**Coding Corner**

**FAQ**

1. **I am seeing a Medicare patient with a stage IV wound who has shown no signs of healing with nursing care. I would like to use diathermy. What is the code?**

CPT G0329 - Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

It is important to remember that per NCD 270.1, electromagnetic therapy is NOT COVERED for the treatment of:

- stage I or stage II wounds;
- when used as an initial treatment modality;
- continued treatment if measurable signs of healing have not been demonstrated within any 30-day period of treatment;
- wounds that demonstrate a 100% epithelialized wound bed;
- a patient in the home setting, as unsupervised use by patients in the home has not been found to be medically reasonable and necessary.

2. **I am seeing a Medicare patient with a stage IV wound who has shown no signs of healing with nursing care. I would like to use ultrasound. What is the code?**

The code would be 97035; however, it should be noted ultrasound is often not billable for wound care for Medicare patients and that due to the potential for non-coverage, Local Coverage Determinations (LCDs) should be reviewed prior to including ultrasound in a wound plan of care.

3. **I am seeing a Medicare patient with a stage IV wound who has shown no signs of healing with nursing care. I would like to use electrical stimulation. What is the code?**

CPT G0281 – Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care.

It is important to remember that per NCD 270.1, electrical stimulation therapy is NOT COVERED for the treatment of:

- stage I or stage II wounds;
- when used as an initial treatment modality;
- continued treatment if measurable signs of healing have not been demonstrated within any 30-day period of treatment;
- wounds that demonstrate a 100% epithelialized wound bed;
- a patient in the home setting, as unsupervised use by patients in the home has not been found to be medically reasonable and necessary.

4. **I am using an unattended (supervised) modality on a Medicare Part A patient, how much time can I count?**

RAI manual Page O-25 states “Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partially skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining...
appropriate stimulation mode, shall be recorded on the 
MDS. “

For all payers, for all unattended modalities (diathermy, unattended estim, paraffin, etc) the skilled time should be entered under MDS (set up, skin checks, parameter setting and decision making, etc) and the non skilled time entered under nonMDS. For example, it took me a total of 7 minutes to complete the set up, skin check, and parameter setting for a diathermy treatment that then continued an additional 15 minutes without the need of therapist intervention. Billing would be 7 minutes under MDS minutes and 15 minutes under nonMDS minutes.

5. Do all the minutes spent on unattended electrical stimulation count on the MDS?

RAI manual Page O-25 states “Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partially skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. “ For example, it took a total of 7 minutes to complete the set up, skin check, and parameter setting for an electrical stimulation treatment that then continued an additional 15 minutes without the need of therapist intervention. Billing would be 7 minutes under MDS minutes and 15 minutes under nonMDS minutes.

6. My patient has difficulty with sit to stand transfers so I have been using electrical stimulation while performing transfer training. How do I code the electrical stimulation?

Your choice for the electrical stimulation would be to bill G0283, unattended, or 97032, attended. It is important to remember that when two “attended” interventions are being performed at the same time you may only bill one of them. Therefore, the clinician needs to use clinical judgment to determine which of the interventions required clinician skill, the e stim or the other attended therapeutic procedure in order to determine which attended intervention to bill.

If the clinician feels that their skill was required for the electrical stimulation more than the other therapeutic procedure then the electrical stimulation would be billed as 97032, attended electrical stimulation, and the other therapeutic procedure performed at the same time would not be billed.

If the clinician feels their skill was required for the therapeutic procedure more than the electrical stimulation that was running via electrode while performing a therapeutic procedure such as therapeutic exercise, therapeutic activity, or neuromuscular reeducation then the electrical stimulation would be billed as G0283, unattended electrical stimulation, and the other therapeutic procedure would be billed. For example, estim was used during therapeutic activity and it took 7 minutes for the estim set up etc and then estim runs for 25 minutes while the therapist focuses on transfer training. Billing would be: G0283 for 7 minutes MDS, then 25 minutes 97530 for the skilled transfer training and note in the daily documentation that estim was used during the 25 minutes of transfer training, and 25 minutes of G0283 under nonMDS.

