Questionable Billing Practices for Medicare Outpatient Therapy Services

An editorial view of the Office of Inspector General's Report on provision of Therapy services in the Outpatient setting in 2009.

Late in December of 2010, the OIG issued 2 reports, one on services provided in the outpatient (OPT) setting and the other in the Part A SNF setting. This article addresses the OPT findings along with editorial comments.

The cost of providing Medicare Part B outpatient therapy services has grown at a massive 133% from 2000 to 2009 whereas the Medicare population has only grown by a relatively small 26%. What does this indicate to the government. Well we know that Medicare fraud and abuse has been a chosen course for many therapy providers. The creation of the HEAT (Health Care Fraud Prevention and Enforcement Action Team) program to combat Fraud and Abuse has resulted in a dramatic return of funds to the Medicare Trust Fund, more than $3 billion of our money. The fraud squads are a combination of the FBI and the DOJ and started in 2009 in ***South Florida (Miami-Dade), and Los Angeles*** have now expanded to ***Baton Rouge, Brooklyn, Detroit, Houston and Tampa Bay***, These program will continue to expand as the cost of Medicare continues to grow and especially with the addition of the baby boomer to the Medicare population.

What was of interest in the report was that, although the LA area was one of the first areas targeted for HEAT, in comparison to Miami-Dade, their utilization, while higher than the national average, was significantly lower than Miami-Dade.

Here is a synopsis of the findings.

Based on data collection and comparison, 20 counties in the US were identified that, in 2009, had provided

1) the highest average Medicare payments per beneficiary, and

2) had services that produced more than $1 million in total Medicare payments, i.e. high utilization counties.

Out of these 20 counties, Miami-Dade was separately analyzed as it had more than 3 times the national average for 5 out of the 6 criteria for investigation. The other counties were analyzed together and had at least 2 times the national average for 1 or more of the 6 criteria. The 19 counties consisted of 6 counties in Louisiana, 4 in Texas, 3 in Mississippi, 2 in Indiana, 2 in New York, 1 in Georgia plus one more in Florida. [1] Medical Necessity was not assessed as part of this investigation.

Triggers for further investigation on data mining and analysis were based on billing practices that <u>may</u> indicate fraudulent activity:

1. Services for which providers indicated that the annual cap would be exceeded.[2]

2. Providers that indicated cap would be exceeded on the first date of service in the calendar year.[3]

3. Payment for services received from multiple providers.[4]

4. Payment for services provided throughout the year, all four quarters.

5. Payment for services above the cap.[5]

6. Providers who were paid for more than 8 hours of therapy in a day.

Now for the details in Miami-Dade

Per beneficiary annual spending was more than 3 times the national average: $3459 vs. $1078

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[1] See end of this report for the actual counties.

[2] We know that this is already being looked at by the Medicare Contractors as probe reviews are already in process in some areas.

[3] CMS has always indicated that the KX modifier should only be added when the cap is getting close to being met and not before.

[4] Although some areas of the country are noted for "snowbird migration", this trigger was based on multiple providers both in the same county and other counties. This could be an indicator of a stolen or purchased Medicare number. One of the most active modes of fraud is the payment to a beneficiary to use their Medicare number for billing of multiple services. In 2009, a Detroit area provider billed over $18 million in charges for PT and OT services that were never provided,

[5] This is conjunction with other triggers as most providers will, at some point, exceed the cap with some patients but not with every patient.

Each beneficiary received an average of 153 services (service equals one billable unit), national average 49 services

Providers were paid an average of $83,867 compared with $10,131 nationally (8 times the national average)

Providers averaged 3828 services compared with 458 services nationally (8 times the national average)

AND

Had at least 3 times the national average for 5 out of the 6 triggers.

The other 19 counties had

Overall per beneficiary spending 72% above national average; per beneficiary payment $1852 vs. $1078.

Twice the national average on 5 out of 6 triggers and each county had at least 2 times the national average for 1 or more triggers.

