2012 Quarter 3

Coding Corner

FAQ

1. Is there a CPT code for iontophoresis or should I bill it under electrical stimulation?

Yes, there is a CPT code for iontophoresis. It is CPT code 97033 and is a timed code. Iontophoresis should never be billed as electrical stimulation due to it having its own CPT code. It is important to be aware of your FI/MAC’s LCDs and commercial payor contracts related to iontophoresis as they may have coverage limitations and/or restrictions. For example, both NGS and CGS will only cover iontophoresis for the treatment of intractable, disabling primary focal hyperhidrosis (ICD-9-CM code 705.21) that has not been responsive to recognized standard therapy.

2. How do I bill for time spent in co-treatment?

The answer is dependent on the payor source. For Medicare Part A patients when two clinicians, each from a different discipline, treat one resident at the same time (with different treatments), both disciplines may code the treatment session in full. The decision to co-treat should be made on a case basis and the need for co-treatments should be well documented for each patient.

For Medicare Part B patients, the time must be divided between the treating disciplines.

3. Can you clarify the Medicare regulations for student billing?

The answer is dependent on the payor source. Under Medicare Part A the student is an extension of the therapist meaning that the definitions of group, individual and concurrent are applied as if the student and therapist are one in the same. For example, if the student is treating and billing individual, the therapist may not be working with another patient at the same time and billing and vice versa. The definition of concurrent is met if both the student and therapist are seeing one patient and billing at the same time; the student is seeing and billing two patients performing different activities simultaneously and the therapist has no patients; or the therapist is seeing and billing two patients performing different activities simultaneously and the student has no patients.

The definition of group is met if the student is seeing and billing 2-4 patients performing the same/similar activity as long as the group was originally planned for 4 patients and the therapist has no patients during this time and vice versa.

Under Medicare Part B, students are allowed to participate in the treating of Medicare Part B patients only if the supervising therapist is directing the service, making the skilled judgment, and is responsible for assessment and treatment. The supervising therapist must not be engaged in treating another patient or doing other tasks at the same time and must be present in the room the entire treatment.

4. I get confused when to use 719.7 vs. 781.2 for my patients with gait difficulty. Can you please help clarify?

ICD-9 code 781.2, abnormal gait, includes ataxic, paralytic, spastic, and staggering gait. All other gait issues should be reported with 719.7, difficulty walking.

5. Please provide me with late effect cerebrovascular disease codes.

Late Effects of Cerebrovascular Disease (438.0-438.9) are to be used to indicate conditions in ICD-9 430-437 as the cause of the late effects. The “late effects” include conditions specified as such, or as sequelae, which may occur at any time after the onset of the causal condition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.0</td>
<td>Cognitive deficits</td>
</tr>
<tr>
<td>438.11</td>
<td>Aphasia</td>
</tr>
<tr>
<td>438.12</td>
<td>Dysphasia</td>
</tr>
<tr>
<td>438.13</td>
<td>Dysarthria</td>
</tr>
<tr>
<td>438.14</td>
<td>Fluency disorder</td>
</tr>
<tr>
<td>438.21</td>
<td>Hemiplegia affecting dominant side</td>
</tr>
<tr>
<td></td>
<td>Excludes: hemiplegia not caused by 430-437. See ICD-9 342.01-342.82</td>
</tr>
<tr>
<td>438.22</td>
<td>Hemiplegia affecting nondominant side</td>
</tr>
<tr>
<td></td>
<td>Excludes: hemiplegia not caused by 430-437. See ICD-9 342.01-342.82</td>
</tr>
</tbody>
</table>
Decoding CPT Codes

Each quarter we focus on decoding the mystery of a specific CPT code. This quarter we will focus on CPT code 92526.