Decoding CPT Codes

Each quarter we focus on decoding the mystery of a specific CPT code. This quarter we will focus on electrical stimulation codes. The three electrical stimulation codes are:

- 97032 – electrical stimulation (manual) (to one or more areas), each 15 minutes
- G0283 – electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
- G0281 – electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care
Neuromuscular Electrical Stimulation (NMES) while performing a therapeutic exercise or functional activity may be billed as 97032 if the electrical stimulation was the focus of the therapist and not the therapeutic exercise or functional activity.

- Stimulation delivered by vaginal or anal probes connected to an external pulse generator may be billed as 97032.

Supportive Documentation Requirements for 97032 that should be included in a daily note includes:

- Type of electrical stimulation used (do not limit the description to “manual” or “attended”) and mode of delivery (probe)
- Area(s) being treated
- If used for muscle weakness, objective rating of strength and functional deficits
- If used for pain include pain rating, location of pain, effect of pain on function

CPT G0281

The use of CPT G0281, electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care requires that the Medicare National Coverage Determination Indications be met (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, section 270.1).

Electrical stimulation for the treatment of wounds is considered adjunctive therapy, and will only be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. ES will be covered only after appropriate standard wound therapy has been provided for at least 30 days and there are no measurable signs of healing. This 30-day period may begin while the wound is acute.

Standard wound care includes optimization of nutritional status, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection that may be present.
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Standard wound care based on the specific type of wound includes frequent repositioning of a patient with pressure ulcers (usually every 2 hours), off-loading of pressure and good glucose control for diabetic ulcers, establishment of adequate circulation for arterial ulcers, and the use of a compression system for patients with venous ulcers.

Measurable signs of healing include a decrease in wound size (either surface area or volume), decrease in amount of exudates, and decrease in amount of necrotic tissue. ES must be discontinued when the wound demonstrates a 100% epithelialized wound bed. ES services can only be covered when performed by a therapist, a physician or incident to a physician's service.

Evaluation of the wound is an integral part of wound therapy. When providing ES, the therapist must evaluate and frequently reassess the wound, contacting the treating physician if the wound worsens (do not bill a re-evaluation code for the wound assessment). If ES is being used, wounds must be evaluated at least monthly by the treating physician.

Per NCD 270.1, electrical stimulation (G0281) is NOT COVERED for the treatment of:

- stage I or stage II wounds;
- electrical stimulation or electromagnetic therapy when used as an initial treatment modality;
- continued treatment with ES or electromagnetic therapy if measurable signs of healing have not been demonstrated within any 30-day period of treatment;
- wounds that demonstrate a 100% epithelialized wound bed;
- a patient in the home setting, as unsupervised use by patients in the home has not been found to be medically reasonable and necessary.

Supportive Documentation Requirements for G0281 include:

- Etiology and duration of wound
- Type of prior treatments by a physician, non-physician practitioner, nurse and/or therapist that failed, including the duration of the failed treatment
- Stage of wound
- Description of wound: length, width, depth, grid drawing and/or photographs
- Amount, frequency, color, odor, type of exudate
- Evidence of infection, undermining, or tunneling
- Nutritional status
- Comorbidities (e.g., diabetes mellitus, peripheral vascular disease)
- Pressure support surfaces in use
- Patient’s functional level
- Skilled plan of treatment, including specific frequency of the modality
- Changing plan of treatment based on clinical judgment of the patient’s response or lack of response to treatment
- Frequent skilled observation and assessment of wound healing (at least weekly, but preferably with each treatment session)

Keeping Straight on the Regulation Road

Congress Passed Protecting Access to Medicare Act of 2014

Congress voted to pass the Protecting Access to Medicare Act of 2014. The Bill includes several key provisions that impact SNFs and Therapy Providers. The Bill extends the current .5% update to the physician fee schedule through 2014 and provides a 0% update through April 1, 2015. Without this extension, physicians and Part B providers faced a 24.1 percent payment cut on April 1, 2014 due to the flawed SGR payment formula. The bill also extends the existing therapy cap exceptions and the manual medical review process through March 31, 2015. Without the extension, patients faced a hard cap on outpatient therapy services as of April 1, 2014. The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare therapy patients. These limits change annually. Therapy caps for 2014 are $1920 for physical therapy and speech therapy combined and $1920 for occupational therapy. In addition, it delays the transition to ICD-10 until October 1, 2015. Finally, the bill describes a Skilled Nursing Facility Value-Based Purchasing Program, which requires the Secretary to specify a SNF all-condition risk-adjusted potentially preventable hospital readmission rate by October 1, 2015. Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities. CMS will rank SNFs based on their achievement (relative to other SNFs) and improvement (relative to that particular SNF.
prior fiscal year) performance scores based on standards established by CMS. The performance and ranking methodology is determined by CMS. In order to fund the incentive payment pool, CMS will withhold 2% of SNF payments starting October 1, 2018. CMS will redistribute 70% of the withheld amount by way of incentive payments to SNFs. The funds are redistributed to the industry based on a re-hospitalization metric that is to be defined by the Secretary.

