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FEATURE

Addressing the 'Biggest Threat' To Physical Therapy

Outstanding compliance is the key to preventing payment cuts and reducing the regulatory burden on physical therapy. A multifaceted APTA initiative will meet the issue head-on - highlighting the profession's hard-earned reputation for excellence and outlining the work needed to honor and protect it.

By Eric Ries
February 2014

Against a backdrop of cuts in payment for physical therapist (PT) services and ever-increasing regulatory burden on the profession, APTA last year conducted a Payment and Practice Challenges Survey.¹

In April and May, 871 physical therapists (PT)-571 association members and 300 nonmembers from around the country and across practice settings-were asked to rate issues related to compliance and fraud and abuse. Respondents expressed the most concern about payment cuts and increased regulatory burden, and less concern about fraud and abuse and the Medicare audit process.

A wide-ranging APTA campaign that will be fully unveiled to the membership this fall contends, however, that all of those issues are related. The best and most effective path to increased payment and less red tape is for PTs to meticulously document what they do and why they're doing it. This will reassure government and private payers that dollars for PT services is money well spent. That confidence, in turn, will mean less regulation, fewer audits and denied claims, and better payment. In the offing, the profession's reputation-which has taken a hit in recent years-again will be based on excellence in care provision.



The APTA initiative kicks off this month with a continuing education course titled "[Navigating the Regulatory Environment: Ensuring Compliance While Promoting Professional Integrity](#)." The module, free to association members and nonmembers (see "Resources" on page 40), is the first ripple in a wave of materials, activities, and collaborations to be initially shared with the APTA Leadership in June at the association's NEXT conference and exposition in Charlotte, North Carolina. The campaign seeks to "show APTA as a leader and partner in the effort to eliminate fraud, abuse, and waste from health care and strengthen the good reputation of physical therapy in the health care system," per the message delivered last fall to the association's State Policy and Payment Forum by Felicity Clancy, APTA's vice president for communications and marketing, and Justin Moore, PT, DPT, the association's vice president for public policy, practice, and professional affairs.

Aiming both inward and outward-at PTs, physical therapist assistants (PTA), and PT and PTA students, as well as at lawmakers and the public-the "multi-pronged approach," as the campaign is described in a white paper and other materials being readied for presentation to Congress, the Centers for Medicare and Medicaid Services (CMS), and third-party payers, aims to curb abuse and improve quality of care by "raising awareness through education and training of physical therapists, payers, and consumers; partnering with other organizations to provide education; establishment of clinical practice guidelines; development of assessment tools; and establishment of a registry for collection of quality and outcomes data."

Put another way, the initiative recognizes that if the profession of physical therapy is to achieve its vision of "Transforming society by optimizing movement to improve the human experience,"² it literally and figuratively cannot afford for compliance concerns to damage its hard-earned reputation for clinical excellence and patient-centeredness.

Count Steve Levine, PT, DPT, MSHA, among those unsurprised by the results of the Payment and Practice Challenge Survey-and on board with the corresponding need for APTA's initiative.

"A big reason that many PTs and PTAs don't see fraud and abuse as a particularly significant issue in our profession is that they likely don't fully understand what it is," says Levine, a partner in the national consulting firm Fearon & Levine, which focuses on practice management and payment policy in the outpatient rehabilitation setting. "A lot of people in our profession think of fraud and abuse as what happens when people deliberately seek to rip off the health care system. But, in fact," he says, "plenty of good therapists don't realize that they're inadvertently guilty of abuse and waste when they make billing, coding, and documentation errors that might easily have been prevented."

Levine, a frequent presenter on fraud and abuse issues and a former member of the APTA Board of Directors, wants all PTs and PTAs to recognize that "the definition of abuse is that you knowingly or unknowingly get paid more than you should, based on lack of adherence to professional guidelines and documentation requirements. When you document incorrectly or insufficiently," he emphasizes, "when you bill Medicare for services the program deems 'not medically necessary,' when you code incorrectly, all of that is part of fraud, abuse, and waste."