The definition of CPT code 92526 is treatment of swallowing dysfunction/oral function for feeding. CPT code 92526 is an untimed code, billed as 1 unit per day. If two or more shorter sessions are performed during the same day, these should be combined and billed as 1 unit. CPT code 92526 is a comprehensive code that includes most aspects of dysphagia treatment. Do not use additional CPT codes in combination with 92526 when the focus of the treatment is for swallowing. For example, if the patient performs strengthening exercises to improve swallowing/feeding, bill 92526 and not 97110. The same is true if the patient is performing neuromuscular reeducation exercise to improve feeding/swallowing—the SLP must bill this intervention under 92526 and not 97112. CMS does not reimburse separately for VitalStim because its efficacy has not been proven. However, as long as an SLP documents other reasonable and necessary dysphagia treatment was provided with or without VitalStim, you can bill for 92526.

Dysphagia treatment commonly addresses the following issues:
- patient caregiver training in feeding and swallowing techniques;
- proper head and body positioning;
- amount of intake per swallow;
- appropriate diet;
- means of facilitating the swallow;
- feeding techniques and need for self help eating/feeding devices;
- food consistencies (texture and size);
- facilitation of more normal tone or oral facilitation techniques;
- oromotor and neuromuscular facilitation exercises to improve oromotor control;
- laryngeal elevation training;
- training in laryngeal and vocal cord adduction exercises;
- compensatory swallowing techniques; and
- oral sensitivity training.

Keeping Straight on the Regulation Road:
CMS Issued a Clarification on Adjusting the ARD for a Scheduled Adjustment

Centers for Medicare and Medicaid Services (CMS) staff have clarified that when a resident on a Medicare Part A stay is discharged, the Assessment Reference Date (ARD) of a scheduled Medicare Prospective Payment System (PPS) assessment may be adjusted to the day the resident is discharged only when the ARD for the scheduled PPS assessment was set prior to the day of discharge. From page A-26 of the MDS 3.0 RAI Manual “When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.”

The ARD should be adjusted on the day of discharge or as soon thereafter as facility staff becomes aware the resident has been discharged. However, in all cases, the ARD must be adjusted no later than day 14 after discharge. As mandated on pages 2-44 and 2-45 of the MDS 3.0 RAI Manual and applicable to all required Medicare PPS MDS, “Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).” Beyond 14 days after discharge, the scheduled PPS assessment becomes a missed assessment.

The following three scenarios illustrate this guidance:

Scenario One: Facility staff set an ARD for day 8 for a PPS 5 day. On day 5, the resident was discharged. On the day of discharge or 1 to 14 days after discharge, staff can adjust the ARD to day 5, as long as the PPS MDS is completed no more than 14 days after the adjusted ARD.

Scenario Two: Facility staff set an ARD for day 18 for a PPS 14 day. On day 17, the resident was discharged. Fifteen or more days after discharge, staff can NOT adjust the ARD to day 17.
Scenario Three: Facility staff had a resident admitted for a Medicare Part A stay. Facility staff never set an ARD in the facility MDS software or on an MDS item set for a PPS 5-day. On day 3, the resident was discharged. Facility staff can NOT adjust the ARD to day 3 because there is no ARD to adjust. From page 2-72 of the MDS 3.0 RAI Manual: “If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system when specific circumstances are met may be used to bill for some Part A days. See chapter 6, Section 6.8 for greater detail.”

CMS Released FY 2012 SNF PPS Monitoring Activities Report

CMS released a report detailing the FY 2012 SNF PPS Monitoring Activities which presents an updated look at the second quarter impact of the FY 2012 policy changes including the recalibration of the parity adjustment, allocation of group therapy and changes to the MDS including the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA). Below are some of the highlights.

- Overall patient case mix is not significantly different from that observed in FY 2011—there have been small decreases in the Rehabilitation Plus Extensive Services categories, and increases in some of the medically-based RUG categories, most notably Special Care.