Interestingly, although these counties combined had lower levels of for 4 of the 6 characteristics but were higher in the other two. Those two areas being a) the number of patients who received therapy throughout the year and b) those beneficiaries that received over 8 hour of therapy in a day.

In 11 of the counties, the number of beneficiaries that received more than 8 hours was more than twice the national overage, and in 8 of those 11 counties at least 5% of the beneficiaries received more than 8 hours - 7 times the national average. What interests me is that this obvious overprovision of services never raised a concern with the Medicare Contractors. With some having edits in place for what appears in comparison to be minor "errors", it would appear to be an easy matter to place an edit for more that 8 units in a day.(FYI, Trailblazer now has an edit of no more than 4 units a day or 60 units in a month).

For counties identified as providing therapy throughout the year, both Kings and Queens in NY won the award with 16.8% and 14.6% respectively with Miami -Dade coming in third with 9.7%. The rest of the counties posted a modest 2% to 4% utilization. The appendix from the report is attached at the end of this report.

What can we learn from the OIG report?

We know that the oversight is only going to continue to grow. Medicare is becoming the "fraud de jour" for many as it has been easy to do and the penalties, if caught, have been minimal compared with other types of illegal activity.

The recommendation made by the OIG and concurred with by CMS were:

1). Target OPT claims in high-utilization areas for further review by monitoring trends in billing practices.

2). Target OPT claims with questionable billing practices by monitoring claims

3). Review geographical areas and providers with questionable billing practices prior to payment and suspend payment if suspected fraudulent claims are submitted

4). Revise the current cap exception process, consider developing per-beneficiary edits and maximum payment amounts to control over-utilization

CMS indicated that they had already instituted complex reviews by both the MACs and Program Safeguard Contractors. Specific areas already identified and under investigation were New York and Texas, the HEAT task forces from Brooklyn and Houston were already working with the Contractors. First Coast Service Options, the MAC for Florida, had already initiated pre-payments edits for claims in the Miami area and is looking at this edit for other contractors in order to lower the high utilization of services.

What should we do based on this report?

We are aware that the Medicare cap is flawed and penalizes Physical Therapists and Speech-Language Pathologists unfairly due to the shared cap. Until CMS implements its new payment system in 2013 we are probably going to be facing the same problems. The use of the exception process allows us to provide services to the patient who needs more treatment due to co-morbidities and other conditions, it should certainly not be something that is used on every patient, just because we can.

My recommendations are to make sure you and your staff:

1. Are aware of the Medicare coverage guidelines and your local coverage determinations from your Medicare Contractor.

2. Are aware that payment under the Medicare system is for Medically Necessary services to bring the patient back to their prior level of function or safety level within their home environment. It is not there to pay for them to play golf, go dancing or even get back to work.

3. Educate the patient on what Medicare will and will not cover and remember, just because the physician orders it doesn't mean that Medicare is going to pay for it.

4. Understands that 2 to 3 months of treatment for the *average patient* is not the norm, especially patients who are living in assisted living facilities. Remember, prior level of function must be clearly identified and goals for them to function at the same level safely within their environment should be established.

5. Realize that Medicare will pay for updating of home programs for the patients who have a progressive debilitating diseases but this is not 3 weeks of treatment every 3 months.

6. Document according to Medicare's guidelines found in the Coverage Manual to clearly demonstrate medical necessity and skilled care.

And Finally!

Not sure if you are up to date with the Medicare guidelines and documentation standards and if you would withstand review? Then plan on attending our live workshops or think about having customized training for your staff.

