the claims were properly reimbursable. The OIG should also acknowledge publicly that Athletic Physical Therapy is not a fraudulent company.

Athletic Physical Therapy also asked for the 67 records that were found by the OIG to be in compliance with Medicare regulations. At the time of this draft report, the OIG has yet to comply with this request. Athletic Physical Therapy believes by comparing the 33 alleged denied claims to the 67 approved claims, it would find that the OIG reviewer's opinions were inconsistent, illogical, and that they regularly contradicted themselves.

It appears that the 33 claims were denied because the OIG reviewer lacked the subject matter expertise to assess the physical therapy documentation. The failure to use reviewers with such basic competence violates sections 3.27 and 6.45 of the Government Auditing Standards issued by the U.S. Government Accountability Office.

3.72 The staff assigned to conduct an audit in accordance with GAGAS should collectively possess the technical knowledge, skills, and experience necessary to be competent for the type of work being performed before beginning work on that audit. The staff assigned to a GAGAS audit should collectively possess a. knowledge of GAGAS applicable to the type of work they are assigned and the education, skills, and Chapter 3 General Standards Page 57 GAO-12-331G Government Auditing Standards experience to apply this knowledge to the work being performed;

Athletic Physical Therapy has requested on multiple occasions to speak with the OIG reviewers, but those requests have been denied which is in violation of section 6.45 d. GAGAS .

6.45 Audit management should assign sufficient staff and specialists with adequate collective professional competence to perform the audit. Staffing an audit includes, among other things:
a. assigning staff and specialists with the collective knowledge, skills, and experience appropriate for the job,

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- b. assigning a sufficient number of staff and supervisors to the audit, to independence.
- c. providing for on-the-job training of staff, and
- d. engaging specialists when necessary.

The OIG reviewer had a MD degree which does not qualify them to determine medical necessity in physical therapy cases. MDs have little to;

- no formal education in the physical therapy field
- no expertise in the application of skilled physical therapy treatments
- no expertise directing complex physical therapy patients in an outpatient setting
- no experience establishing plans of care with functional goals

Therefore any opinion from a MD about medical necessity and reasonableness should be viewed as lacking specific subject matter and expertise and are therefore in violation of the General Auditing Standards 3.27.

Beneficiaries' Rights to Medical Care

In 2013, "the U. S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an "Improvement Standard" in making claims determinations for Medicare coverage involving skilled care (e.g., the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits)." Under the terms of the settlement agreement, to ensure beneficiaries receive the care to which they are entitled, CMS is to "engage in accountability measures, including review of a random sample of SNF, HH, and OPT coverage decisions to determine overall trends and identify any problems, as well as a review of individual claims determinations..."

(<https://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPFS/downloads/jimmo-factsheet.pdf>).

In the initial audit letter to Athletic Physical Therapy from the OIG, there was no reason given for the audit. There was no mention of "reasonable suspicion" or "credible evidence" nor was Athletic Physical Therapy being subpoenaed for fraud or abuse.

Athletic Physical Therapy has been in good standing with the Medicare Administrative Contractors (MAC) and CMS for years. It has worked closely with them on many occasions to improve its methodology and clarify points to improve its procedures. At no time did the MAC or CMS have any reason to audit Athletic Physical Therapy records. Athletic Physical Therapy pays strict attention to the Medicare cap and use of the "KX" modifier, treats every patient with individualized plans of care, provides skilled interventions, and does not over treat.

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It is possible the OIG is auditing Athletic Physical Therapy in order to determine if the MAC and CMS are in compliance with the settlement agreement from Jimmo v. Sebelius.

If this is the case, Athletic Physical Therapy believes that, based on the facts and clinical judgments of its therapists and independent referring physicians, the MAC and CMS are upholding the settlement agreement by allowing beneficiaries to receive medical care that is skilled, reasonable, and medically necessary.

After reviewing the draft report from the OIG, Athletic Physical Therapy believes that there are no legal or factual grounds for denying claims and that the MAC and CMS have done an outstanding job on provider compliancy.

Beneficiaries Choose to Use Their Entitlement

Beneficiaries have a legal right to use their Medicare benefits. For every treatment that the OIG alleges was not medically necessary, there is a patient who disagrees. Each treatment and all sample cases involve a person who called Athletic Physical Therapy, scheduled their own appointments, walked into our clinics and laid down on our tables.

This is not a case of a sham medical clinic scheduling fake appointments for the deceased or homeless. These are law abiding citizens of the United States that requested the skilled services of a trained physical therapist to help them live a better life with less pain. These patients are legally entitled to have these treatments, and Athletic Physical Therapy has a legal right to be paid under the CMS provider agreements.