<table>
<thead>
<tr>
<th></th>
<th>FY 2011</th>
<th>FY 2012 QTR 1 &amp; 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Plus Extensive Services</td>
<td>2.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>87.9%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>0.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Special Care</td>
<td>4.6%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>2.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Behavioral Symptoms and Cognitive Performance</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td>1.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

- The percentage of residents in Ultra-High Rehabilitation has increased from FY 2011 and although there have been decreases in the High and Medium therapy RUG-IV categories, CMS stated that some of the decrease may be due to index maximization into the Special Care category.

<table>
<thead>
<tr>
<th></th>
<th>FY 2011</th>
<th>FY 2012 QTR 1 &amp; 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra-High Rehabilitation (≥ 720 minutes of therapy per week)</td>
<td>44.9%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Very-High Rehabilitation (500 – 719 minutes of therapy per week)</td>
<td>26.9%</td>
<td>26.7%</td>
</tr>
<tr>
<td>High Rehabilitation (325 – 499 minutes of therapy per week)</td>
<td>10.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Medium Rehabilitation (150 – 324 minutes of therapy per week)</td>
<td>7.6%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Low Rehabilitation (45 – 149 minutes of therapy per week)</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

- Initial FY 2012 data indicate that after the allocation of group therapy facilities are providing individual therapy almost exclusively.

<table>
<thead>
<tr>
<th></th>
<th>STRIVE</th>
<th>FY 2011</th>
<th>FY 2012 QTR 1 &amp; 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>74%</td>
<td>91.8%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Concurrent</td>
<td>25%</td>
<td>0.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Group</td>
<td>&lt;1%</td>
<td>7.4%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
CMS stated in this report that prior to the implementation of the COT OMRA, scheduled PPS assessments comprised the majority of the completed assessments. With the addition of the COT OMRA, scheduled PPS assessments continue to be the majority of the completed assessments; however, the COT OMRA is the most frequently completed unscheduled assessment.

<table>
<thead>
<tr>
<th></th>
<th>FY 2011</th>
<th>FY 2012 QTR 1 &amp; 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled PPS assessment</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Start-of-Therapy (SOT) assessment</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>End-of-Therapy (EOT) assessment (w/o Resumption)</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Combined SOT/EOT</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>End-of-Therapy assessment (w/ Resumption) (EOT-R)</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>Combined SOT/EOT-R</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>Change-of-Therapy (COT) assessment</td>
<td>N/A</td>
<td>11%</td>
</tr>
</tbody>
</table>

CMS Announces Partnership to Improve Dementia Care in Nursing Homes

On May 30, CMS announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership – among federal and state partners, nursing homes and other providers, advocacy groups and caregivers – has set a national goal of reducing use of antipsychotic drugs in nursing home residents by 15 percent by the end of 2012. CMS and industry and advocacy partners are taking several steps to achieve this goal of improved care:

- Enhanced training: CMS has developed Hand in Hand, a training series for nursing homes that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training focused on behavioral health to state and federal surveyors;
- Increased transparency: CMS is making data on each nursing home’s antipsychotic drug use available on Nursing Home Compare starting in July of this year, and will update this data;
- Alternatives to antipsychotic medication: CMS is emphasizing non-pharmacological alternatives for nursing home residents, including potential approaches such as consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.

In addition, to address this challenge in the long-term CMS is conducting research to better understand the decision to use or not to use antipsychotic drugs in residents with dementia. A study is underway in 20 to 25 nursing homes, evaluating this decision-making process. Findings will be used to target and implement approaches to improve the overall management of residents with dementia, including equipment and supplies for people with Medicare. The rule also helps ensure beneficiaries receive quality care because CMS will verify the credentials of a provider who is ordering or certifying equipment and supplies. In addition, the final rule continues to require that all providers and suppliers who qualify for a unique identification number - the National Provider Identifier (NPI) - include their NPI on applications to enroll in Medicare and Medicaid and on all reimbursement claims submitted. This gives CMS and States the ability to tie specific claims to the ordering or certifying physician or eligible professional and to check for suspicious ordering activity.