Massachusetts-based consultant Bruce Levine, PT, MS, echoes that concern.

"Somebody once asked me in an interview," he says "'What do you believe is the biggest threat to physical therapy?'" Levine, whose bread and butter is medical record review for private insurers, thought about the subpar documentation he often sees in his work and told the interviewer, "The biggest threat to physical therapy, I really do think sometimes, is physical therapists."

Prepare to Be Audited

Consider the monetary impact. Losses to the American health care system due to fraud, waste, and abuse are estimated at \$765 billion annually, with \$210 billion of that total attributed to unnecessary services, \$190 billion to excessive administrative costs, \$130 billion to inefficiently delivered services, \$105 billion to excessive prices, \$75 billion to fraud, and \$55 billion to missed prevention opportunities.³

The Affordable Care Act includes "powerful steps toward combating health care fraud, waste, and abuse," touts the website StopMedicareFraud.gov. Those include enhanced screening, predictive modeling technology to "target resources [toward] highly suspect behaviors," and \$350 million over 10 years to boost anti-fraud efforts.

What that means to PTs is a greater chance of being audited.

Yes, the profession's reputation has taken a hit in recent years from headline-grabbing cases such as the alleged fraud perpetrated by Florida osteopath Christopher Gregory Wayne, who is charged with having received more than \$2.6 million from Medicare between 2007 and 2009, according to the Wall Street Journal, much of it in physical therapy claims that the US Attorney's office deems false. But ask Steve Levine why Medicare has put particular emphasis on physical therapy in its efforts to root out fraud and abuse and recover ill-spent taxpayer dollars, and he doesn't reference the flamboyant, spike-haired Wayne (aka the "Rock Doc"), the Russian Mafia and its front operations, or any of the other non-PT fraudsters and alleged scammers whose purported get-rich-quick commodifications of physical therapy services have given physical therapy a black eye. Rather, he puts the onus squarely on his colleagues.

"Why is there so much focus on physical therapy in Medicare's program integrity efforts? Because," he says, "PTs, frankly, can be easy pickings. Because a lot of therapists haven't developed skills in documentation. Because some therapists don't know the basic rules of engagement-the billing requirements outlined in the Medicare benefit policy, claims processing, and program integrity manuals-and may not know they're making problematic errors. "

Levine gets that PTs see themselves first and foremost as caregivers whose priority is optimal outcomes for their patients and clients. He understands that his colleagues "would rather use their continuing education dollars to learn a new mobilization technique for the shoulder or a therapeutic exercise than to take a documentation course, or a module about fraud and abuse in physical therapy." But the result, he says, is that many PTs do not have the knowledge to ensure compliance with all the rules and regulations.

Hence the can't-miss-it, multi-stakeholder initiative that is set to kick off in earnest this fall-of which the "Navigating the Regulatory Environment" course and this article are initial pieces.

While altering a mindset and changing ingrained behaviors is a formidable challenge, the effort is vital and the consequences immense, says Ellen Strunk, PT, MS, GCS, CEEAA. A self-described longtime "champion of moving discussions about fraud and abuse into the open," she owns Rehab Resources and Consulting Inc in Birmingham, Alabama, which provides consulting services and training to providers in skilled nursing and inpatient rehabilitation facilities, as well as in home health.

Strunk is one of 4 presenters whose voices are heard in "Navigating the Regulatory Environment." (The others are the medical director of CMS's Center for Program Integrity, an auditor for a Medicare Zone Program Integrity Contractor who also is a PT, and an attorney specializing in health care law who describes federal anti-fraud statutes and lists the key elements of strong compliance plans. A second, interactive segment of the module seeks listener feedback on case scenarios related to fraud, abuse, and waste issues.)

The first PowerPoint slide in Strunk's part of the module lists what she deems the "top compliance issues in physical therapy": services not medically necessary, services not provided or documented, unbundling or upcoding, time documentation inconsistent with service billed, inappropriate use of personnel, provider identification numbers misused, care below accepted standards, and waving of co-pays or deductibles. After describing each issue in detail, she advises, "Remember that regardless of who does the billing, PTs and PTAs have a responsibility to make sure what they are documenting is accurate." Keeping current with the latest compliance directives is a "professional obligation," she tells listeners-offering the example of mandatory functional limitation reporting under Medicare Part B, which took effect last year.