Section 10.3 (a) of the Medicare Benefit Policy Manual, Chapter 5, states that, “The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines.”

In the case for Athletic Physical Therapy, the OIG reviewer denied claims alleging only that the medical record did not support the medical necessity of services above the cap. As will be explained in greater detail the medical records provided to the OIG met the Medicare guidelines for medical necessity.

The services provided were reasonable and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities, or changes in the physical function or health status of the beneficiary. The OIG has no authority or jurisdiction to deny these individuals their rightful use of their Medicare benefits.

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Therefore, the OIG must reverse course in its final report and find that these claims were properly reimbursed by the CMS.

Athletic Physical Therapy Does Not Agree with Recommendation #1

Athletic Physical Therapy provides outpatient rehabilitation services to patients in California. The audit at issue covers services provided from January 1, 2013 through September 30, 2014. In the audit findings, the OIG reviewed 100 sample claims and alleged that 33 of the 100 sample claims were improperly reimbursed by Medicare. According to the audit, the claims were allegedly deficient for at least one of the following reasons:

- (1) independent home exercise program appropriate (60% n=20);
- (2) excessive number of treatments (73% n=24);
- (3) record does not support visits (83% n=27);
- (4) not medically reasonable or necessary (21% n=7);
- (5) progress had reached plateau (36% n=12);
- (6) improvement not in a predictable time (58% n=19);
- (7) care not specific for the patient's condition (15% n=5) ;
- (8) no expectations for further improvement (6% n=2);
- (9) examination incomplete (3% n=1);
- (10) care not skilled (9% n=3);
- (11) plan of care not appropriate (3% n=1); and/or
- (12) goals were excessive (3% n=1)

A remarkably high percentage of the 33 samples claims were "rubber stamped" with vague and biased opinions for reasons such as predictability, home exercise, excessive treatments and visits not supported. Of the 33 sample claims, 31 were deemed by the OIG reviewer to be deficient for reasons of "medical necessity". The 31 samples are samples 3, 4, 5, 6, 8, 12, 16, 18, 20, 21, 23, 30, 32, 34, 35, 37, 39, 43, 45, 47, 52, 55, 61, 62, 69, 74, 75, 76, 78, 87, 100. The remaining 2 samples--samples 67 and 72--were simple clerical errors that will be explained and resubmitted.

The OIG's findings were then applied to all claims provided between January 2013 and September 2014. As will be demonstrated below, these claims were appropriately billed and paid by Medicare.

2% Documentation Errors

The sheer amount of documentation requirements from Medicare for each medical record is astounding. From the patient information, evaluations, signed plans of care, discharge

summaries, signatures, dates, time and treatments stamps , functional scales, g-codes, treatment codes, and physician prescriptions, the list is enormous.

Athletic Physical Therapy had no factual deficiencies with 98 out of 100 samples which shows the exemplary staff training and attention to detail placed on all Medicare records.

0% Administrative Errors

There is an equally enormous and tedious list of administrative requirements from Medicare. All of the 100 samples were completed to 100% satisfaction of the OIG auditors and reviewers. This list includes the collection, maintenance, and billing procedures, beginning with the initial phone call from the patient and concluding with the claims reimbursement being mailed.

There are no issues with billing under the wrong therapists, using the wrong billing codes or modifiers, or treatment codes not supporting the units billed.

Athletic Physical Therapy would expect this to be unprecedented when reviewing physical therapy claims. The fact there were 0 administrative errors shows the emphasis Athletic Physical Therapy places on compliance with all aspects of processing Medicare claims.

OIG Lacks Factual Evidence to Deny Claims

The OIG audit found 2% documentation and 0% administrative factual deficiencies in 100 medical records submitted for audit. A 2% error rate is well within reasonable when comparing Athletic Physical Therapy to other similar out patient medical entities across the country. Therefore, the OIG must reverse course in its final report and find that these claims were properly reimbursable.

Athletic Physical Therapy Agrees with Recommendation #2

Athletic Physical Therapy prides itself on strong documentation for compliancy and patient care. Each employee is given a company policy manual and training manual that helps them to understand how to best document on intervention with a patient.

Athletic Physical Therapy's documentation is almost identical across all payer types which helps to strengthen our commitment to strong documentation on all patients for the purpose of getting timely payments.

As recently as 2015, each physical therapist is personal trained by the owner on how to document evaluations, progress reports and daily notes. The owner reads all newly employed physical therapists' documentation until they are in compliance with CMS regulations. This process can take up to 6 months.

Athletic Physical Therapy conducts random and regular Medicare "self- audits" and we post these at each therapists desk.

