Evergreen Rehabilitation

Clinical and Compliance Bulletin

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2013 Quarter 3

## Coding Corner

### FAQ

**1. I have been reporting G codes during the testing period, do I just continue or do I need to do something different as of July 1?**

As of July 1, 2013, all those billing outpatient therapy services under Medicare Part B must begin or continue submitting functional limitation data (G-codes) for any beneficiary, or claims will be returned unpaid. Those providers who have submitted functional limitation data to the Centers for Medicare and Medicaid Services (CMS) prior to July 1 do not need to restart functional limitation reporting on the first date of service on or after July 1. Instead, for those patients only, therapists can wait to submit functional limitation data until the next required reporting interval (e.g., at the patient's 10th visit or at discharge).

**2. I have not been reporting G codes during the testing period, what do I need to do as of July 1?**

As of July 1, 2013, all those billing outpatient therapy services under Medicare Part B must begin or continue submitting functional limitation data (G-codes) for any beneficiary, or claims will be returned unpaid. For beneficiaries whose treatment began prior to July 1, but for whom functional limitation reporting information has not been submitted prior to July 1, therapists must submit data on the first claim with a date of service on or after July 1. In this case, the CMS claims processing system will open a new therapy reporting episode, and start counting to the next 10 treatment dates of service, starting with the first July 1-or-later claim containing the appropriate current and goal status G-codes and corresponding modifiers. Moving forward, therapists must submit functional limitation information for any new patients seen on or after July 1.

**3. I documented the G-codes and modifiers for the end of the primary functional limitation and those to begin the start of the second functional limitation in the progress report on 6/20/13. Is this acceptable or do the G-codes and modifiers for the second functional limitation need to be documented in the daily treatment note on the same day they are reported on the claim?**

Yes, you can document the G-codes and modifiers used to end the reporting period of the first (primary) functional limitation and those for the second functional limitation in the progress report. At the next treatment day, the therapist could simply note where the G-codes and modifiers for the second functional limitation are located in the medical record. For example, the therapist could document the following in the daily treatment note for 6/21/13: "The G-codes and modifiers used in today's functional reporting are found in the progress report dated 6/20/13."

**4. In the above scenario, could a therapy assistant furnish the therapy services on the day that the second functional limitation is reported on the claim, 6/21/13?**

Yes, the therapy assistant who furnished the services can report the G-codes and modifiers to begin reporting for a second functional limitation when a therapist previously determined the functional information.

**5. Do I need to end reporting of the current primary functional limitation when a new functional limitation develops, e.g. a new condition, before reporting on the second functional limitation?**

You need to end reporting on the first functional limitation by reporting the appropriate goal and discharge status codes before reporting on a second functional limitation can begin. Discharge reporting applies in all situations, except when the patient unexpectedly does not return to therapy and discharge information is not available.

**6. How do I report the functional information when I provide an evaluation only and determine that the patient does not need further therapy services?**

For one-time visits, you report all three G-codes for the functional limitation being evaluated, along with the corresponding severity modifiers for each.

**7. How do I report the functional limitation information on wound care patients?**

In some cases patients may be receiving therapy services when there is no functional limitation. A clinical example would be a patient receiving services for wound care in the absence of a functional limitation. In these cases, the therapist should select the "Other PT/OT Primary Functional Limitation" and select severity modifier CH (or 0% impaired, limited, or restricted) for the current status and the projected goal. Additional clinical examples that fit this scenario may be contracture, positioning and lymphedema treatment.

## Decoding CPT Codes

Each quarter we focus on decoding the mystery of a specific CPT code. This quarter we will focus on CPT code 97750, Physical Performance Test or Measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes.

Physical performance testing may be reasonable and necessary for patients with neurological, musculoskeletal, or pulmonary conditions. These tests and measurements are beyond the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE), Tinetti, or 6-minute walk test.

