Physical therapists are an important part of the health care system, providing medically necessary high-quality care to patients. At the same time, PTs and PTAs play an important role in protecting the integrity of the health care programs so patients can continue to receive the high-quality services they need. It is important that PTs, PTAs, and students of physical therapy are knowledgeable about fraud and abuse laws to help prevent any potential fraud and abuse.

While the vast majority of health care providers are ethical and honest, and provide high-quality care, fraud and abuse laws are very broad and can have an impact on most providers.
APTA has developed a booklet titled “Preventing Fraud, Abuse, and Waste: A Primer for Physical Therapists” to help you learn about fraud and abuse laws and avoid potential risk areas.

In addition to reading the primer booklet, I encourage you to explore the resources referenced in it to obtain additional information on these topics.
During today’s presentation, I will:

1) Provide some background on the health care fraud problem
2) Explain the distinction between fraud, abuse, and waste
3) Describe fraud and abuse laws
4) Discuss risk areas involving physical therapist relationships with payers, referral sources, and patients
5) Emphasize the importance of professionalism and ethics
6) Explain the best ways to minimize risk of fraud and abuse through compliance programs as well as how to take action if you have witnessed fraud, abuse, and waste
Health care fraud, abuse, and waste is a serious problem. The National Academy of Medicine has reported that approximately $765 billion per year has been lost due to fraud, abuse, and waste. Of that amount, approximately $75 billion is due to fraud.

Fraud, abuse, and waste is a major concern because it results in overutilization of services and increased costs for payers, corrupts medical decision-making, and can lead to unfair competition in the marketplace. It puts patients’ health and welfare at risk by potentially exposing them to unnecessary services and ultimately taking money away from necessary care.
Increasingly the government has invested more resources to fight fraud, abuse, and waste. The government has found that for every $1.00 spent on fighting fraud, abuse, and waste, $8.10 is returned.

In 2013 alone, the federal government recovered $4.3 billion and was able to return that money to the Medicare Trust Fund to pay for legitimate care.
Fraud involves obtaining something of value for which you are not entitled through intentional deception or misrepresentation of material facts. Examples of fraud include, but are not limited to:

- Knowingly billing for services that were never furnished
- Knowingly altering claims forms to receive more payment
- Falsifying documentation to receive payment for which you are not entitled
Abuse involves payment for items or services for which there is no entitlement. In contrast to fraud, abuse involves instances in which the provider has not intentionally misrepresented facts to obtain payment.

Examples of abuse include:

• Billing services that are not medically necessary
• Billing for services that do not meet professional standards of practice
• Unbundling services and billing for them; for example billing separately for electrodes, which are considered part of the payment for electrical stimulation
Waste involves incurring unnecessary costs due to deficient management practices, systems, or controls.

Examples include:
- Duplication of tests and services that were already provided elsewhere
- Spending on services that lack evidence of producing better outcomes compared with less-expensive alternatives
- Ordering unnecessary tests to guard against liability
- Failures of care coordination that result in hospital readmissions or complications
As I mentioned earlier, physical therapists and other providers play an important role in providing services and protecting the integrity of health care programs. To be partners in preventing health care fraud and abuse, it is important for you to understand fraud and abuse laws.

There are a number of fraud and abuse laws. The 5 that are most relevant to physical therapists include:

1. False Claims Act
2. Federal Anti-Kickback Statute
3. Physician Self-Referral Law
4. Exclusion Authorities
5. Civil Monetary Penalty Law
Under the False Claims Act, it is illegal to submit false claims or use a false record to obtain payment from the Medicare or Medicaid programs. The penalties for violation of this law are significant—they can as high as $22,000 per claim, plus 3 times the damages sustained by the government. The government may also exclude providers from future participation in any federal payment program.

The total dollar amount in health care cases can be significant (millions of dollars) because the penalties apply to each health care claim submitted. Most providers submit numerous claims for payment.
It is important to understand what the term “knowing” means under the False Claims Act. Knowing includes actual knowledge. In addition, it also includes deliberate ignorance and reckless disregard. An example of “deliberate ignorance” would be a provider who receives bulletins and information describing new policies regarding coverage and payment, but does not bother to read them.