The auditors from the OIG have been given all of these manuals and are fully aware of Athletic Physical Therapy's policy and procedures. The OIG auditors have been in the offices and seen first hand how it does everything in its power to comply with the CMS regulations.

So it is with full agreement that Athletic Physical Therapy continues to strengthen its policies and procedures to ensure that claims for outpatient physical comply with Medicare requirements.

31 of 33 Alleged Deficiencies Not Based on Facts; Only Vague Opinion

All of the 31 alleged deficiencies were prescribed and certified in a timely manner by the actual treating physician in accordance with the CMS Benefits Manual Chapter 15, section 220.1.3 - Certification and Recertification of Need for Treatment and Therapy Plans of Care.

Recommendations for claims denial for 31 of 100 sample records are based only on opinion; not fact or law.

1.All Certified By Treating Physician

In these 31 cases, there are 31 different primary care treating physicians who have certified the plan of care and established medical necessity. All of these physicians are separate and distinct from Athletic Physical Therapy. There is no one physician who can be considered "illegitimate" and working with Athletic Physical Therapy for the purposes of over prescribing physical therapy services.

All of the treating physicians are Certified Medicare providers and duly licensed physicians to practice medicine in California. Each treating physician is equally or more qualified than the OIG reviewer.

Athletic Physical Therapy finds it highly unreasonable that OIG reviewers know more about patients' cases than 31 separate and distinct treating physicians.

Most importantly, each treating physician personally observed and examined the actual patients in all claims. All cases had signed plans of care from physicians who were actively treating and seeing the patient on a regular basis and prescribing physical therapy.

Since medical necessity is based on "reasonableness", the fact that each one of these 31 claims was certified by a different licensed MD shows that all claims should be paid in accordance with CSM Benefits Manual.

2. All Performed By Medicare Certified Physical Therapist

It is highly unreasonable to assume that the OIG reviewer knows more about physical therapy treatments for these individual patients than the actual treating physical therapists.

Clinical judgment is not defined in the CMS Benefits Manual Chapter 15. However, it is defined as "The application of information based on *actual observation of a patient* combined with subjective and objective data that lead to a conclusion" (emphasis added).

For the 31 claims, there are 12 different Medicare Certified and State licensed physical therapists who in their expert clinical judgment determined that all claims were medically reasonable and necessary.

There is a reason the OIG reviewer is not able to determine "medically reasonable care" more effectively by reading documents compared to the treating physical therapist.

This was explained by Gunver Kienle, MD in the "Clinical Judgment and the Medical Profession" [J Eval Clin Pract.](#) 2011 Aug; 17(4): 621–627.

Technical Rationality (TR) used by MD medical reviewers for clinical judgment comes from the "application of external science" meaning judgment is applied using information.

Tacit Knowledge (TK) used by treating physical therapists for clinical judgment comes from "experience and expert knowledge" meaning judgment is applied using experience.

Gunver concludes: " The first approach (TR) can assess, on cohort level, the superiority of one treatment compared to another but cannot evaluate treatment effects in individual patients. The second approach (TK) can assess individual effectiveness but cannot determine general superiority.

The OIG reviewer possess only Technical Rationality, however, the treating physical therapist possesses both Technical Rationality and Tacit Knowledge. Therefore, it is reasonable to assume, the information based opinion of the OIG reviewer cannot not supersede the expert knowledge of the treating physical therapist.

Therefore, all 31 claims should be paid in accordance with CSM Benefits Manual.

3. No Financial Incentive for Treating Physical Therapist to Over Treat

There were 12 different physical therapist who treated the 33 alleged deficient claims. Eleven of these therapists were not owners of the company and did not share in the profits of the company. These 11 therapists had no financial gain from over treating Medicare patients.

One of the 12 treating physical therapist was an owner of Athletic Physical Therapy and had the potential for financial gain. However, this therapists was the treating physical therapist in only 2 of the 33 sample dates.

These facts show that there is no evidence that any of the physical therapists including the sole owner of Athletic Physical Therapy over treated Medicare patients for financial gain. Therefore, lacking motivation for excessive treatment, all 31 claims should be paid in accordance with CSM Benefits Manual.

4. All Documented Evidence of Medical Necessity

All of the 31 cases that have been recommended for denial have factual and documented evidence based on CMS Benefits Manual Chapter 15, section 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services.

It is the opinion of Athletic Physical Therapy that the OIG reviewer simply did not review or lacked subject matter expertise for the submitted documentation. For the 31 sample cases, there are subjective, objective, and functional measurable improvements right there in the record. Oftentimes the OIG reviewer simply ignores the facts, misses the complexity, misunderstands the term "skilled", and has an unrealistic perception that every patient must follow guidelines.