There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. It is not reasonable and necessary for the test to be performed and billed on a routine basis (i.e., monthly or instead of billing a reevaluation) or to be routinely performed on all patients treated. CPT code 97750 is not covered on the same day as CPT codes 97001-97004 (due to CCI edits). Supportive Documentation Requirements for 97750 includes:

- Problem requiring the test and the specific test performed
- Separate measurement report, including any graphic reports
- Application to functional activity
- How the test impacts the plan of care

# Keeping Straight on the Regulation Road

## Functional Limitation Reporting (G codes) for Medicare Part B Required July 1

As of July 1, 2013, all those billing outpatient therapy services under Medicare Part B must begin or continue submitting functional limitation data (G-codes) for any beneficiary, or claims will be returned unpaid. There are three scenarios that may occur as of July 1:

- Those providers who have submitted functional limitation data to the Centers for Medicare and Medicaid Services (CMS) prior to July 1 do not need to restart functional limitation reporting on the first date of service on or after July 1. Instead, for those patients only, therapists can wait to submit functional limitation data until the next required reporting interval (eg, at the patient's 10th visit or at discharge).
- For beneficiaries whose treatment began prior to July 1, but for whom functional limitation reporting information has not been submitted prior to July 1, therapists must submit data on the first claim with a date of service on or after July 1. In this case, the CMS claims processing system will open a new therapy reporting episode, and start counting to the next 10 treatment dates of service, starting with the first July 1-or-later claim containing the appropriate current and goal status G-codes and corresponding modifiers.
- Therapists must submit functional limitation information for any new patients seen on or after July 1.

Once the therapy reporting episode begins, per the 3 scenarios described above, nonpayable G-codes and modifiers must be included on claim forms to capture the beneficiary's functional limitation data:

(1) at the outset of the therapy episode,
(2) at each re-evaluation,
(3) no less frequently than every 10th visit, and
(4) at discharge.

## SNS PPS Proposed Rule for FY2014

The Centers for Medicare and Medicaid Services (CMS) SNF PPS Proposed Rule for FY2014 includes a market basket increase of 2.3%. However, due to a "forecast error correction" and other mandated adjustments, the payment rate would actually increase 1.4% next year. This would increase total Medicare reimbursements to skilled nursing facilities by $500 million in 2014.

The Proposed Rule also includes a new Minimum Data Set item that would record how many "distinct calendar days of

therapy" a beneficiary receives across all types of rehabilitation during the seven-day look-back period.

## OIG Issues Spring 2013 Semiannual Report to Congress

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) Semiannual Report to Congress describes significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. The Spring Semiannual Report addresses work completed during the first half of fiscal year (FY) 2013 (October - March) and provides summary data on key accomplishments during the period and for the year. The full report is available at http://oig.hhs.gov/reports-and-publications/archives/semiannual/2013

## HHS Issues Revised Self Disclosure Protocol April 2013

The Department of Health and Human Services Office of Inspector General issued a revised Self-Disclosure Protocol (SDP). The revisions mark the first time the agency has explicitly acknowledged systematically imposing lower penalties for self-reported fraud. As a general practice, OIG requires a minimum multiplier of 1.5 times the single damages, but the agency may use a higher multiplier depending on the circumstances of a case, according to the updated guidelines.

Providers who self-disclose fraud generally do not have to submit to corporate integrity agreements as part of a settlement with OIG. Since 1998, only one SDP settlement out of 235 has involved an integrity agreement, OIG stated in the protocol.

The new protocol

- changed the timeframe in which self-reporting providers must submit findings from an internal investigation and a calculation of damages. Previously, providers had 90 days from the time of acceptance into SDP, and they now have 90 days from the date of submission
- lists the specific requirements for all self-disclosures, with sections devoted to cases of false billing, anti-kickback violations and conduct of persons excluded from federal health programs
- stresses that the SDP is meant only for resolving cases of law-breaking, and is not a way to report errors or non-fraudulent overpayments.