An example of reckless disregard would be a provider who hires a staff person to do the practice’s coding and billing even though the provider knows the staff person is incompetent and as a result submits inaccurate claims for payment.
Under the False Claims Act, there is a strong incentive for whistleblowers to report fraud that they have witnessed to the government, since they can receive up to 30% of the recovery. There have been cases in which whistleblowers received millions of dollars. A whistleblower could include an ex-business partner, staff, competitor, or patient.
In one actual fraud case, an employee of a physical therapy service signed his name on patient medical records, such as progress reports and daily notes, as the provider of the therapy services. However, he was not licensed, trained, or in any way qualified to provide physical therapy to patients. This individual was sentenced to 9 years in prison and ordered to pay more than $26 million for health care fraud.
Another actual case provides some good information regarding how the penalties are applied under the False Claims Act. In this case, titled US v Mackby, the defendant (Mackby) billed physical therapist services using his father’s (a physician) provider number. However, his father did not provide the services and, in fact, was located in another state. The government determined that the damages were $58,151.64 and multiplied this number by 3 to get triple damages. They based their review on 111 claims that were filed. For each claim, they imposed a penalty of $5,000, resulting in a total amount of $555,000. When added to the triple damages, the total amount owed was $729,454.92.
The government is very concerned with payment of kickbacks since they can distort medical decision making, increase costs, and result in unfair competition against other providers. In addition, they can distort decision making by encouraging physicians and other health care professionals to order services or recommend supplies based on profit rather than patient need.

Asking for or receiving any form of payment (referred to as remuneration) in exchange for referrals of Medicare and Medicaid patients would be considered a crime under the Anti-Kickback Statute. This law applies to both the payers and the recipients of the payment. It is important to be aware that payment can include anything of value. For example, it could be an obvious kickback, such as cash in exchange for referrals, or a more subtle kickback, like free rent for a practice or season tickets to baseball.

There are safe harbors established by the government that protect certain arrangements that do not pose a harm. An arrangement must satisfy all the requirements of the safe harbor to be legal.

Penalties under the Anti-Kickback Statute include prison sentences, fines, and penalties up to $50,000 per kickback and 3 times the amount of the remuneration.
Examples of kickbacks include a physical therapist giving a physician who sends him referrals free or steeply discounted office space, a durable medical equipment (DME) company paying cash in exchange for referral of its DME items to patients; and discounts or waivers of copayments and deductibles. There are certain exceptions to the waiver of copayments and deductibles that I will talk about later in this presentation.
In a case in Brooklyn, NY, defendants who were not physical therapists operated what they called a physical therapy clinic. They recruited Medicare patients to go to the clinic by offering to pay them $50 per visit. They then billed Medicare for physical therapy services when no services were ever provided. They collected millions of dollars from this fraudulent billing scheme, which the government later recovered.
The physician self-referral law (or Stark law) prohibits physicians from referring Medicare and Medicaid patients for certain designated health services to entities in which that physician has a financial relationship, unless an exception applies. “Designated health services” include hospital services, physical therapy services, and home health services. A financial relationship can include either an ownership interest in the entity receiving the referral or some form of compensation.
To determine if there is a violation of Stark, you need to ask the following questions:

1. Is there a referral by a physician for physical therapy services payable by Medicare?
2. If so, does that physician have a financial relationship with the practice furnishing the physical therapy services? A financial relationship is when the physician has an ownership interest in that practice or is compensated by that practice for providing services.

If the answer to the first 2 questions is “yes,” there could be a violation of Stark II laws unless the financial relationship fits into an exception. For example, there is an exception if the practice receiving the referrals is located in a rural area. There is also an exception referred to as the “in-office ancillary services” exception that enables ownership as long as the practice is structured in a manner that satisfied certain criteria. Under the Stark law, the physician is subject to monetary penalties and possible exclusion from participation in federal health care programs. The entity submitting the improper claims would be required to repay all the amounts received.
The government has the authority to exclude providers from participation in federal health care programs, such as Medicare and Medicaid. Excluded providers may not bill for treating patients, and their employers may not bill for their services.
In most cases, third-party payers, such as Medicare, Medicaid, worker’s compensation, and commercial insurers, cover the cost of your patient’s medical bills. It is important for you to be familiar with the coverage and payment policies for these different payers.