Medicare Contractors Reporting Erroneous Claim Rejections due to G-code Edits

Medicare Contractors are reporting that Medicare Part B claims are erroneously rejecting with reason codes U5450-U5454. This problem has been reported to the Common Working File (CWF). CWF has acknowledged a problem with the edit and a correction is being developed. Until the correction is implemented, claims will continue to reject. Instructions will be provided by MACs once the correction has been implemented.

Medicare Fraud Strike Force Set Record Numbers for Health Care Fraud Prosecutions in FY2013

The Justice Department announced that its Medicare Fraud Strike Force has set record numbers for health care prosecutions in Fiscal Year 2013. The Medicare Fraud Strike Force is part of an unprecedented partnership between the Departments of Justice and Health and Human Services called HEAT (Health care Enforcement and Prevention Action Team) that was formed in May 2009. By focusing on the worst offenders engaged in current fraud schemes in the highest intensity regions, the strike force seeks to deter fraud in the target community and prevent it from spreading to other areas. The strike force is currently operating in nine cities: Baton Rouge, La.; Brooklyn, N.Y.; Chicago; Dallas; Detroit; Houston; Los Angeles; Miami and Tampa, Fla. Since its inception in March 2007, strike force prosecutors have charged more than 1,700 defendants who have collectively billed the Medicare program more than $5.5 billion. In Fiscal Year 2013, the strike force set records in the number of cases filed (137), individuals charged (345), guilty pleas secured (234) and jury trial convictions (46). In addition, the defendants who were charged and sentenced are facing significant time in prison – an average of 52 months in prison for those sentenced in FY 2013, and an average of 47 months in prison for those sentenced since 2007. According to a recent report by the Inspector General for the U.S. Department of Health and Human Services, for every dollar the Departments of Justice and Health and Human Services have spent against health care fraud, they have returned an average of nearly eight dollars to the U.S. Treasury, the Medicare Trust Fund and others.

OIG Work Plan for FY2014 Released
http://go.usa.gov/Bj4z

The HHS Office of Inspector General (OIG) Work Plan for Fiscal Year 2014 provides brief descriptions of activities that the OIG plans to initiate or continue with respect to HHS programs and operations in fiscal year 2014. The planned SNF focus areas in the FY2014 OIG Work Plan are:

- Medicare Part A billing by skilled nursing facilities (new)
- Questionable billing patterns for Part B services during nursing home stays
- State agency verification of deficiency corrections
- Program for national background checks for long-term-care employees
- Hospitalizations of nursing home residents for manageable and preventable conditions

Office of Medicare Hearings and Appeals (OMHA) Public Forum

On February 12, 2013, the Office of Medicare Hearings and Appeals (OMHA) hosted a public forum to address concerns raised by its recent announcement that, effective July 15, 2013, OMHA had “temporarily suspended the assignment of most new requests for an Administrative Law Judge hearing to allow OMHA to adjudicate appeals involving almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges (ALJs).” The objectives of the forum were to:

- Provide updates on the status of OMHA operations;
- Provide information on OMHA’s initiatives to help mitigate the growing backlog;
- Provide information on what appellants can do to make the process more efficient; and
- Answer questions from the appellant community.
Evergreen Rehabilitation

RAC Update

Region A: Performant Recovery; Region B: CGI Federal, Inc; Region C: Connolly, Inc; Region D: HealthDataInsights, Inc.

