Making the Journey to a Better Physical Therapy Practice

Physical Therapy Audits
What are they looking for?

- Commercial insurers, third party administrators, and most importantly, government payers, routinely conduct audits to identify potential red flags in the billing practices of providers, including physical therapists.
- The goal of these audits is not to address every anomaly, but to identify inappropriate billings that drive up health care costs through fraud, waste and abuse.
- Though these might start off as routine claims audits, (contractual mechanisms to determine if benefits are paid according to the terms of provider contracts) often times they identify patterns and outliers in billing which can create the predication for establishing investigations.
- These patterns and outliers, though often explainable, are commonly referred to as red flags in billing. They do not constitute stand alone evidence of criminal activity, but they certainly help form the basis of establishing the need for in-depth investigation

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Physical Therapy Audits
What are they looking for?

- These red flags can point insurers, auditors and investigators to common fraud, waste and abuse schemes related to physical therapy services. Schemes such as:
  - Kickbacks
  - Upcoding
  - Double Billing
  - Billing for Services Not Rendered
- Since many of these can overlap, let's focus on just two
  - Kickbacks
  - Billing for Services Not Rendered

Kickbacks – Not Just a Glute Strengthening Exercise

- The federal Anti-Kickback Statute prohibits providers from knowingly and willingly receiving remuneration (payment) in exchange for patient referrals. This includes physical therapy services covered by:
  - Medicare
  - Medicaid
  - Tricare
  - VA
  - Other federal healthcare payers
- Kickbacks can take the form of:
  - Paying doctors for referrals; includes in-kind payments or providing discounts, vacations, extravagant entertainment, etc.

Kickbacks – Not Just a Glute Strengthening Exercise

- Kickbacks can take the form of:
  - Excessive discounts for referrals
  - Free services for referrals
  - Paying for marketing services, kickbacks to marketers/recruiters
- What auditors look for:
  - Unusually high referral volumes for one specific provider or provider group
  - Physical therapists offering special deals or discounts not available to other patients
  - Pressure on patients to schedule unnecessary treatments
  - Suspicious relationships between physical therapist and referring physicians

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Services Not Rendered – It Can Be More Than You Realize

- Services not rendered – the pinnacle violation of fraud, waste and abuse. Above all things – medical necessity concerns, overutilization findings, treatment outside of scope – this is the cardinal sin in healthcare billing. We can all agree that you cannot bill for a service that you did not perform. If a patient never got in the pool, you can't bill aquatic therapy. If the patient missed their appointment, you can't bill for what you would have done. We all agree these should be the no brainers, right? If you do these, you should expect to get caught. Yet, providers still do this every day across the country. Every insurance payer wants to identify and eliminate these types of fraud. It is one of the leading reasons why payers conduct claims audits.
  - Billing for something you simply did not do, is virtually indefensible.

Services Not Rendered – It Can Be More Than You Realize

- But what else falls under this category"
  - Billing for physical therapy services provided by aides
    - Direct, one-on-one skilled patient care
  - Billing for services provided by physical therapist assistants not properly supervised
  - Billing for excessive duration and frequency of services
  - Billing for a full treatment when only a portion was provided
  - Intentionally over-documenting treatment time to justify a higher billing code (upcoding)
    - Excessive treatment durations
    - Billing for group therapy as individual sessions
    - Billing for an hour long, one-on-one therapeutic session when session only lasted 30 minutes

Services Not Rendered – It Can Be More Than You Realize

- What auditors look for:
  - Providers submitting claims for therapeutic activities at a significant higher frequency than peers
  - Billing for services exceeding 24 hours a day (of course, depends on the size of the clinic)
    - Multiple days with more than 15 hours of billable hours, for one insurance plan
  - Lack of re-evaluations billed
  - High volume of treatment or a single patient within a short period of time
  - Significant discrepancies between treatment plan and patient progress
  - Cloned documentation

Services Not Rendered – It Can Be More Than You Realize

- What auditors look for:
  - Under documentation or lack of documentation
    - Poor or incomplete documentation is the major contributor to negative audit findings
    - Poor or incomplete documentation has strong evidentiary value in criminal/civil investigations
      - If you didn't write it down, it didn't happen
      - It's not enough to say all of my patients receive 1 hour of therapeutic exercise. You must document the actual time spent performing the service to justify the amount of time you bill. You can check 15 exercises, if you bill an hour, you better be able to account for that hour in your notes.

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So Why Am I Being Audited

- What triggers audits:
  - Data analysis/data mining
  - Patient Complaints
  - Former Employee Complaints
  - Peer Complaints
  - SIU/OIG Initiatives

Commonly Used Audit Techniques

- Data Analysis/Data Mining
  - Utilize billing software with advanced analytic capabilities to identify patterns and outliers in billing practices
    - Uses behavior patterns and algorithms to compare/contrast providers against their peers
    - Sophisticated data mining tools that can ferret out attempts to conceal wrongdoing, or it may just show an outlier. The purpose of the audit, or investigation, is to gather facts to explain the data findings.
  - Medical Record/Documentation Review
    - Medical records are reviewed to identify discrepancies in what was performed and what was billed.
    - Compliance with billing guidelines
    - Documentation standards justify services billed

Commonly Used Audit Techniques

- Interviews
  - Patient Interviews
  - Former employee interviews
  - Whistleblower complaints
- Referrals To Law Enforcement
  - FBI
  - HHS OIG
  - OPM OIG
  - VA OIG
  - DCIS
  - Louisiana State Police

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Potential Consequences of Audits