CMS Posted Final Decision Memo on Transcutaneous Electrical Nerve Stimulation for Chronic Low Back Pain

CMS posted a final decision memo on June 8, 2012 stating that Transcutaneous Electrical Nerve Stimulation (TENS) is not reasonable and necessary for the treatment of chronic low back pain (CLBP) under section 1862(a)(1)(A) of the Social Security Act. For the purposes of this decision CLBP is defined as an episode of low back pain that has persisted for three months or longer; and is not a manifestation of a clearly defined and generally recognizable primary disease entity. For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom; and certain systemic diseases such as rheumatoid arthritis and multiple sclerosis manifest many debilitating symptoms of which low back pain is not the primary focus.

CMS Issues Rule Estimated to Save Nearly $1.6 billion

The Centers for Medicare & Medicaid Services (CMS) announced a final rule April 24, 2012 that prevents fraud in Medicare and is estimated to save taxpayers nearly $1.6 billion over 10 years. The rule ensures that only qualified, identifiable providers and suppliers can order or certify certain medical services, equipment and supplies for people with Medicare. The rule also helps ensure beneficiaries receive quality care because CMS will verify the credentials of a provider who is ordering or certifying equipment and supplies. In addition, the final rule continues to require that all providers and suppliers who qualify for a unique identification number - the National Provider Identifier (NPI) - include their NPI on applications to enroll in Medicare and Medicaid and on all reimbursement claims submitted. This gives CMS and States the ability to tie specific claims to the ordering or certifying physician or eligible professional and to check for suspicious ordering activity.
reducing the use of antipsychotic drugs in this population.

**Senate Finance Committee Members Solicit Ideas from Health Care Community Stakeholders**

On May 2, 2012, members of the Senate Finance Committee issued a letter to members of the Health Care Community to solicit ideas regarding solutions and suggestions for how to better prevent and combat fraud, waste and abuse in the Medicare and Medicaid programs. The general categories in which they seek input are program integrity reforms to protect beneficiaries and prevent fraud and abuse; payment integrity reforms to ensure accuracy, efficiency and value; and fraud and abuse enforcement reforms to ensure tougher penalties against those who commit fraud. White papers should be emailed in Microsoft Word or PDF format to ProgramIntegrityWhitePapers@finance.senate.gov by June 29, 2012.

**J8 A/B MAC Transition to WPS**

Wisconsin Physicians Service Insurance Corporation (WPS) was awarded the contract for the J8 A/B MAC by the Centers for Medicare & Medicaid Services (CMS). J8 includes Indiana and Michigan. At the cutover date, providers should submit all claims to WPS that have not been previously filed to NGS. The cutover date is for submission of all claims, and is not for the date of service on the claim. There are different cutover dates by state and workload segment, for a total of three dates:
- July 16, 2012 Michigan Part B WPS
- August 20, 2012 Indiana Part B NGS

**JH MAC Transitioning to Novitas**

Novitas Solutions Inc. will become the new Medicare Administrative Contractor for the newly formed MAC Jurisdiction H. CMS is forming Jurisdiction H by consolidating A/B MAC Jurisdictions 4 and 7 and will include the states of Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas. This change reflects the CMS MAC jurisdiction strategy, announced in 2010, to consolidate from 15 (fifteen) Part A/B MAC jurisdictions to 10 (ten) by 2016.

There are different cutover dates by state and workload segment:

<table>
<thead>
<tr>
<th>States</th>
<th>Cutover Date</th>
</tr>
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<tbody>
<tr>
<td>Arkansas, Louisiana (Medicare Part B)</td>
<td>August 13, 2012</td>
</tr>
<tr>
<td>Arkansas, Louisiana, Mississippi (Medicare Part A)</td>
<td>August 20, 2012</td>
</tr>
<tr>
<td>Mississippi (Medicare Part B)</td>
<td>October 22, 2012</td>
</tr>
<tr>
<td>Colorado, New Mexico, Oklahoma, Texas, WPS Providers (Medicare Part A)</td>
<td>October 29, 2012</td>
</tr>
<tr>
<td>Colorado, New Mexico, Oklahoma, Texas (Medicare Part B)</td>
<td>November 19, 2012</td>
</tr>
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**The OIG Semiannual Report to Congress Released**