Payers will be focused on making sure that your claims are submitted with accurate coding and billing, that documentation supports the medical necessity of the services provided, and that legitimate, qualified providers are enrolled in their health care programs.
With regard to coding, payers will rely on you as a physical therapist to submit claims for payment with accurate information. When claims are submitted for Medicare and Medicaid beneficiaries, the 5 federal fraud and abuse laws apply.

For private payers, many states have similar laws that apply.

When you submit a claim for services, you are attesting that you have earned the payment requested and that you are in compliance with the coding and billing requirements.
Examples of improper coding and billing:

- Billing for services not provided
- Billing for services that are not medically necessary
- Billing for services provided by aides
- Billing for services provided by PTAs not properly supervised

Examples of claims that would be considered improper are:

- Billing for services that you did not provide
- Billing for services that are not medically necessary
- Billing for services under Medicare that are provided by aides
- Billing for services that are provided by physical therapist assistants who are not properly supervised
- Billing for excessive duration and frequency of services
- Billing for direct 1-on-1 services when they were provided to multiple patients at the same time and there is no direct 1-on-1 contact
- Billing for the incorrect level of evaluation
In 1 actual case brought by the government, a physical therapist billed for treatments that lasted 30-60 minutes, when she spent only 10-20 minutes with patients. In another case, a skilled nursing facility engaged in a scheme to place Medicare patients in the “ultra high” rehabilitation utilization group (RUG), which pays a higher amount. Therapists in the facility were pressured to provide services to patients that were not necessary. RUGs are determined, in part, based on the number of minutes of therapy provided to patients in the SNF.
While safety and quality of care is paramount when working with your patients, documentation throughout the episode of care is a professional responsibility and legal requirement. Payers require physical therapists and other providers to support the claims that they submit through complete documentation of the care provided. Often, payers will perform audits and reviews of medical records to verify that the claims submitted are for services that should be covered.
While physical therapists may find documentation to be onerous, appropriate documentation of level of evaluation and services is crucial for several reasons.

It serves as a record of patient care and is a good means of communication among providers. If the physical therapist who usually treats the patient is absent for a day of treatment, it enables another physical therapist to have information about the patient’s care available so that he or she can treat the patient.

Documentation also shows compliance with federal, state, payer, and local regulations and can demonstrate appropriate utilization and reimbursement of services when reviewed by the payer.

Documentation should be done at the point of care or soon afterward. Late entries, addendums, and corrections to the medical record are legitimate occurrences. However, if a late entry is made, it should bear the current date of that entry and be signed by the person making the entry.
Medicare has identified common problems with physical therapist documentation. These include:

1) Missing or incomplete plan of care
2) Missing provider signatures and dates on the plan of care
3) Missing total time for procedures and modalities in the documentation
4) Missing certification and recertification of the plan of care by the provider

While you may feel strongly that the care provided to the patient was medically necessary, if this information is missing from the documentation, the Medicare program will identify these claims as improper payments.

If you are not sure of documentation requirements for a particular payer, you should check with that payer or documentation experts to find out more information. “Preventing Fraud, Abuse, and Waste: A Primer for Physical Therapists” also includes a list of resources for you to find out more information about proper documentation.
A recent case demonstrates the risk involved in failure to document for services and altering patient records. A physical therapist in private practice was notified by a Medicare contractor that they would be auditing his practice. The physical therapist instructed his employees to delay the audit by telling the contractor that medical records were stored at a nonexistent storage facility. In fact, there were no records.

The employees used the extra time to alter and augment the patient records by creating notes for the patients that did not exist for the services provided. They pretended as if these notes were created at the time of the service to the patient, but in actuality that was not the case.

The physical therapist was charged with fraud violations under the false claims act for falsifying documentation. The physical therapist would have been in a better position with the government if he had admitted that the records did not exist instead of creating false records.
The government views enrollment in the Medicare and Medicaid program as an important mechanism to ensure that qualified providers are furnishing services to the beneficiaries in these programs. Through the enrollment process they are able to screen providers and ensure that they meet certain requirements related to licensure, practice setting, and other areas.

Physical therapists in private practice should enroll individually in the Medicare and Medicaid programs. They are required to resubmit their enrollment every 5 years (referred to as “revalidation.”)

Physical therapists in an institutional setting (such as a hospital or SNF) do not enroll as individuals. Instead, their services are billed under the facility.