Medicare to Suspend RAC Document Requests Until New Contracts in Place

The Centers for Medicare & Medicaid Services announced in February it will suspend the ability of Recovery Auditor Contractors to request documents associated with claims reviews until it finishes the procurement process for new RAC contracts. The pause in additional documentation requests (ADRs) is intended to allow the CMS to wind down the current RAC contracts and allow the RACs to finish any outstanding claims reviews. CMS has provided the following deadlines on its website. These apply to the entire RA program, including Manual Medical Review:

- February 21 was the last day a Recovery Auditor could send a post-payment Additional Documentation Request (ADR);
- February 28 was the last day a MAC could send prepayment ADRs for the Recovery Auditor Prepayment Review Demonstration; and
- June 1 is the last day a Recovery Auditor may send improper payment files to the MACs for payment adjustment (taken directly from the CMS website).

In addition to announcing the ADR suspension, the CMS also released some changes to the RAC program that will take effect under the new contracts. The changes, which were made in response to industry concerns, include:

- requiring RACs to wait 30 days after making a claims determination before sending the claim to the MAC for adjustment
- requiring RAC to confirm that they have received a provider’s discussion request within three days;
- preventing RACs from being paid their contingency fee “until the second level of appeal is exhausted”;
- creating separate ADR limits for different claims types; and
- requiring RACs to adjust the amount of ADRs a provider can receive based on their denial rate. If a provider has a low denial rate, then it will receive fewer ADRs, and vice versa.

OIG Report: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries

According to a newly released OIG report, twenty-two percent of Medicare beneficiaries experienced adverse events during their SNF stays, resulting in prolonged SNFs stays or hospitalizations, permanent harm, life-sustaining intervention, or death. An additional 11 percent experienced temporary harm events. This total harm rate is similar to what the OIG found in its 2010 hospital report, which stated that 27 percent of Medicare beneficiaries had experienced adverse and temporary harm events during their hospital stays. Also, 59 percent of events in SNFs were preventable, and hospitalizations necessitated by the events increased costs to Medicare by an estimated $208 million in a single month, suggesting potential savings from reducing the incidence of adverse events that occur in SNFs.

OIG Releases Compendium of Priority Recommendations

The OIG’s Compendium of Priority Recommendations (Compendium), renames the Compendium of Unimplemented Recommendations, a core publication of the Department of Health and Human Services (HHS) Office of Inspector General (OIG). The Compendium identifies significant recommendations described in previous Semiannual Reports to Congress with respect to problems, abuses, or deficiencies for which corrective
actions have not been completed. The 2014 edition also responds to a requirement associated with the Consolidated Appropriations Act of 2014 directing OIG to report its top 25 unimplemented recommendations that, on the basis of the professional opinion of OIG, would best protect the integrity of HHS programs if implemented.

The recommendations related to Skilled Nursing Facilities included in the Compendium:

**Improve controls to address improper Medicare billings by community mental health centers, home health agencies, and skilled nursing facilities.**

- Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than $1 Billion in 2009. OEI-02-09-00200. 2012 NOV. Increase and expand reviews of SNF claims, monitor compliance with the new therapy assessments, change the current method for determining how much therapy is needed to ensure appropriate payments, improve the accuracy of data items submitted by SNFs, and follow up on SNFs that billed in error.

- Questionable Billing by Skilled Nursing Facilities. OEI-02-09-00202. 2010 DEC. Monitor overall Medicare payments to SNFs and adjust rates as necessary, strengthen monitoring of SNFs that disproportionately bill for higher paying resource utilization groups (RUGs), and follow up on the SNFs identified as having questionable billing practices.

**Improve care planning and discharge planning for beneficiaries in nursing home settings.**

- Plans for Care and Discharge—Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements. OEI-02-09-00201. 2013 FEB. Strengthen regulations on care planning and discharge planning, provide guidance to SNFs to improve care planning and discharge planning, increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable, link payments to meeting quality of care requirements, and follow up on the SNFs that failed to meet care planning and discharge planning requirements and that provided poor quality of care.

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**All Eyes on Therapy**

Therapy remains the focus of many Medicare Administrative Contractors (MACs)/Fiscal Intermediaries (FIs) as well as the Regulatory and Law Enforcement Agencies of the Federal Government as the commitment to deterring fraud, waste and abuse in the Medicare and Medicaid systems has increased.