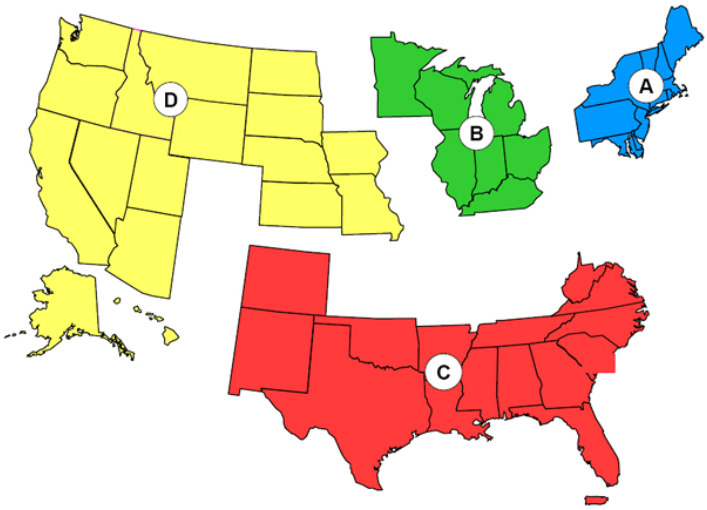
## OIG Issues Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs

Providers can now refer to newly updated government guidelines on hiring or contracting with people excluded from participating in federal health programs. Certain individuals, such as those convicted of healthcare fraud and abuse, are excluded from participating in federal health programs such as Medicare and Medicaid. Since the 1999 guidelines on exclusion came out, OIG's authority in this area has been modified and expanded by legislation such as the Affordable Care Act. The guidelines state "The effect of an OIG exclusion is that no federal healthcare program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person."

Providers should be aware that they face potential fines and removal from the Medicare and Medicaid programs if an excluded person is providing goods or services at the facility. This includes items or services unrelated to direct patient care, including in administrative, health information technology and human resources roles. Even a temporary worker or a volunteer is not allowed to be an excluded person.

For the first time, the guidelines include a recommended timeframe for checking the List of Excluded Individuals and Entities online database. Providers are encouraged to check the LEIE monthly to limit their potential liability, and to use the OIG self-reporting process if any issues are discovered.

## RAC Update




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

| Issue | Description | RAC |
|---|---|---|
| Manual Medical Review of Outpatient Therapy Claims Above the $3700 Threshold | Manual Medical Review of Outpatient Therapy Claims Above the $3700 Threshold (pre-pay or post-pay based on state) | A, B, C, D |
| SNF Psychiatric Condition/Level of Care | Patients with only a psychiatric condition who are transitioned from a psychiatric hospital to a participating SNF are likely to receive only non-covered care. Also patients whose primary condition/needs are psychiatric in nature often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs (SNFs primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare) | A, B, C |
| Untimed Codes | Untimed codes maximum units = 1 | A, B, C, D |
| SNF Unrelated to Terminal Condition | A hospice beneficiary certified as having a terminal illness with a life expectancy of 6 months or less waives all rights to Medicare payment for services related to the terminal condition. Services unrelated to the terminal condition may still be payable and are | B |
| SNF Consolidated Billing | Services are being billed separately that should be included in the SNF consolidated billing. Consolidated billing is when services provided during the resident's stay in a SNF are bundled into one package and billed by the SNF. Under consolidated billing requirements a SNF itself must submit all Medicare claims for the services that its residents receive (except for specifically excluded services) | B, D |
| Units in Excess of PPS Assessment Maximum | Medicare assigns standard scheduled payment periods for SNF assessment. Overpayment occurs when additional units in excess of assessment maximums are billed. | C |
| SNF Coding Validation | Claims submitted by SNFs will be reviewed to determine the extent to which the MDS is accurate and supported by the resident's medical records. Upon receipt of the requested documentation, the entire benefit period will be reviewed to determine the appropriate level of care (medical necessity will not be included in the review). | C |
| Excessive units SNF 14 day assessment | The 14 day Medicare MDS assessment authorizes coverage and payment for a maximum of 16 days. | D- MAC J1 |
| Excessive units SNF 30 day assessment | The 30 day Medicare MDS assessment authorizes coverage and payment for a maximum of 30 days. | D-MAC J1 |
| Excessive units SNF 60 day assessment | The 60 day Medicare MDS assessment authorizes coverage and payment for a maximum of 30 days. | D-MAC J1 |
| SNF Medical Necessity | SNF stays will be reviewed for documentation of covered SNF services that are medically reasonable and necessary | D |

*RAC Related Bills and Response*

As of April 15, the 35-record minimum request has been decreased to 20 records in a 45 day period. Also effective April 15, RACs who are auditing a campus will be able to select only 75% of any single claim type for review, down from 100%. CMS defines a campus as one or more facilities that are located in the same area and use the same Tax Identification Number. For example, under the new regulation, 75% of a document request could be skilled nursing claims, while the additional 25% of records would have to come from other claim types, such as inpatient rehabilitation.