"Hopefully your place of employment provided you with lots of information to prepare you," Strunk says in "Navigating the Regulatory Environment," "but even if they didn't, you have an obligation to learn about it, because it is now a required part of physical therapy billing."

Ultimately, Strunk hopes the module and APTA's broader initiative on the importance of meticulous documentation will cause PTs and PTAs to realize, "I am a change agent. What I do matters. Fraud, waste, and abuse aren't my company's or my manager's fault. This is on me. I need to be responsible. I need to be present. I need to be interested in knowing exactly what I'm signing off on, what the elements of my company's compliance plan are, and whether I'm following them."

The Power of Presence

"Passivity" is a word that comes up in conversations with Strunk and Bruce Levine, referencing the Medicare and private-pay worlds, respectively.

"I've seen it at times in the post-acute care setting," says Strunk. "Some PTs and PTAs seem content simply to follow instruction and not question things that don't seem right," she says. "But if you think of physical therapy as a job-as opposed to a dynamic profession that's peopled by autonomous, independent thinkers-that may be reflected in problematic documentation and billing practices. Cumulatively, that can affect the way payers see PTs, with negative implications for reimbursement of physical therapist services."

Levine, a self-employed consultant and clinician based in North Attleboro, Massachusetts, works primarily with carriers of automotive insurance-an arena that has proven ripe for fraud and abuse because providers typically pay 100% of liability claims. "I do a lot of education with carriers on questionable billing practices related to physical therapy services," he says. Levine emphasizes that the vast majority of PTs are honest, and he notes that where there truly are "bad actors," often they are non-PTs caught billing unnecessary or even nonexistent physical therapy services.

But that's not to say he lets his colleagues off the hook.

"What I went on to say to that interviewer," Levine recounts, "is that we have therapists out there who just follow orders. I wrote an article once that I titled 'The Doctor Said It Was Okay.' Well, I just as easily could've substituted for 'doctor' the word 'supervisor,' 'administrator,' or 'director of physical therapy.' When PTs are content simply to follow, the door opens to potential fraud, abuse, and waste, because they might pay insufficient attention to unacceptable things happening right under their noses."

That's why "raising awareness through education and training" is listed first among 5 proactive steps detailed in APTA's white paper. The association is developing new in-service continuing education training and online courses directed not only toward identifying fraud and abuse, but also on such related subjects as proper coding and compliance, reducing hospital readmissions, and documentation of skilled therapy. (APTA is considering ways to recognize PTs and PTAs who have completed requisite coursework. Details will be forthcoming.)

Other steps listed in the white paper to address fraud, abuse, and waste are partnering with other organizations (PT education programs, state licensing boards, associations representing various practice settings and relevant provider chains, government agencies and private payers), facilitating the development and use of evidence-based practice guidelines in each of APTA's specialty sections, promoting the use of decision-support tools and knowledge-management systems such as the PTNow online portal and a registry of patient outcomes data to ensure that patient-care decisions are informed by best evidence, and developing an assessment tool to measure quality.

Extending the theme of partnership, the APTA white paper will ask Congress and CMS to do their parts to strike a "proper

balance" between efforts to detect fraud, abuse, and improper payments and the imposition of unnecessary administrative burdens on providers. And it will offer lawmakers and Medicare officials specific recommendations related to the audit process, predictive modeling, contractor oversight, physician self-referral rules, physician-owned physical therapy practices, Medicare payment models in the post-acute care setting, and provider-enrollment regulations.

The Payoff

The Physical Therapy Classification and Payment System (PTCPS), while not directly related to APTA's broad-ranging initiative to curb fraud, abuse, and waste in physical therapy, is in alignment with the campaign's goals of improving quality of care, recognizing and promoting the clinical judgment of the PT, and ensuring the integrity of medically necessary services.