The OIG Semiannual Report to Congress keeps the Secretary of the Department of Health & Human Services and Congress informed about OIG's most significant findings, recommendations, and activities for specific 6-month periods. Historically, about 80 percent of OIG's resources are directed to work related to Medicare and Medicaid. The spring edition of the Semiannual Report to Congress covers October 1, 2011 to March 31, 2012.

For the first half of FY 2012, the OIG reported:
- expected recoveries of about $1.2 billion consisting of $483.1 million in audit receivables and $748 million in investigative receivables (which includes $136.6 million in non-HHS investigative receivables resulting from work in areas such as the States' shares of Medicaid restitution);
- exclusions of 1,264 individuals and entities from participation in Federal health care programs;
- 388 criminal actions against individuals or entities that engaged in crimes against HHS programs;
- 164 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters.

**OIG Report: Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 13 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations**

The OIG found that Medicare overpaid some FY 2009 Jurisdiction 13 IRF claims that did not comply with transfer regulations. It was found that because NGS management did not communicate the CMS change request to its staff, NGS did not review the CWF edit alert reports notifying it that the miscoded claims required payment adjustment.
Accordingly, NGS did not respond appropriately to the CWF edit alerts, and it incorrectly paid 60 transfer claims as discharges. As a result, Medicare overpaid 26 IRFs by $413,445 for FYs 2008 and 2009. The OIG recommend that NGS: recover $413,445 in overpayments, ensure that it receives and properly addresses future CWF edit alerts in a timely manner, and educate Jurisdiction 13 IRFs on the importance of reporting the correct patient status code on transfer claims.

**OIG Report: Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters**

Due to Federal regulations requiring that Medicare- and Medicaid-certified nursing homes have written emergency plans and provide employees with emergency preparedness training, the OIG conducted a study to assess emergency preparedness and response of nursing homes that experienced more recent disasters. They analyzed national survey data to determine compliance with Federal regulations, conducted site visits to 24 selected nursing homes that experienced floods, hurricanes, and wildfires in 2007-2010, interviewed nursing home administrators and staff, local emergency managers, and representatives from State LTC ombudsman programs and SAs, and compared the emergency plans of each selected nursing home to the CMS checklist for health care facilities.

The OIG study found that most nursing homes nationwide met Federal requirements for written emergency plans and preparedness training. However, they identified many of the same gaps in nursing home preparedness and response that were found in their 2006 report:

- Emergency plans lacked relevant information—including only about half of the tasks on the CMS checklist.
- Nursing homes faced challenges with unreliable transportation contracts, lack of collaboration with local emergency management, and residents who developed health problems.
- LTC ombudsmen were often unable to support nursing home residents during disasters; most had no contact with residents until after the disasters.
- SAs reported making some efforts to assist nursing homes during disasters, mostly related to nursing home compliance issues and ad hoc needs.

As a result of the study findings, the OIG made three recommendations to CMS and one recommendation to the Administration on Aging (AoA). CMS agreed with the OIG’s recommendations to revise Federal regulations to include specific requirements for emergency plans and training, update the State Operations Manual to provide detailed guidance for SAs on nursing home compliance with emergency plans and training, and promote use of the checklists. AoA agreed with the OIG recommendation to develop model policies and procedures for LTC ombudsmen to protect residents during and after disasters.