As an enrolled physical therapist, you are responsible for making sure correct claims are submitted under your provider number. In addition, you must update your enrollment if any changes occur, such as address updates or additions to your practice.
This next topic relates to physical therapist relationships with physicians and other referral sources. Common situations that may occur involving physical therapists and physicians include rental of office space from a physician, hiring a medical director to provide services to your practice, and providing gifts to physicians to express appreciation.

I am going to speak in more detail about the potential for risk involving these relationships and how to avoid any relationships that would be problematic.
If you are offered something for free or below fair market value, you should question the reason. Three questions to ask are:

1. Am I getting paid by a company for very little work?
2. Does the amount of money I am offered seem appropriate for the services I am going to provide; and
3. Am I being asked to refer patients to that particular company?

If you determine that you are getting paid by a company well beyond fair market value for your work and you are being asked to refer patients to that company, there is a possibility that your arrangement could involve a violation of anti-kickback laws.
As a physical therapist you may want to open your own practice. You may have the opportunity to rent office space from a physician who owns some office space that she is not using. While it may be acceptable to rent the office space from the physician, you need to be careful in how you structure the rental agreement so that the physician does not decide to send her patients to your practice for care instead of elsewhere based on financial considerations.

The Office of Inspector General (OIG) has issued a fraud alert that provides useful information regarding what would be considered an appropriate arrangement for rental of office space. In this slide, I have included a link to the fraud alert on rental of office space. Specifically, OIG states that you should not pay for more space than you need, the rental amount should be based on fair market value, the rent should not be based on volume and value of referrals, and the agreement should be set forth in writing in advance.
A physician could serve an important role to ensuring quality of care by serving as a medical director. However, hospitals, nursing homes, and other facilities should not offer a physician a position as a medical director to funnel money to the physician in exchange for referring patients to the facility.

If a physician is receiving payment to serve as a medical director, that physician should spend an appropriate amount of time providing services, such as actively overseeing clinical care, identifying ways to improve quality, and training staff. The physician should be paid fair market value for the services provided as a medical director.
You may want to give a gift to a physician who has been a referral source to express appreciation, particularly around holiday time. It is important to be aware that a gift to a physician could be considered an inducement to the physician to refer his patients to your practice (potential violation of anti-kickback laws). Stark II law allows nominal gifts. The Stark II law allows nominal gifts. (The annual allowable gift value is updated each year for inflation). However, gifts should be analyzed on a case-by-case basis. If a physician practice routinely accepts free lunches from a physical therapist that don’t include a component of education, it could be easy for the government to prove that the sole intent of the free lunches is to encourage future referrals to the physical therapist’s practice. Alternatively, if the physical therapist provides modest lunches to the physician along with genuine education about physical therapist services, the “free lunch” could be acceptable.
If a health care provider offers patients gifts, provides free services, or waives coinsurance and deductibles, there is a likelihood that the federal government and private payers would question the reason.

In addition, the federal government has restrictions regarding the ability of providers to collect cash from Medicare beneficiaries for their services. I will speak in more detail about financial relationships involving patients.
Generally, federal laws prohibit gifts to Medicare and Medicaid beneficiaries, because these gifts can be seen as a way to encourage a patient to come to your practice for services.

However, the government will allow inexpensive gifts to patients as long as the gift is not cash or cash equivalent and the retail value of the gift is no more than $15 individually or $75 in the aggregate annually per patient. For example, the federal government has clarified that it is acceptable to give a patient a $15 gift card if the patient had a long delay time waiting for an appointment. Paying for a patient’s transportation costs, up to $15, to a facility also would be allowed. The link on this slide is to more information issued by the Office of the Inspector General (OIG) regarding gifts to patients.
On occasion, physical therapists and other health care providers have expressed an interest in providing free services to their patients or waiving copayments and deductibles. Although this sounds generous and altruistic, this practice could be considered a violation of anti-kickback laws. It could be seen as an attempt to convince patients to come to your practice for their health care services.