The calculation for determining the limit on RAC additional document requests remains the same: 2% of all claims a facility submitted in the previous calendar year, divided by eight. For SNFs, one additional document request applies to a resident's entire episode of care, meaning the provider will have to furnish all the medical records from admittance to discharge.

A bill introduced in the House of Representatives (HR. 1250) and in the Senate (S. 1012), the *Medicare Audit Improvement Act of 2013*, would establish further limits on records requests. A similar bill introduced last fall in both the House and Senate died in committee. The *Medicare Audit Improvement Act of 2013* has been sent to committee. The bill would rein in auditors and improve transparency, which have been provider concerns. The goal is for less redundant audits, less burdensome and unreasonable requests for records and less inappropriate payment denials. The bill:

- Directs the Secretary of Health and Human Services (HHS) to establish a process which subjects to a single, combined maximum annual limit, applied incrementally, the number of additional documentation requests made to a hospital by Medicare administrative contractors, recovery audit contractors, or Comprehensive Error Rate Testing (CERT) program contractors pursuant to prepayment and postpayment audits requiring a hospital to submit a medical record for audit purposes.
- Directs the Secretary also to establish a distinct additional documentation request limit, computed according to a specified formula, for each hospital claim type for each hospital for a 45-day period in a year.
- Amends title XVIII (Medicare) of the Social Security Act with respect to the Medicare Integrity Program and use of recovery audit contractors.
- Requires the Secretary to ensure that recovery audit contracts include certain mandatory terms and conditions pertaining to:
  (1) penalties for certain compliance failures,
  (2) penalties for overturned appeals,
  (3) postpayment and prepayment audits, and
  (4) guidelines for prepayment review.
- Directs the Secretary to publish on the Internet website of the Centers for Medicare & Medicaid Services information on recovery audit contractor performance regarding:
  (1) audit rates, denials, and appeals outcomes, and
  (2) independent performance evaluations.
- Deems to be an original claim for Medicare part B (Supplementary Medical Insurance) payment a resubmitted hospital claim for Medicare part A payment for inpatient hospital services which a recovery audit contractor determines:
  (1) were not medically necessary and reasonable based on the site of service, but
  (2) would be medically necessary and reasonable in an outpatient setting of the hospital.
- Requires payment to be made for such a resubmitted claim for all furnished items and services for which payment may be made under Medicare part B. Deems to be a reopened claim, for purposes of a hospital's ability to resubmit a claim for Medicare payment in timely fashion, any claim that is the subject of an audit by a recovery audit contractor or a Medicare administrative contractor.
- Requires contracts for a recovery audit contractor to require that a physician review each denial of a claim for medical necessity made by an employee of the contractor who is not a physician.
- Subjects to administrative and judicial review the Secretary's compliance with guidelines for reopening and revising benefit determinations.

The American Coalition for Healthcare Claims Integrity, a group representing RACs, has sharply criticized the two bills that would put new controls on Recovery Audit Contractors. In a statement released by the American Coalition for Healthcare Claims Integrity, a group representing RACs, said the bills would "hamstring" the auditors and allow waste, fraud and abuse to proceed unchecked citing that Medicare improperly paid out more than $65 billion in 2012. The next day, the American Hospital Association released its RACTrac Survey for the first quarter of 2013. Medical records requests were up 53% year-over-year, the survey showed. Hospitals appealed 44% of RAC denials, with a 72% success rate.