In an effort to help the OIG reviewer understand this information, Athletic Physical Therapy has taken each case and written a report demonstrating medical necessity based on the CMS Benefits Manual Chapter 15.

Each record demonstrates that the treatment required skilled physical therapy services, services were specific for the condition, there was an expectation for significant improvement within a reasonable and predictable time or was necessary for a safe and effective maintenance program, and care was appropriate given the diagnosis, complexities, severities, and interaction of the current active condition and services.

5. Skilled Services Medically Necessary

The skill of the Athletic Physical Therapy provider is looked upon by the OIG reviewer from a medical perspective but not a patient perspective.

Physical Therapists (DPT) spend 7 years in training and education to become a licensed physical therapist. They spend 2080 hours per year implementing and gathering expertise based on hundreds of patient interactions each month. The OIG reviewer's conclusion that a patient can self-manage their entire condition independently is not based on fact. Instead, it appears to be based on an MD's low opinion of the work performed by a DPT. This is not a shared belief among injured, aging patients and highly trained Doctors of Physical Therapy.

The OIG reviewer may be able to understand home exercises, but the reviewer fails to take into account that patients are non-medical people. Expecting patients to understand and perform only self-administered home programs is not the same as being closely supervised by a trained and competent physical therapist who also delivers hands-on manual therapy treatments.

In many of the sample cases that the OIG reviewer felt should have been discharged to a home program, the patient had already been discharged to home and regressed. This caused the patient to return to physical therapy because they could not self-manage their condition.

All of the patients at Athletic Physical Therapy get home exercise programs to supplement their treatments. Having a patient do exercises at home is not the same as being under a therapist's direct supervision coupled with manual therapy techniques.

The OIG reviewer has such a low opinion of physical therapy they go as far to say that "home theraband" would be enough to rehabilitate a patient. Ask Harry Reid, a United States Senator, how his home exercise program is going. Apparently, he couldn't figure out how to do home physical therapy exercises in his own bathroom without blinding himself.

6. A Home Program Involves More than Simple Exercises

Manual therapy techniques are highly skilled applications of massage, joint mobilization and range of motion techniques that integrate the nervous, lymphatic, skeletal, respirator and muscular systems. Non-trained people have a very poor understanding of body position, movements, biomechanics and functional movement patterns. In all of the sample cases, there is evidence of restricted joint motion, changes in soft tissue and pain all relating to a functional limitation.

Non-skilled people do not have the ability to perform these techniques to the same level of a skilled and trained physical therapist.

Manual therapy techniques CPT Code 97140

1. Joint Mobilization (Peripheral or Spinal)

- This procedure may be considered reasonable and necessary if restricted joint motion and/or pain is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.

2. Soft Tissue Mobilization

- This procedure involves the application of skilled manual therapy techniques (active or passive) to soft tissues in order to effect changes in the soft tissues, articular structures,

neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened muscular or connective tissue.

Soft tissue mobilization can be considered reasonable and necessary if at least one of the following conditions is present and documented:

- a) The patient having restricted joint or soft tissue motion in an extremity, neck or trunk
- b) treatment being a necessary adjunct to other physical therapy interventions such as 97110, 97112 or 97530.

3. Manipulation

- This procedure may be considered reasonable and necessary for treatment of painful spasm, the loss of articular motion, or restricted motion of soft tissues or joints. It may also be used as an adjunct to other therapeutic procedures such as 97110, 97112 or 97530.

It is easy for a medical reviewer to simplify physical therapy from far away. It also helps them keep their jobs. Teaching and instructing a non-skilled person to do only a home exercise program to remediate pain and dysfunction after surgery is quite another thing.

7. Services Were Specific and Effective Treatment for the Patient's Condition

There were 5 samples that the OIG alleges did not receive services that were specific to the patient's condition. However, in each case, the patient demonstrated measurable improvements towards stated functional goals and met all the requirements for the CMS benefits Manual for Outpatient Therapy Services.

For example, sample 23 was deemed not specific for aquatic therapy for degenerative disc disease of the lumbar spine. The documentation shows that the treating physician wrote "aquatic therapy" on the prescription.

No treatment interventions existed outside of the standard of care for any of the samples at Athletic Physical Therapy. Claims cannot be denied based on an opinion of the OIG that contradicts the documentation and certification for the treating physician.

8. Improvements Within a Reasonable and Predictable Time

The word "predictable" is found in the CMS Benefits Manual Section 220.3 page 190 only once for Outpatient Services.

"Care must be taken to assure that documentation justifies the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency.

Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time."