The PTCPS proposes to reform payment for outpatient physical PT services by shifting from the current fee-for-service, procedure-based payment system to a per-session payment system based on the severity of the patient's condition and the intensity of care provided. Currently being fine-tuned by the constituent groups that bill the 97000 (physical medicine and rehabilitation) CPT code set, it is on a track to take effect no later than January 1, 2016.

Steve Levine chaired the Alternative Payment System Task Force that oversaw development of the PTCPS when he was an APTA board member. While he concedes that it's not a panacea, he is enthusiastic about the new system's potential to meaningfully address the problems inherent in the existing system, which incentivizes overutilization by linking payment to the number of units of services provided rather than to the value of those services.

"I think it's going to help dramatically," Levine says. "I believe that issues related to fraud and abuse are going to be significantly lessened under this kind of system."

The combined effects on fraud, abuse, and waste of the PTCPS and of APTA's multi-pronged initiative remain to be seen and will be years in the revealing. But Ellen Strunk has seen the "light bulbs click" when the post-acute care PTs she counsels internalize that they must be accountable and are key to the solution. Multiply those light bulbs thousands-fold and the future brightens, she believes, for a profession that's been feeling beaten down by continued payment cuts and ever-more-burdensome regulations.

"I'm very passionate about this," Strunk says. "Like I said, each one of us-every single PT and every single PTA-is a change factor."

"The better we get at compliance," Steve Levine concludes, "the better off our profession is going to be."

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References

1. American Physical Therapy Association/Fleishman Hillard. Payment and Practice Challenges Survey. June 10, 2013.
2. American Physical Therapy Association. Vision Statement for the Physical Therapy Profession. <http://www.apta.org/Vision/>. Accessed November 1, 2013.
3. Institute of Medicine. Best Care At Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: National Academies Press; 2012.

Fraud and Abuse Defined

From the US Department of Health and Human Services:

"In general, fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts.

"Fraud schemes range from solo to broad-based operations by an institution or group. Examples of Medicare fraud may include:

- Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicare for appointments that the patient failed to keep; and
- Knowingly altering claims forms and/or receipts to receive a higher payment amount.

"Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

"Examples of Medicare abuse may include:

- Misusing codes on a claim,
- Charging excessively for services or supplies, and
- Billing for services that were not medically necessary.

"Both fraud and abuse can expose providers to criminal and civil liability."

Source: US Department of Health and Human Services Centers for Medicare and Medicaid Services. Medicare Fraud & Abuse: Detection, Prevention, and Reporting. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf. Accessed November 19, 2013.

Taking a Stand By Standing Up

"A Medicare Audit: All the Way to the ALJs-an Empowering Experience."

That's what Todd Mason, PT, DPT, titled his presentation last November at the APTA Private Practice Section's annual conference. He'd chosen those words carefully, to accentuate the gains ("empowering") while hinting at the process's length and vicissitudes ("all the way").

During an hour-long interview with PT in Motion, Mason traced the winding, frustrating, but ultimately affirming path that began with a smart business decision and concluded only after nearly 3 years of letters, phone calls, paperwork, and rungs up the review-process ladder.

Here's the short version.

It all started in 2001, when Mason and his business partner opened Total Fitness Connection/TFC Physical Therapy in Bowling Green, Kentucky. They wanted to meet a community need and fill an entrepreneurial niche by making aquatic therapy a major focus. This attracted patients and clients, but it also caught the attention of Medicare, which saw the large number of aquatics-related billings as an outlier among area practices-an alert to possible fraud and abuse.

On what Mason later would call an "infamous" day in July 2006, he received a letter from the Medicare Administrative Contractor (MAC) for Kentucky's region, requesting records for 10 patients for dates from June to November 2005.

"No problem," he thought.

Big problem, came the implicit reply from the medical review administrator with whom he'd corresponded. Mason was informed that Medicare had overpaid him \$4,350 for those 10 patients' care, that his practice's error rate in those instances was 90%, and that, by the way, the review now was being expanded. The MAC would be needing records on more than 300 Total Fitness Connection patients.