**OIG Report: Obstacles to Collection of Millions in Medicare Overpayments Audit**

The OIG released an article detailing the results of their audit of overpayment collections made by the Centers for Medicare and Medicaid Services (CMS) during fiscal years 2007 and 2008, as well as the first half of fiscal year 2009. The OIG found that as of October 8, 2010, of the 154 OIG audit reports with sustained overpayment amounts totaling $416.3 million, CMS reported collecting $84.2 million. Of the $84.2 million, CMS reported collecting the full sustained amounts totaling $83.3 million for 113 reports and partial amounts totaling $896,000 for 8 reports. However, for various reasons, CMS did not collect the remaining $332.1 million. CMS' collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate guidance for collecting overpayments and did not have an effective system for monitoring its contractors' collection efforts.

Furthermore, the OIG could not verify the $84.2 million that CMS reported collecting, and the OIG identified inaccuracies in the reported amount. These issues arose because CMS did not have adequate systems for (1) documenting overpayment collections identified in OIG audit reports or (2) detecting data entry errors. Therefore, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

The OIG recommended that CMS:
(1) Pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments;
(2) Ensure that its Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations;
(3) Ensure that CMS staff record collections information consistently in ATARS;
(4) Collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law; (5) Verify that the $84.2 million reported as collected has actually been collected; and (6) Provide specific guidance to its contractors concerning the timeframe in which the contractor must take action to collect an overpayment, how to report collections, the type of documentation that the contractor must maintain to substantiate an overpayment collection, and how to report reasons for not collecting overpayments.

In response to the OIG’s recommendations CMS concurred with the second, third, and sixth recommendations, partially concurred with the fourth recommendation, and did not concur with the fifth recommendation.

OIG Report: Review of CERT Errors Overturned Through the Appeals Process for FY 2009 and FY 2010

An OIG report released March 2012 found that in FY 2009, 1,092 of the 2,060 appealed CERT claim payment denials were overturned, and for FY 2010, 1,557 of the 3,256 appealed CERT claim payment denials were overturned. The majority of appealed CERT claim payment denials that were overturned occurred during the first level of appeal. Providers appealed about 10 percent of denied claims in 2009, 16 percent in 2010, and 48 percent of those appealed were overturned. OIG says the overturned appeals were worth $6.1 million.

According to CMS officials, appeal decisions made after the cutoff period for determining error rates have not been reflected in past reported error rates. If CMS had included the overturned CERT claim payment denials that were discussed in this report in the Agency Financial Reports and Improper Medicare Fee-for-Service Payments Reports, the published error rates would have been reduced from 7.8 percent to 7.2 percent, or approximately $2 billion, for FY 2009 and from 10.5 percent to 9.9 percent, or approximately $2 billion, for FY 2010.

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.

HHS and Department of Justice Highlight Obama Administration Efforts & Health Reform Tools to Combat Medicare Fraud at the Seventh Regional Health Care Fraud Prevention Summit in Chicago

At the Seventh Regional Health Care Fraud Prevention Summit in Chicago in April, Health and Human Services (HHS) Secretary Kathleen Sebelius and Attorney General Eric Holder discussed how the Affordable Care Act and the Obama Administration’s Health Care Fraud Prevention and Enforcement Action Team (HEAT) are helping fight Medicare fraud. In fiscal year 2011, for the second year in a row, the departments’ anti-fraud activities resulted in more than $4 billion in recoveries, an all-time high, and strike force operations in nine locations charged a total of more than 320 defendants for allegedly billing more than $1 billion in false claims.

New tools provided by the Affordable Care Act are strengthening the Obama Administration’s efforts to fight health care fraud. As a result of Affordable Care Act provisions:

- Criminals face tougher sentences for health care fraud, 20-50 percent longer for crimes that involve more than $1 million in losses;
- Contractors that police the Medicare program for waste, fraud, and abuse will expand their work to Medicaid, Medicare Advantage, and Medicare Part D programs;
- Government entities, including states, the Centers for Medicare & Medicaid Services (CMS), and law enforcement partners at the Office of the Inspector General (OIG) and DOJ, have greater abilities to work together and share information so that CMS can prevent money from going to bad actors by using its authority to suspend payments to providers and suppliers engaged in suspected fraudulent activity.