In the 20 samples that were deemed non-predictable by the OIG, all 20 cases have clear documentation indicating without a doubt that the patient was improving or had the potential to improve. In some cases improvement was rapid and marked. In others, improvements were slower and more subtle. However, each and every case documents the requirements of Medicare and at no time was the improvement insignificant in relation to the extent and duration of services.

In the 20 samples that were deemed non-predictable by the OIG, 3 sample cases (samples 32, 39 and 45) have clear documentation indicating a transition from rehabilitative to maintenance therapy. In each of these case, the therapist documented rehabilitative therapy at the onset of care, demonstrated a regression while decreasing the care, and then transitioned to maintenance therapy to avoid deterioration in the patient's condition as allowed in the CMS Benefits Manual 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services C and D and CMS Benefits Manual Section 220.3 page 190 .

- "In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel."

While guidelines exist for what is expected for a given diagnosis, they never tell the true story. Why do some patients do well and others don't? Why do some patients recover from cancer with chemotherapy and others die? The answer is and always has been "We don't know". To make a judgment from afar about why or why not a patient recovers within an expected period of time is guessing and inexact.

Medical professionals have guidelines to help manage cases and to help patients understand what will be required for their recovery. The providers at Athletic Physical Therapy made every effort to get each patient better as fast as possible. Some get better faster than others.

There is no legal reason Athletic Physical Therapy should be penalized for patients who go beyond what are considered guidelines. Athletic Physical Therapy met the requirement of

"anticipated improvement is attainable in a reasonable and generally predictable period of time" and therefore all 31 claims should be paid in accordance with CSM Benefits Manual.

9. Appropriate Care Was Given

The OIG fails to account for the fact that "predictable duration of care" can vary based on an individual's personal healing abilities, diagnosis, complexities, severities, and interactions of current active conditions

In numerous cases the OIG reviewer neglected to recognize the complexities of cases. There were numerous instances where comorbidities such as advanced age, previous injuries, surgery, illness, and life style changed the outcome for these patients.

In one example, a patient had an exacerbation during the holidays due to family and cooking activities. This prolonged the case, but it was no fault of the therapist and clearly allowable by Medicare.

In another case, a patient had a one level fusion as a last effort to cure her pain for chronic multilevel scoliosis. She was still on pain medication 4 months post surgery, wore her brace 6 months post operative, had surgery for aortic stenosis which caused leg weakness and dizziness, and battled gastric issues. This is all clearly documented and the reviewer seemingly ignored the regulations as stated in the CMS Benefits Manual page 153:

"COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

The reviewer also seemingly ignored CMS Manual page 180:

Contractors determine the patient's needs through knowledge of the individual patient's condition, and any complexities that impact that condition, as described in documentation (usually in the evaluation, re-evaluation, and progress report). Factors that contribute to need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability.

Athletic Physical Therapy is in complete disagreement with the medical reviewer regarding the 31 cases deemed deficient. Everything Medicare and CMS required has been documented and supplied to the OIG. The OIG's proposed denial of these claims based on medical necessity are not factually supported and directly contradict the documentation that was supplied. For this

reason, all 31 claims should remain paid in accordance with CSM Benefits Manual. The OIG must reverse course in its final report and find that these claims were properly reimbursable. *

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

*** OIG Note:** We redacted information on this page and the following page and did not include pages 17 through 85 of Athletic’s detailed comments because they were too voluminous and contained personally identifiable information.

[REDACTED]

[REDACTED]

[REDACTED]

Extrapolation

The method used for extrapolating a refund for the alleged deficient files is under question. Before a final draft report is finished, Athletic Physical Therapy would like the opportunity to discuss this method and have a chance to hire statisticians who have more knowledge on the subject in order to get an accurate refund if one is found to be necessary.

It is the opinion of Athletic Physical Therapy that the OIG has grossly miscalculated the refund amount and that a cost of hiring a statistician will not be necessary and the OIG and Athletic Physical Therapy can come to terms after final review of the submitted documentation.

Conclusion

Athletic Physical Therapy's specific responses to the OIG's findings definitively demonstrate that the vast majority of the deficiencies identified in the draft report are based on personal opinion instead of fact and law.

Athletic Physical Therapy has demonstrated beyond doubt that 31 of 33 records demonstrate compliance in accordance with the governing rules and regulations and are consistent with generally accepted government auditing standards.

Athletic Physical Therapy has submitted additional documentation on 2 of 33 cases due to clerical errors and is awaiting response from the OIG.

The OIG has the authority to correct these findings before issuing a final report. The OIG must revise its final report to correct Athletic Physical Therapy's records generally met Medicare's requirements, and support the services billed.