## Bipartisan Legislation Introduced in Senate: The Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2013 (PRIME)

*The Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2013* proposes a variety of reforms to cut down on waste, fraud and abuse. The PRIME Act was introduced by Sens. Tom Carper (D-DE) and Tom Coburn (R-OK), and Reps. John Carney (D-DE) and Peter Roskam (R-IL). The Centers for Medicare & Medicaid Services should move faster to make changes based on Medicare audits and should have more direct oversight over Medicaid, according to bipartisan legislation. If PRIME passes, CMS would be less dependent on contractors for program oversight. The agency would be funded to hire more full-time staff dedicated to Medicaid integrity, to cultivate more "in-house program integrity expertise." CMS also would face increased pressure to act more quickly and effectively on reports from Recovery Audit Contractors about vulnerabilities leading to improper payments. The 2012 error rate for the Medicare fee-for-service program was 8.5%, which equaled nearly $30 billion in improper payments, according to the legislation. Department of Defense reimbursement contractors are liable for any amount exceeding a 2% error rate, and the PRIME Act proposes a similar system for Medicare Administrative Contractors. "The plan may include a sliding scale of bonus payments and additional incentives for MACs that reduce their error rates to certain benchmark levels and may include substantial reduction in payments under award fee contracts, for MACs that reach certain error thresholds," according to the draft legislation. Other PRIME provisions include: beefing up Medicare fraud education for seniors and increasing whistleblower rewards; requiring National Provider Identifiers on pharmacy claims; and improving data sharing protocols.

## Minimum Data Set Information Identifying Providers Will Be Shared with Health Plans to Fight Fraud

In accordance with the requirements of the Privacy Act of 1974 (5 U.S.C. 552a), CMS is adding a new routine use to twenty-three CMS systems of records to assist in preventing and detecting fraud, waste and abuse. The new routine use will authorize CMS to disclose provider and beneficiary-identifiable records to representatives of health plans for the purpose of preventing and detecting fraud, waste and abuse, pursuant to section 1128C(a)(2) of the Social Security Act ("the Act").

Disclosures made pursuant to the routine use will be coordinated through CMS' Data Sharing and Partnership Group, Center for Program Integrity, CMS. CMS has identified twenty-three systems that contain the data potentially necessary to disclose to health plans for the prevention and detection of fraud, waste and abuse. The MDS is one of 23 records systems that would be affected by the new "routine use" defined by CMS.

## CMS Crackdown Doubles Providers and Suppliers Removed from the Medicare Program

The Centers for Medicare & Medicaid Services has removed 14,663 healthcare providers and suppliers from the Medicare program in the last two years. The figure more than doubles the number of removals from the prior two-year period. The statistics do not break down removals by provider type. The agency has revoked Medicare eligibility because providers are not in compliance with rules, are not operating from the address on file, or because of felony convictions.

In 18 states, the number of Medicare revocations has quadrupled since the healthcare reform law took effect, according to CMS. The number of states with more than 600 revocations went from three to six, with New York, Ohio and Pennsylvania joining California, Texas and Florida.

## Update to the Medicare Claims Processing Manual Provides Detailed Instructions for Provider Responsibilities for Expedited Review of Medicare Service Termination

Beneficiaries can appeal to a Quality Improvement Organization (QIO) when certain long-term care providers, including skilled nursing facilities and hospices, notify them that services will no longer be covered by Medicare. In a May 24, 2013 update to the Medicare Claims Processing manual, CMS provided detailed instructions regarding these expedited determinations, identifying the following four responsibilities for providers:

- Deliver a Detailed Explanation of Non-coverage (DENC) to the beneficiary within 24 hours of being notified by a QIO of the request for expedited determination.
- Provide the QIO with the DENC and the Notice of Medicare Non-Coverage (NOMNC) by end of business on the day when notification of the expedited determination is received.
- Furnish all requested information, including medical records, to the QIO, keeping written records of the

transmittal if the information is shared via phone
- Provide the beneficiary access to all documentation given to the QIO upon request. These documents must be transmitted to the beneficiary by the end of business on the first day after the material is requested.

The Medicare Claims Processing manual update includes further details about who qualifies for an expedited determination, what should be included in the DENC and the NOMNC, and how deliveries of documents should be made.