The Obama Administration also announced more progress from its anti-fraud efforts, beyond the nearly $4.1 billion recovered last year:

- In the early phase of revalidating the enrollment of providers in Medicare, 234 providers were removed from the program because they were deceased, debarred or excluded by other federal agencies, or were found to be in false storefronts or otherwise invalid business locations;
- In 2011, HHS revoked 4,850 Medicaid providers and suppliers and deactivated 56,733 Medicare providers and suppliers as HHS took steps to close vulnerabilities in the Medicare program;
- In 2011, HHS saved $208 million through pre-payment edits that stop implausible claims before they’re paid;
Prosecutions are up: the number of individuals charged with fraud increased from 797 in fiscal year 2008 to 1,430 in fiscal 2011 – nearly a 75 percent increase;

In the first few weeks of enhanced site visits required under the ACA screening requirements, HHS found 15 providers and suppliers whose business locations were non-operational and terminated their billing privileges;

Through outreach and engagement efforts more than 49,000 complaints of fraud from seniors and people with disabilities reported to 1-800-MEDICARE were referred for further evaluation;

A recent re-design of the quarterly Medicare Summary Notices received by Medicare beneficiaries makes it easier to spot and report fraud.

Medicare Fraud Strike Force Charges 107 Individuals for Approximately $452 Million in False Billing

Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced on May 2, 2012 that a nationwide takedown by Medicare Fraud Strike Force operations in seven cities resulted in charges against 107 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $452 million in false billing. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in strike force history. HHS also suspended or took other administrative action against 52 providers following a data-driven analysis and credible allegations of fraud. The new health care law, the Affordable Care Act, significantly increased HHS’ ability to suspend payments until an investigation is complete. In addition to making arrests, agents also executed 20 search warrants in connection with ongoing strike force investigations.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services such as home health care, mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and ambulance services. According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, court documents allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided.

Dallas-based Tenet Healthcare Pays More Than $42 Million to Settle Self-Reported Improper Medicare Billing Related to Inpatient Rehabilitation Facilities

According to a press release April 10, 2012, Tenet Healthcare Corporation has agreed to pay the United States $42.75 million to settle allegations that it violated the False Claims Act by overbilling the Federal Medicare program. The settlement resolves allegations pertaining to the various inpatient rehabilitation facilities (IRFs) that Dallas-based Tenet has owned and operated throughout the country. The Justice Department alleged that, between May 15, 2005, and Dec. 31, 2007, Tenet improperly billed Medicare for the treatment of patients at its IRFs when, in fact, these patient stays did not meet the standards to qualify for an IRF admission. The settlement is the United States’ single largest recovery pertaining to inappropriate admissions to IRFs.

Occupational Therapy Assistant Sentenced For Medicare and Medicaid Fraud

United States Attorney Robert E. O’Neill announced May 9, 2012 that Patrick Timothy Crisler (46, Inverness) was sentenced to 30 months in federal prison for defrauding Medicare and Medicaid. The court also ordered Crisler to forfeit $455,537.30, which are proceeds traceable to his offense. Crisler pled guilty on March 5, 2012. According to court documents, Crisler, an occupational therapy assistant and owner of Active Life Rehab, Inc., was charged with health care fraud and aggravated identity theft for submitting fraudulent claims of more than $1 million to the Medicaid program. The claims submitted were for occupational therapy services that were either not provided at all, or not provided as billed to Medicaid. Specifically, Crisler falsified patient records and knowingly engaged in “upcoding” by using the unauthorized Medical Provider Numbers of other licensed occupational therapists to submit claims to Medicaid for payment to Active Life Rehab. Crisler also submitted false claims to Medicare. In total, he billed or caused Medicaid and Medicare to be billed approximately $1.5 million.
Co-Owners of Detroit-Area Physical Therapy Company Sentenced

The Department of Justice, the FBI and the Department of Health and Human Services (HHS) announced on May 17, 2012 that Fatima Hassan, co-owner of a Detroit-area physical therapy company, was sentenced to 48 months in prison for her leading role in a more than $1.9 million Medicare fraud scheme. In addition to her prison term, Fatima Hassan was sentenced to three years of supervised release and ordered to pay $855,484 in restitution. In addition, they announced on June 7, 2012 that Victor Jayasundera, Hassan’s co-owner, was sentenced to 30 months in prison, three years of supervised release and was ordered to pay $855,484 in restitution, joint and several with his co-defendants.

