HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Nine
Number Eleven
November 2007
Published Monthly

Earn CEU credit

SEE INSERT

Meet

Juliann Tenney

Institutional Research Compliance and Privacy Officer and Director, Institutional Research Compliance Program for The University of North Carolina at Chapel Hill

PAGE 14

Quality of care initiatives: Malpractice and pay for performance

PAGE 4

Also:

CMS audit activity is fierce: Is your Medicare Advantage and Part D Program prepared?

PAGE 27

Feature Focus:

Risk Assessments and Compliance

PAGE 44

Therapy provided "incident To": Developing a framework for compliance by identifying risk

By Nancy J. Beckley, MS, MBA, CHC

Editor's note: Nancy Beckley is a health care administrator and rehab consultant in Brandon, Florida specializing in compliance programs for small providers. She can be reached at 888/999-0275 or by e-mail at nancy@bloomingdaleconsulting.com.

Do you provide physical or occupational therapy services incident to your practice? Are you considering adding these services? This article will provide your practice with a basic framework for understanding key elements of a voluntary compliance program with an emphasis on risk areas that have been identified by the OIG.

Background

The Office of the Inspector General of the Department of Health & Human Services (OIG) issued the final version of its "Compliance Program for Individual and Small Group Practices" (Guidance) in October of 2000. The Guidance stressed the voluntary nature of a compliance program, but also highlighted the benefits that such a program can confer on physician practices, not only to do the right thing, but also to streamline business operations.

Over the past 13 years, the OIG has been reviewing rehabilitation therapy, specifically physical therapy. The scope of their work has included therapy provided in rehab agencies, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs), and private practice, as well as therapy provided and billed as "incident to."

In more recent years, OIG has been studying therapy in physician offices and, as a direct result of these investigations, CMS revised the Medicare program requirements in 2005 to require that staff providing services "incident-to" must meet the same standards and conditions as qualified therapists, with the exception of licensure.

The OIG's annual Work Plans have continued to highlight therapy as an area of study and investigation. The 2007 Work Plan identifies three areas related to outpatient therapy:

1. **Physical and occupational therapy services**
   "…. review Medicare claims for therapy services provided by physical and occupational therapists to determine whether the services were reasonable and medically necessary, adequately documented, and certified by physician certification statements."
2. **Evaluation of "incident to" services**
   "…. evaluate the appropriateness of Medicare services performed "incident to" the professional services of physicians…determine the extent to which the services met Medicare standards for medical necessity, documentation, and quality of care."
3. **Potential duplicate physical therapy claims**
   "….assess whether CMS's systems are able to identify and prevent payment for potential duplicate claims for physical therapy submitted by providers." In May 2004, CMS issued a fraud alert regarding physical therapy suppliers who switch their submission of claims between Part A and Part B."

Table 1 illustrates examples of risks to consider

OIG Guidance recognizes that small providers may not have the resources to fully implement a compliance program with all seven standards elements, but sets forth a series of ranked steps based upon the seven components. The Guidance further offers suggestions which can be adapted to suit the needs of an individual practice.

Establishing a compliance program that includes therapy

Your practice may have a compliance program, but the standards and procedures that have been developed may be specific to the practice and may not differentiate enough between physical and occupational therapy services and physician services. Your practice may not have a fully operational compliance program, and as it is developing, you want to make sure that therapy services are appropriately addressed.

To begin developing a compliance program in your practice's therapy program, OIG suggests using the same seven elements identified in the Guidance as ordered steps:

1. Auditing and monitoring
2. Establishing practice standards and procedures
3. Designating a compliance officer/contact
4. Conducting appropriate training and education
5. Responding to detected offenses and developing corrective action initiatives