- Demand for payment reimbursement
  - Contractual remedies such as claims offsets are often utilized
  - Mediation
  - Civil litigation
- Civil Actions
  - Federal FCA actions often result in treble damages and extremely high fines, up to $11,000 per claim!
- Referrals To Law Enforcement
  - FBI - HHS OIG - OPM OIG - VA OIG - DCIS
  - Louisiana State Police – Louisiana Attorney General's Office
- Referrals to State Licensing Boards
- Administrative Sanctions
  - Suspension and debarment
    - Federal debarments are government wide, if debarred by Medicare, debarred for ALL federal payers

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No Slap on the Wrist

- False Claims Act:
  - Civil: Treble damages plus penalty of $13,946 to $27,894 per violation (claim)
  - Criminal: Felony, up to seven years incarceration per count
- Civil Monetary Penalties
  - $10,000 to $50,000 depending on violation
  - Program level/administrative prosecution, usually tried before ALJ at affected agency
- Anti-Kickback Statute
  - Felony, up to ten years incarceration per count
- Health Care Fraud
  - - Felony, up to ten years incarceration, per count
- Government Wide Debarment
- State Prosecutions and Sanctions
- Loss to reputation

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Real World Examples

- Miami physical therapist assistant convicted of over $2.6 million in fraudulent claims – June 2024

  Yesterday, a federal judge in Miami, sentenced Tania Cesar, a local physical therapist assistant (PTA), to 39 months in prison and three years of supervised release after a jury found her guilty of conspiracy to commit healthcare fraud and wire fraud, and five counts of healthcare fraud.

  According to evidence presented during a weeklong trial last February, over a two-year period at Elite Therapy Clinic, Cesar signed over 1,500 physical therapy notes for treatments and services that she never provided to patients. Several patients testified at trial, many of whom were paid cash in exchange for visiting Elite Therapy, that they did not recognize Cesar, despite their medical records reflecting months of treatment that Cesar purportedly provided. Elite Therapy coworkers testified that Cesar only visited Elite once or twice per week for a few hours to fill out fabricated progress notes. The fraudulent treatment notes led to over $2.6 million in claims billed to Blue Cross Blue Shield (BCBS) and other insurance companies. Trial testimony showed that the year before Cesar started committing fraud at Elite Therapy, Cesar fabricated patient therapy notes at Zion Medical Group Inc., a clinic whose owner was separately convicted for conspiracy to commit health care fraud and wire fraud. The sentencing record showed that the year before the Elite Therapy fraud, Cesar was fired from another medical clinic for billing for therapy that she never provided.

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Real World Examples

- Peak Physical Therapy Agreed to Pay $1.8 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Services by Unenrolled or Uncredentialed Providers and for Services Not Provided as Claimed

  After they self-disclosed conduct to OIG, Peak Physical Therapy P.C., Peak Physical Therapy Specialists, LLC, PPT Holdings, P.C., Peak Business Management, LLC, and Confluent Health, LLC (collectively, "PPT"), Idaho, agreed to pay $1,872,708.34 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that PPT submitted claims to Federal health care programs: (1) for services that were improperly claimed to have been furnished by a credentialed physical therapist when, in fact, another physical therapist actually rendered the services and the rendering physical therapist was not enrolled or credentialled with the applicable Federal health care programs at the time the services were provided; and (2) for physical therapy services by a physical therapist who was on medical leave on the dates when the physical therapy services were actually provided and/or supervised by different rendering physical therapists.

Real World Examples

- RehabAuthority LLC - $4M FCA settlement

  RehabAuthority, LLC, a physical therapy company with operations in Minnesota, has agreed to pay $4 million to resolve allegations that it submitted false claims for payment for outpatient physical therapy services in violation of the False Claims Act.

  The settlement resolves allegations that, from January 1, 2014, to December 31, 2018, RehabAuthority clinics submitted or caused to be submitted false claims for payment to the government for outpatient physical therapy. The clinics, located in Minnesota, North Dakota, Idaho, and Wyoming, improperly billed Medicare Part B, Minnesota Medicaid, TRICARE, and the Veterans Health Administration for one-on-one outpatient physical therapy, including therapeutic exercises, manual therapy, ultrasounds, therapeutic activities, and gait training. The resolution centered on allegations that the company billed the government for direct, one-one-one care with physical therapists, but did not provide it when it overbooked government beneficiaries for certain outpatient physical therapy services.

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Real World Examples

- **Hertel & Brown Physical & Aquatic Therapy, Its Two Founders Aaron Hertel and Michael Brown, and 18 Employees Indicted on Fraud Charges**

  According to Acting U.S. Attorney Stephen R. Kaufman, Hertel & Brown Physical and Aquatic Therapy main office in Erie, founders Aaron Hertel and Michael Brown, and 18 employees, have been indicted by a federal grand jury on charges of health care fraud and conspiracy to commit wire and health care fraud.

  Components of the alleged fraudulent activity include: allowing and requiring unlicensed technicians to provide treatment that was documented and billed as if performed by a licensed professional; recording and billing treatment times in excess of actual treatment times; failing to use group therapy codes "even when group billing codes were the only appropriate" codes; billing treatment time using the name and credentials of a physical therapist who was on vacation and not working on the day in question; allowing assistants and unlicensed personnel to treat patients with insurance that only reimbursed for treatment performed by a physical therapist and covering up who treated the patient; and changing the patient schedule, after the fact, in order to conceal that Medicare patients "did not have one on one treatment with a physical therapist as billed by the practice and required by Medicare."

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Questions

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