## 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.

### June 2013 MedPAC Report to Congress Recommends Cuts to Outpatient Therapy Services

MedPAC is an independent Congressional agency tasked with advising Congress on Medicare reimbursement policy and analyzing access to care, quality of care, and other issues affecting Medicare. The Middle Class Tax Relief and Job Creation Act of 2012 mandated that MedPAC recommend payment reform for outpatient, Part B therapy services. MedPAC was required to consider the payment based on the patient's condition and to examine private sector initiatives regarding therapy services.

The June 2013 report fulfills the biannual requirement for MedPAC to advise Congress regarding Medicare payment across all services. Chapter 9, Mandated Report: Improving Medicare's payment system for outpatient therapy service, specifically addresses all therapy services: speech-language pathology, physical therapy, and occupational therapy. The recommendations are considered by Congress for future legislation regarding the therapy cap and therapy services and utilized by CMS in regulatory changes. The recommendations are not statute or policy and include the MedPAC commissioner's estimations of the implications for federal spending, patient access, quality, and health care delivery reform. Congress and CMS are not required to enact recommendations from MedPAC.

In its June 2013 Mandatory Report to Congress, MedPAC made the following recommendations related to Outpatient Therapy Services:

- reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and
- develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.
- reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index.
- direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose.
- permanently include services delivered in hospital outpatient departments under therapy caps.
- apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.
- prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and
- collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.

### CGS Probe Medical Review for OH: Resource Utilization Group (RUG) Code RUB10

The J15 Part A Medical Review department will implement a service specific probe edit for type of bill (TOB) 21X for RUG code RUB10. Approximately 100 claims will be reviewed as part of this probe review. RUB10 represents ultra high therapy (720+ minutes) with an ADL score of 6-10 for the 5 day scheduled PPS assessment.

## CGS Probe Medical Review for KY and OH: Resource Utilization Group (RUG) Code RUC10

The J15 Part A Medical Review will implement a service specific probe edit for type of bill (TOB) 21X for RUG code RUC10. Approximately 100 claims will be reviewed as part of this probe review. RUC10 represents ultra high therapy (720+ minutes) with an ADL score of 11-16 for the 5 day scheduled PPS assessment.

## CGS to Require Additional Documentation to Add a KX Modifier

Effective June 20, 2013, Cigna Government Services, Medicare Administrative Contractor in the states of Kentucky and Ohio, will require additional documentation be included with all Reopening requests that are being submitted for the purpose of adding a KX modifier to a therapy claim. The documentation may include but is not limited to: treatment plans, history and physicals, progress notes, consult notes and reports. After this date, if the documentation is not included with the reopening request, the claim cannot be processed for an adjustment.

## WPS CERT Findings: Outpatient Rehabilitation Therapy Services Treatment Plan Certification

WPS Medicare recently noted CERT findings for physical therapy services because the initial certification plan of care or recertification was not signed by the physician/non-physician practitioner (NPP). Medicare regulations regarding initial certification and recertification of the plan of care state:

- Timely certification of the initial plan of care is met when the physician/NPP certification of the plan of care is documented, by signature or verbal order, and dated within 30 days following the first day of treatment (including evaluation). Verbal orders must be followed within 14 days by a signature and date.
- Recertification documenting the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan of care becomes evident, or at least every 90 days after initiation of treatment under the plan of care, unless the certification is delayed. Recertification is required sooner when the duration of the plan of care is less than 90 days.

## Therapy Caps, Liability, and the Advance Beneficiary Notice of Noncoverage (ABN)

Section 603 (c) of the American Taxpayer Relief Act (ATRA) amended §1833(g)(5) of the Social Security Act (the Act) to provide limitation of liability (LOL) protections (See §1879 of the Act) to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. Now, the provider/supplier must issue a valid, mandatory ABN (CMS-R-131) to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. The ABN informs the beneficiary why Medicare may not or won't pay for a specific item or service and allows the beneficiary to choose whether or not to get the item or service and accept financial responsibility. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Medicare would like to caution providers against issuing the ABN to all beneficiaries who have exceeded the cap. The ABN should only be issued before providing services above the cap when the therapy coverage exceptions process isn't applicable. Issuing the ABN to all beneficiaries who have exceeded the cap would be in violation of the routine notice prohibition.