Although providing free services and waiving coinsurance and deductibles is generally prohibited, a waiver of coinsurance and deductible amounts is allowed if certain conditions are met.
The exception allows discounts and waivers of copays if:

1. The provider does not advertise the discount or waiver
2. The provider does not routinely waive copays and discount care
3. The provider shows extensive efforts were made to collect money from the patient or
4. The patient meets federal poverty guidelines or facility-specific poverty/catastrophic guidelines

It is advisable to have an indigence policy in your facility that is applied uniformly to all patients and that sets forth guidelines for how you determine whether a patient would qualify for a discount or waiver of copays due to poverty or other catastrophic circumstances.
The Office of the Inspector General and the Department of Health and Human Services have issued guidance to hospitals acknowledging that discounts to uninsured and underinsured patients is acceptable. In subsequent correspondence, they have indicated that this policy applies not only to hospitals but to all providers.

A link to this resource is on this slide. You can review these letters to find out more about how to establish a policy regarding discounts in your practice and how to document in order to support that a discount to a particular patient is warranted.
Some physical therapists have indicated they would prefer to collect out-of-pocket payments from Medicare beneficiaries, rather than enroll in the Medicare program, and submit bills to Medicare for reimbursement. However, Medicare has a requirement that all claims for Medicare beneficiaries must be submitted to Medicare for reimbursement if they are for services that Medicare would cover.

The only exception would be for physicians who “opt out” of the Medicare program and agree not to bill for any Medicare beneficiaries for 2 years. Physical therapists are not included in the group of providers who can “opt out” under Medicare.

It is permissible for a physical therapist to receive cash payment from a Medicare beneficiary for a service that Medicare would not cover. For example, Medicare will not cover “wellness and prevention” services provided by a physical therapist. Therefore, if a physical therapist has Medicare beneficiaries who are participating in a wellness program, she could collect cash from those Medicare beneficiaries for those services.
In addition to their own regulations and policies regarding payment and coverage for services, the government and private payers also consider professional standards of practice when making determinations regarding whether services were medically necessary and should be covered.

To protect against the risk of fraud, abuse, and waste and to ensure high-quality care, physical therapists should incorporate clinical practice guidelines and evidence-based patient care decisions when determining appropriate health care for specific clinical conditions.

You can access more information regarding clinical practice guidelines, evidence, ethics, and professionalism at the link on this slide.
Establishing and embracing a compliance program is a good step to help you avoid any activities that could ultimately be considered fraud, abuse, or waste. The Affordable Care Act mandates compliance programs for Medicare and Medicaid providers. It also requires the Secretary of the Department of Health and Human Services, in consultation with OIG, to establish core elements for compliance programs. However, an enforcement date for providers compliance plans has not yet been issued, so as of now compliance programs are voluntary. OIG has identified 7 core elements that form the basis for a compliance program and has provided examples of voluntary compliance programs for different types of providers on its website. These examples can provide good guidance.
The 7 elements of a compliance program are:

1. Developing and distributing written policies, procedures, and standards of conduct to prevent inappropriate conduct.
2. Designation of a compliance officer who has responsibility for this area. This does not have to be a full-time job, particularly if you are in a small practice.
3. Providing effective education and training programs for your staff regarding compliance, coding, and billing.
4. Establishing open lines of communication for reporting compliance concerns. This could include a hotline to receive complaints.
5. Having a system in place to respond to any allegations of improper conduct, including disciplinary action.
6. Performing internal evaluation and audits to monitor compliance.
7. Investigating and remediating any problems that are identified.
If you have witnessed fraud or abuse, or are in engaged in a relationship or billing practice that you think might be problematic, you should consider taking the following steps:

1) Contact the compliance officer in the facility if there is one.
2) Immediately stop submitting any problematic bills.
3) Seek knowledgeable legal counsel.
4) Determine whether there are overpayments that need to be returned.
5) Disentangle yourself from the problematic relationship.
6) When appropriate, consider reporting the information to the Office of the Inspector General, Centers for Medicare and Medicaid Services, or the private payer, particularly if the compliance offer has not responded adequately.
Potential resources that can help you if you have a concern about a particular billing practice, business relationship, or other relationship include:

1. Experienced health care lawyers
2. Your state physical therapy board
3. CMS Medicare administrative contractors (MACs)
4. The Office of Inspector the General hotline and email
   800-HHS-TIPS (1-800-447-8477)
   HHSTIPS@oig.hhs.gov

You can report anonymously to the hotline, but the more specific information you provide, the better position OIG will be in to investigate the suspected fraud.
These issues are complex, and certainly you are not expected to be an expert on all of them. However, after listening to this presentation, you should be able to recognize when there is a potential problem and where to go to get some resolution.