A copy of the OIG report can be found on our website in the Guidelines and Resource section (formerly Items of Interest) in the OPT section

High Utilization Counties:

New York: Kings and Queens

Indiana: DeKalb and Dubois

Louisiana: St Mary; Avoyelles; Ouachita; Lincoln; Acadia and Iberia

Texas: Rusk; Liberty; San Patricio and Angelina

Georgia: Thomas

Mississippi: Lauderdale, LeFlare and Warren

Florida: Okeechobee and Miami-Dade

APPENDIX ~ B

Questionable Billing Characteristics for 20 High-Utilization Counties, Compared to National Levels

			Questionable Billing Characteristics						
County/Parish	Average Payment per Beneficiary	Total Medicare Payments	Average Number of Services Billed With KX Modifier per Beneficiary	Percentage of Services Billed With KX Modifier on First Date of Service per Beneficiary	Average Payment for Beneficiaries Who Received Services From More Than One Provider	Percentage of Beneficiaries Receiving Services Throughout the Year	Percentage of Beneficiaries Exceeding Annual Cap	Percentage of Beneficiaries With More Than 8 Hours of Service in a Single Day	Number of Questionable Billing Characteristics at Least Twice the National Level*
National	$1,078	$4,922,328,414	14	4.9%	$1,670	3.1%	21.6%	0.7%	NA
Miami-Dade, FL	$3,459	$159,180,288	**60**	**20.2%**	**$5,664**	**9.7%**	**63.0%**	0.3%	5
St. Mary, LA	$2,343	$1,571,955	**48**	7.2%	$2,365	2.7%	35.3%	**6.1%**	2
Avoyelles, LA	$2,054	$1,244,468	**43**	**10.2%**	$2,103	2.6%	39.1%	0.5%	2
Leflore, MS	$2,031	$1,062,159	**45**	6.9%	$1,773	3.4%	29.6%	0.6%	1
Okeechobee, FL	$2,026	$1,616,424	17	4.9%	**$4,301**	4.0%	38.2%	0.3%	1
Kings, NY	$1,972	$79,973,326	**41**	**9.8%**	**$3,361**	**16.8%**	40.7%	0.3%	4
Rusk, TX	$1,890	$1,124,662	**52**	**16.6%**	$1,785	3.4%	30.1%	**6.2%**	3
Lauderdale, MS	$1,814	$2,368,575	**39**	**15.0%**	$2,883	2.7%	27.9%	**5.8%**	3
Liberty, TX	$1,807	$1,442,333	**51**	**15.0%**	$2,394	2.6%	27.8%	**5.8%**	3
Warren, MS	$1,791	$1,296,449	**37**	4.3%	$3,201	3.7%	38.0%	1.0%	1
Ouachita, LA	$1,749	$3,255,832	**32**	6.9%	$2,307	3.3%	31.8%	**5.0%**	2
Thomas, GA	$1,747	$1,864,483	**45**	7.6%	$2,024	2.2%	36.7%	0.7%	1
Lincoln, LA	$1,747	$1,109,029	**39**	8.7%	$2,493	2.7%	29.6%	**5.2%**	2
San Patricio, TX	$1,744	$1,641,316	**33**	5.2%	$2,821	3.1%	35.0%	**4.0%**	2
Acadia, LA	$1,742	$1,332,625	**34**	3.3%	$1,836	2.4%	31.5%	**1.7%**	2
Iberia, LA	$1,742	$1,929,809	27	7.4%	$1,506	2.1%	30.4%	**2.9%**	1
De Kalb, IN	$1,739	$1,038,248	**48**	8.0%	$1,973	2.7%	27.5%	**8.4%**	2
Angelina, TX	$1,718	$2,283,187	**30**	**10.0%**	$2,696	2.6%	34.6%	1.4%	2
Queens, NY	$1,714	$53,872,258	**33**	8.0%	$3,007	**14.6%**	37.3%	0.5%	2
Dubois, IN	$1,676	$1,670,940	**36**	7.9%	$1,753	2.8%	27.2%	**5.0%**	2

Note: Bolded figures indicate levels that are at least twice the national level.

* Figures are based on rounded questionable billing levels.

Source: Office of Inspector General analysis of 2009 Medicare outpatient therapy services claims.