**South Florida President of CORF Pledged Guilty**

Milagros Cruz pleaded guilty in the U.S. District Court for the Middle District of Florida to conspiring to commit health care fraud. She faces a maximum penalty of 10 years in prison when she is sentenced. According to court documents, Cruz conspired with others to execute a health care fraud scheme involving the submission of claims for reimbursement to Medicare for rehabilitation therapy services that were not legitimately prescribed by physicians and not legitimately provided to Medicare beneficiaries. Cruz, as president of CORF National Development, located in Doral, Fla., paid cash kickbacks to Medicare beneficiaries who came to CORF National Development in exchange for using the beneficiaries’ identifying information in the fraud scheme. Cruz would combine the Medicare beneficiaries’ identifying information with other billing information and provide the information to other conspirators. These conspirators then converted the information into reimbursement claims submitted to Medicare in the name of a completely different clinic known as Renew Therapy Centers of Port St. Lucie LLC. From January through August 2008, Cruz’s clinic received approximately $90,950 from Renew Therapy in connection with the fraud scheme.

**Physical Therapist Arrested on Health Care Fraud Charges**

In February, Danielle Faux was indicted on 46 counts of health care fraud and one count of obstruction of a federal audit. According to the indictment, Faux owned and operated Danielle Faux PT, LLC, a physical therapy clinic and was a part owner of a gym, Achieve Rehab and Fitness. The indictment alleges that Faux engaged in a scheme to defraud Medicare and Anthem Blue Cross Blue Shield by referring some of her patients for personal training sessions at Achieve Rehab and Fitness and then billing the sessions as if they were physical therapy procedures.
Physician Agrees to $1.5 Million Payment and 15-Year Exclusion to Settle Civil Monetary Penalty Case

Joseph A. Raia, M.D. agreed to pay $1.5 million in assessments and penalties and be excluded from participation in all Federal health care programs for at least 15 years under the terms of the agreement to resolve his liability for submitting false and fraudulent Medicare claims. OIG alleged that between January 2006 and November 2011, Dr. Raia submitted, or caused to be submitted, thousands of claims for physical therapy and related physical medicine and rehabilitation services to Medicare for services that were never provided or were otherwise false or fraudulent.

Dr. Raia, a physiatrist licensed in New Jersey and New York, was the owner and chief operating officer of Grafton Medical Center, PC, and Joseph A. Raia, M.D., P.C., physical medicine and rehabilitation practices located in Newark and Brooklyn. Dr. Raia was also an employee of a physician group practice with multiple locations in Brooklyn. OIG had initiated an administrative case alleging Dr. Raia:

- submitted claims to Medicare for the provision or supervision of physical therapy and related services for which he was not in the State where the services were allegedly performed
- submitted claims for physical therapy and related services simultaneously rendered in five different locations in two States
- improperly used chiropractors to provide physical therapy services “incident to” his professional services.
- routinely submitted claims for time-based procedures that exceeded 24 hours in one day.

In resolving this matter through settlement, Dr. Raia has denied any liability. No judgment or finding of liability has been made against Dr. Raia.

Houston Speech Therapy and Swallow Therapy Services Billed Fraudulently

Rebecca Lee Rabon, 44, and Tiffany Nicole Thompson, 31, both of Houston, have been charged in a 44-count indictment alleging conspiracy to commit health care fraud, health care fraud and aggravated identity theft. The indictment alleges Rabon, the owner of Rabon Communication Enhancement (RCE) fraudulently billed TRICARE and Blue Cross and Blue Shield of Texas approximately $3,784,642 for speech therapy and swallowing therapy services that were not provided to patients. Of that amount, the indictment alleges approximately $1,285,827.67 was paid on the fraudulent claims. Rabon and Thompson also allegedly submitted fraudulent claims for themselves and three employees of RCE for services that were not provided. Two individuals are identified in the indictment as victims of identity theft.

Rabon and Thompson both face up to 10 years in federal prison for each of the conspiracy to commit health care fraud and 36 substantive health care fraud charges. Rabon, who is also charged with five counts of mail fraud, faces up to 20 years in prison on each of those charges. If convicted of either of the two counts of aggravated identity theft, each also face an additional two-year-term which must be served consecutively to any sentence for the underlying offenses. There is also a possibility of up to a $250,000 fine for conviction of any of the offenses.

The indictment also alleges that Faux created and altered patient records when Medicare audited her practice in August 2009. If convicted, Faux faces a maximum term of imprisonment of 10 years and a fine of up to $250,000 on each of the health care fraud counts, and a maximum term of imprisonment of five years and a fine of $250,000 on the obstruction count.

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