## Detroit-Area Home Health Agency Owner and Physical Therapist Convicted in $2.3 Million Medicare Fraud Scheme

A federal jury in Detroit convicted a home health agency owner and a physical therapist for their participation in a $2.3 million Medicare fraud scheme on April 2, 2013. Mehran Javidan, 52, was found guilty in U.S. District Court for the Eastern District of Michigan of one count of conspiracy to commit health care fraud, three counts of health care fraud, three counts of making false statements related to health care matters, and one count of conspiracy to solicit or pay health care kickbacks in exchange for referrals of patients to a Detroit-area home health care company, Acure Home Care Inc. Vishnu Meda, 32, a physical therapist, was found guilty of one count of conspiracy to commit health care fraud, two counts of health care fraud and two counts of making false statements relating to health care matters.

According to evidence presented at trial, Javidan owned and operated Acure Home Care Inc., a home health care company in Oak Park, Mich., and later Troy, Mich. As shown at trial, Javidan paid doctors to refer non-homebound patients for physical therapy treatment and also paid patient recruiters to obtain Medicare information and pre-signed physical therapy documents from Medicare beneficiaries. The recruiters for Acure obtained the Medicare information and pre-signed forms by paying patients in cash and by promising that the referring doctors would prescribe them narcotic prescriptions. Evidence presented at trial established that Meda and other physical therapists and physical therapy assistants employed by Acure created false and fraudulent physical therapy files using the blank, pre-signed forms to make it appear as if physical therapy services were actually rendered, when, in fact, the services had not been rendered.

## OIG Report: Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services

The OIG released a report detailing their findings in an audit of therapy claims submitted by Spectrum Rehabilitation. Of the 100 claims in the random sample, 17 claims were paid and 83 denied resulting in an overpayment of $3,112,501. A primary denial reason was "certification requirements were not met." Below is detail on the denials:

For 45 claims, Medicare physician certification requirements were not met.

- Services were not certified in a timely manner. For 33 claims, services were not certified by a physician or non-physician practitioner when obtained or within 30 days of the first treatment (31 claims) or during the duration of the initial plan or within 90 days of the initial treatment under that plan (2 claims).
- Physician certifications of initial plans were not dated. For 11 claims, certifications were signed by a physician or non-physician practitioner but were not dated.
- Services were not certified. For one claim, services were not certified (i.e., there was no dated physician or non-physician signature on the plan).

For 36 claims, the treatment notes maintained by Spectrum did not meet Medicare requirements.

For 35 claims, the therapist who billed Medicare did not perform or supervise the service.

For 21 claims, the therapy services were not medically necessary.

For 4 claims, the plan did not meet Medicare requirements.

The OIG recommended that Spectrum:
(1) refund $3.1 million to the Federal Government;
(2) strengthen its policies and procedures to ensure that outpatient therapy services are provided and document ed in accordance with Medicare requirments; and
(3) obtain a better understanding of the Medicare reimbursement requirements related to outpatient therapy services, through such means as attending provider outreach and education seminars.

## Straw Owner of Venice Physical Therapy Clinic Pleads Guilty to Conspiracy to Commit Health Care Fraud

United States Attorney Robert E. O'Neill announced that Roberto Fernandez Gonzalez pleaded guilty June 20, 2013 to conspiracy to commit health care fraud. Gonzalez faces a maximum penalty of 10 years in federal prison. According to the plea agreement, from January 16, 2008 through at least March 31, 2008, Gonzalez conspired with various individuals to execute a scheme to defraud Medicare. During the course of this conspiracy, Gonzalez functioned as the nominee (straw) owner of Rehab Dynamics Inc. (Rehab Dynamics), a physical therapy clinic located in Venice, Florida. Gonzalez had no background in the health care industry, nor did he have money to buy Rehab Dynamics. Rather, the conspirators paid Gonzalez more than $20,000 to serve as the straw owner of Rehab Dynamics as a sham. During the three months that Gonzalez served as the nominee owner of Rehab Dynamics, the conspirators submitted approximately $1,633,512.21 in fraudulent claims for reimbursement to Medicare. Ultimately, Medicare paid $446,738.85 of those false claims.

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