"It threw me into a tailspin," Mason says. "You think to yourself, 'What just happened?'"

And you start asking questions. The astronomical error rate, he would find, was based on noncompliance with a local coverage determination that Mason, who monitored LCDs closely, felt certain didn't exist. It turned out he was right. Then, however, the stated reason for claims denial shifted to lack of documentation of medical necessity. He was sure that wasn't right, either.

His visceral response was to fight, rather than "give up and let them have the money." Payment staff at APTA encouraged him to do so-for his sake and that of a profession increasingly scrutinized by the government for possible fraud and abuse.

Over the course of a process that would continue through 2007 and 2008, then on into 2009-across the appeals levels of redetermination, reconsideration, and, finally, a hearing before an administrative law judge (ALJ)-Mason stuck to his belief in himself, his practice, and the mail-delivery system, through which 2 big boxes of paperwork made the rounds.

That last stop, the hearing before the ALJ, was a 7-hour telephone conference in February 2009. For the first time in the appeals process, Mason and an investigatory official concurrently reviewed the same documents.

"I was able to sit there that day and go, 'Judge, here's what they're claiming, but here's what it actually looks like,'" Mason notes. "And he'd look at the documents and say, 'I see your point. We're good to go. Next?'" At long last in a sporadic and bureaucratic process, he felt heard. The hearing was the bright light, Mason says, that made worthwhile his years-long journey through a dark tunnel of suspicion.

April 8, 2009, was what he calls "the day of glory." That was when Mason received a "wholly favorable" decision on his case. He concedes that the audit process was an ordeal, during which he lost sleep, leaned on his religious faith, and nearly was done in when he allegedly missed a filing deadline for redetermination of his case. It was only after he produced paperwork displaying the name of the person who had signed for the document that it was discovered in another room at the audit destination.

Which brings up the second message-after the primary one of empowerment-that Mason hopes his fellow private practitioners carried home with them from his November presentation: "Don't lose on a careless error." In the end, Total Fitness Connection recouped "about 98%," Mason says, of the approximately \$26,000 Medicare took out of the practice's billings over the course of the expanded records review. But the fact that he had to pay that other 2% still eats at him. One denied claim was for narrowly missing the deadline to submit a progress note to a physician. In another instance, the practice had billed but failed to document a single unit of therapy under Medicare's timed "rule of 8."

So, about that overarching message: Surely the outcome of Mason's case was economically and morally gratifying. But how, exactly, was it "empowering"?

"We've hired therapists at this practice who tell us that our policies for documenting Medicare claims are so different from those of the big companies they worked for," Mason explains, "and that their employers' philosophy on challenged claims often was, 'Just let them have the money.' But what that tells Medicare contractors is, 'This is easy. Just scare 'em a little bit, they'll pay the money, and we'll move on to the next guy.'"

"What happens then," Mason says, "is that our profession's standing takes another hit-and more rules and regulations result from aggregate numbers suggesting fraud and abuse is a problem in physical therapy."

What's empowering to Mason about his audit experience is that it illustrates what a PT can accomplish when he or she stands up to the array of officials involved in the audit process-few if any of whom tend to be PTs themselves-and has the necessary documentation to prove, "I know what I'm doing. I provide needed services. I'm worth every penny-and more-of the government's money. I represent an awesome profession."

His case, Mason says, wasn't ultimately about \$26,000. It was about the reputation of physical therapy. "That's everything," he holds. "That is the cost."

Resources

Government

CMS MAC Contract Status Page

www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACContractStatus.html

The site features links to fact sheets on and websites of Medicare Administrative Contractors.

CMS "Spotlight" Sites

www.cms.gov/Medicare/Medicare.html

Scroll down to "Provider Types" for the latest news and directives related to home health, hospitals, skilled nursing

facilities, and other settings.

Medicare Benefit Policy, Claims Processing, and Program Integrity Manuals

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

Office of Inspector General Compliance Guidance

<https://oig.hhs.gov/compliance/compliance-guidance/index.asp>

A compilation of documents directed at various segments of the health care industry-including hospitals and home health agencies-to encourage development and use of internal controls.