Continued on page 24

Table 1

Risk Area Identified	Specific Risk	Examples
Coding & Billing	Billing for items or services not rendered or provided as claimed	PT bills for individual therapy, but therapy was provided simultaneously with three other patients.
	Submitting claims for equipment, medical supplies, and/or services that are not reasonable and necessary	PT bills for services that are not warranted under the current documented plan of care for the patient's condition
	Double billing resulting in duplicate payment	OT bills for the same service twice – could actually be a clerical error.
	Billing for non-covered services as if covered	PT bills for Anodyne therapy which is not covered by Medicare.
	Knowing misuse of provider identification numbers, which results in improper billing	The service is provided by a PTA, and billed "incident to." A PTA can only be "incident to" a PT.
	Unbundling (billing for each component of the services instead of using all-inclusive codes)	A PT bills for the medications used in iontophoresis.
	Failure to properly use coding modifiers	The practice appends the KX modifier (for services beyond the therapy cap) for every patient that has a qualifying diagnosis, complexity, or condition.
	Clustering	A PT bills for 2 units of 97110 for every patient visit, regardless of actual time in therapy as required, figuring that it will all even out in the end.
	Upcoding the level of service provided	An OT uses the re-eval code every 30 days, when documentation or patient's condition does not warrant it.
Reasonable & Necessary Services	Provision of services that are not reasonable and/or necessary	Therapy records indicate that the patient has achieved all goals, but therapy continues for several more visits.
	Billing in order to receive a denial for services, but only if the denial is needed for reimbursement from the secondary payor	NOTE: The claim submission should indicate the reason for this type of billing.
Documentation (Note: the Guidance identifies these as examples of internal documentation guidelines.	The medical record is incomplete and/or illegible	The PT's handwriting is not legible, and all the documents, including evaluation, daily notes, and plan of care are not legible.
	The documentation of each patient encounter does not include the reason for the encounter; any relevant history; physical exam findings; prior diagnostic test results; assessment, clinical impression or diagnosis, plan of care and date and/or fails to identify of the observer.	The OT evaluates the patient and initiates patient treatment, but does not develop a plan of care that is certified by the referring physician.
	Not documenting the rationale for ordering diagnostic and other ancillary services so it can be easily inferred by an independent reviewer or third party who has appropriate medical training	The referring physician asks for additional tests and measurements prior to the patient's follow-up visit. The PT does not document the reason why the tests were ordered and the documentation does not support it.
	CPT© and ICD-9-CM codes used for claims submission are not supported by documentation and the medical record.	Daily encounter notes do not specify procedures and modalities and timed procedures were not tallied, along with total therapy time.
	Appropriate health risk factors are not identified. The patient's progress, his or her response to therapy, any changes in treatment, and any revision in diagnosis are not documented.	The progress note (every 10 visits) which compares current status to baseline, and records patient response to therapy is missing.
	CMS and local carriers are unable to determine the person who provided the service	The therapist fails to sign daily encounter notes with her name and professional designation: PT or OT.

 ...continued from page 20

Table 1 continued

Risk Area Identified	Specific Risk	Examples
Note: these three areas refer to the HCFA 1500 claim form	Failure to link the diagnosis code with the reason for the visit.	The PT used the medical diagnosis code, rather than a diagnosis code that supports therapy.
	Failure to use modifiers appropriately.	The OT bills for 97530 and 97150 (provided as distinct procedural services) and inappropriately appends modifier -59 according to the CCI edits.
	Failure to provide Medicare with all information about other insurance coverage under the MSP policy, if the practice is aware of beneficiary's additional coverage.	The billing manager determines that Medicare therapy reimbursement is better than the primary payer, so bills them as primary, rather than secondary.
Improper Inducements, Kickbacks & Self-referrals	Not having standards and procedures that encourage compliance with the Anti-kickback Statute (AKS) and the physician self-referral law (Stark Law).	One of the physicians in the practice refers patients for therapy to his son, who has opened an office down the street.
	Not having standards and procedures to avoid offering inappropriate inducements to patients.	The therapy office manager routinely waives coinsurance and deductible amounts without a good faith determination that the patient is in financial need.

6. Developing open lines of communication
7. Enforcing disciplinary standards through well-publicized guidelines

OIG has identified specific potential risk areas for individual and small physician practices. The remainder of this article will serve to identify and clarify those risk areas identified under Step #2 above. Table 1 includes risks to keep in mind as you develop and/or update therapy policies and procedures.

Stark and AKS consideration

The Stark Law prohibits a physician from making a referral to an entity with which the physician or any member of the physician's immediate family has a financial relationship, if the referral is for the furnishing of designated health services, unless the financial relationship fits into an exception set forth in the statute or implementing regulations.

The Anti-kickback Statute (AKS) provides criminal penalties for individuals and entities that knowingly offer, pay, solicit, or receive bribes or kickbacks or other remuneration in order to induce business reimbursable by federal health care programs.

Other risk areas include:

1. Financial arrangements with outside entities to whom the practice may refer federal health care program business.
2. Joint ventures with entities supplying goods or services to the practice or its patients.
3. Consulting contracts or medical directorships.
4. Office and equipment leases with entities to which the physician refers.
5. Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit from a physician's practice's referral of federal health care program business.

This is not an all inclusive list of the risks associated with providing therapy services "incident to," but rather a list of those risks that have been identified by the OIG specific to individual and small group physician practices. CMS has been "over-active" in the past 18 months in terms of updating and clarifying therapy practice standards under Medicare as well as therapy documentation requirements. For additional guidance on therapy requirements, particularly extensive revisions to documentation requirements effective this year, consult the Medicare Benefits Policy Manual, Chapter, 15, Section 220-230.

Conclusion

Understanding of the history of OIG regarding therapy services, and their interest in having small group and individual physicians implement voluntary compliance programs, will give you a good start on developing your compliance program policies and procedures with identified risk areas in mind. One of the identified goals, in the eyes of the OIG, is that a voluntary compliance program will provide a tool to strengthen the efforts of providers to prevent and reduce improper conduct, to streamline business operations, and ultimately, to improve the quality of care. ■

Note: OIG Compliance Program for Individual and Small Group Physician Practices was published in the Federal Register, Volume 65, No. 194, Thursday, October 5, 2005 (available at http://oig.hhs.gov/authorities/docs/physician.pdf).