According to the plea documents, in 2005, Hassan incorporated a company known as Jos Campau Physical Therapy, which she owned with Jayasundera. Jos Campau Physical Therapy did not have a Medicare provider number and was not entitled to bill Medicare for therapy services. According to court documents, kickbacks were paid to recruiters who obtained Medicare beneficiary information and signatures needed to create fictitious physical and occupational therapy files. The Medicare beneficiaries pre-signed forms and visit sheets that were later falsified to indicate that they received therapy services that were never provided. Hassan and Jayasundera hired and paid an occupational therapist and an uncertified occupational therapy assistant to falsify medical files. The occupational therapist created patient evaluation forms for beneficiaries whom she had never met, seen or evaluated. The uncertified therapy assistant fabricated and signed patient notes for occupational therapy visits. The uncertified therapy assistant did not provide the services reflected in the fictitious patient notes. Additionally, Jayasundera, a physical therapist, falsified patient evaluation forms and fictitious patient notes for physical therapy services that were never rendered.

Hassan and Jayasundera sold the fictitious physical and occupational therapy files to multiple fraudulent therapy companies that had obtained Medicare provider numbers. Those companies billed the fictitious files created by Jos Campau Physical Therapy to Medicare and paid kickbacks to Jos Campau Physical Therapy based on these billings. Hassan and Jayasundera split the profits from the sale of the falsified files. It was admitted that, between approximately June 2005 and May 2007, Jos Campau Physical Therapy submitted or caused the submission of approximately $1.9 million in fraudulent claims to the Medicare program for physical and occupational therapy services that were never rendered.

Tariq Mahmud, the owner of a Medicare provider company that bought and billed Jos Campau Physical Therapy’s fake files, was convicted at trial on Feb. 2, 2012, for his role in the scheme and is scheduled to be sentenced on June 11, 2012.

Michigan Physical Therapist Pleads Guilty, Agrees to Pay More than $2 Million in Damages in Connection with Healthcare Fraud Scheme

The US Attorney’s office announced on May 30, 2012 that Chyawan Bansil, P.T., Ph.D., 60, of Farmington Hills, Michigan pled guilty before U.S. District Judge Robert to allegations that between February 2007 and January 2012, Dr. Bansil defrauded Medicare, Medicaid, and Blue Cross Blue Shield of Michigan by billing those programs, or causing those programs to be billed, for expensive nerve conduction studies and needle electromyography tests that Dr. Bansil did not perform. The government also alleged that Dr. Bansil laundered the proceeds of his fraud scheme by withdrawing funds from his individual and corporate bank accounts in the form of cashier’s checks, only to later redeposit those funds into bank accounts that Dr. Bansil controlled.

Along with a written plea agreement, Dr. Bansil will execute a settlement agreement and pay treble damages in the amount of $2,250,000 to resolve the government’s claims that Dr. Bansil defrauded Federal health care programs in violation of the civil False Claims Act. As part of his plea agreement, Dr. Bansil will pay an additional $350,000 in criminal restitution to Blue Cross Blue Shield of Michigan, forfeit $156,435.44 in seized funds, and file amended tax returns for 2008 through 2010. As a result of his guilty plea, Dr. Bansil will also be mandatorily excluded from participation in any Federal health care program for a period of at least five years. Dr. Bansil’s sentence will be imposed by Judge Bell on September 27, 2012. Health care fraud and money laundering are each punishable by up to ten years in prison, plus other penalties.

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