Stop Medicare Fraud Website

www.stopmedicarefraud.gov/

The site includes information for providers on compliance training.

APTA

Coding & Billing Page

www.apta.org/Payment/CodingBilling/

The site includes links to course information, podcasts, frequently asked questions, and more.

Compliance Page

www.apta.org/Compliance

The site features information on fraud and abuse, Medicare audits, physician self-referral, and more.

Core Documents Page

www.apta.org/Policies/CoreDocuments/

The site features links to the Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Professional Conduct, Guide for Conduct of the Physical Therapist Assistant, and Professionalism in Physical Therapy: Core Values. Each document sheds light on responsibility to prevent fraud, abuse, and waste.

Defensible Documentation for Patient/Client Management Page

www.apta.org/Documentation/DefensibleDocumentation/

The site features a variety of downloadable documents, covering everything from elements and checklist samples to current concerns in physical therapy documentation and case scenarios.

Learning Center

<http://learningcenter.apta.org/>

This is the site for information about all APTA audio courses (including "Navigating the Regulatory Environment"), seminars and conferences, and webinars.

Physical Therapy Classification and Payment System Page

www.apta.org/PTCPS/

The site for information about a payment-reform plan for outpatient physical therapy services.

PT in Motion Articles

www.apta.org/PTinMotion/

["Fighting Fraud and Abuse in Physical Therapy"](#)

(June 2012)

["Medicare Prepayment Review"](#)

(June 2013)

["Determining Medical Necessity Under Medicare"](#)

(November 2012)

["Medicare Audits: Reducing Risk"](#)

(February 2012)

Strategic Plan

www.apta.org/StrategicPlan/Plan/

The document the specific objectives for goals related to effectiveness of care, patient- and client-centered care across the lifespan, professional growth and development, and value and accountability.

Part of the Plan

APTA's initiative to eliminate fraud, abuse, and waste in physical therapy is a manifestation of the association's strategic plan. The campaign directly addresses 3 key objectives of the plan's goal of "Value and Accountability," which states: "APTA will be the recognized leader in setting the standards for physical therapy service delivery and establishing and promoting the value of physical therapist practice to all stakeholders."

Among the goal's objectives are directives to:

- Advocate for appropriate administrative, legislative, and regulatory policies that demonstrate value, ensure safe and effective delivery, enhance access, and protect the integrity of the health care system.
- Improve compliance with regulations, laws, and professional standards.
- Advance payment systems that recognize the severity of patient condition and the intensity of interventions required; reflect the clinical reasoning, judgment, and decision-making of the physical therapist; and appropriately pay for the value of the services.

PT in Motion, APTA's official member magazine, is the successor to *PT—Magazine of Physical Therapy*, which published 1993-2009. All links within articles reflect the URLs at the time of publication and may have expired.

Comments

OI am convinced that "fraud" is not the driving force behind these audits and in order to "pass" these audits is is ENTIRELY dependent on crossing your "t's" and dotting your "l's": it has ABSOLUTELY NOTHING to do with quality! Simply put, Medicare has hired these pre-payment auditors to find the fastest and cheapest method to deny claims on minor technicalities just to save money because they do not have the resources to pay for all the demands out there. They don't even read and consider the quality of the care provided or the amount of \$ saved by a practice demonstrating excellent and efficient care: they simply deny on the technicality, thus saving time and energy required to look at the actual care provided. You have to be a documenting wizard to meet the criteria. Why not look at the care first, then "correct" the documentation errors?

Posted by Sherrie Odom -> >IR^? on 2/1/2014 4:21:47 PM

I had once evaluated a patient who was having a lot of falls and my documentation revolved around berg balance scale/scores, the patient had med B as her insurance. medicare denied the claim and said patient did not need gait training or any skilled PT services. I didn't even bill for gait training. my progress notes were based on patient's berg balance scores. I felt that they didn't even read my evaluation.

Posted by Ashwini Mahajani -> BJU_EO on 2/16/2014 6:42:00 PM

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