

# PREVENTING FRAUD, ABUSE, AND WASTE:

## A Primer for Physical Therapists



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Preventing Fraud, Abuse, & Waste: A Primer for Physical Therapists

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# INTRODUCTION

*Health care consumers trust physical therapists to use their expert training to improve, maintain, restore, and enhance movement, activity, and health for optimal functioning and quality of life.*

The federal government and other payers rely on physical therapists to use their clinical judgment to provide patients with appropriate services and to submit proper claims for payment with accurate information. While the vast majority of health care providers are ethical and provide high-quality care, the few who abuse the system are costing payers and consumers billions of dollars and place beneficiaries' health at risk. Beneficiaries who have had services billed improperly under their identity could later be denied coverage for services when they need them.

The prevalence of health care fraud, abuse, and waste has resulted in the need for laws, regulations, and other policies to prevent their occurrence.

The drain on public funds from fraud, waste, and abuse—not to mention the needed enforcement tools to combat it— means that fewer resources are available for patient-centered care. This jeopardizes the long-term solvency of Medicare, Medicaid, and other health care payment programs.

Given the complexity of the payment systems, payment errors referred to as "improper payments" are much more common than fraud and abuse. These errors, often referred to as "waste" can result from billing for services with insufficient documentation, incorrectly coding claims, or providing services that do not meet the coverage criteria to be considered "reasonable and necessary."



This document provides physical therapists with information on how to comply with the relevant laws and regulations by identifying risk areas that could lead to potential liability. It is divided into 8 areas:

1. Explanation of fraud, abuse, and waste
2. Fraud and abuse laws
3. Relationships with payers
4. Relationships with referral sources
5. Relationships with patients
6. Evidence-based practice and ethics/professionalism
7. Compliance guidance
8. Taking action if there is a problem

# 1. EXPLANATION OF FRAUD, ABUSE, AND WASTE

## WHAT IS FRAUD?

Fraud generally is defined as an intentional deception or intentional misrepresentation that a person makes to gain a benefit for which that person is not entitled.

Examples of fraud in health care may include:

- Knowingly billing for services that were not furnished
- Knowingly altering claim forms to receive a higher payment amount
- Falsifying documentation
- Using unlicensed individuals to provide services

## WHAT IS ABUSE?

Abuse involves payment for items or services when there is no legal entitlement to that payment, and the health care provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary
- Unbundling and billing individual components of a service instead of the all-inclusive procedure

## WHAT IS WASTE?

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system. It is not generally considered to be caused by criminally negligent actions but by payment errors, referred to as “improper payments,” and the misuse of resources. Deficient management, practices, or controls can result in waste. Given the complexity of payment systems, waste is much more common than fraud or abuse.

Examples of waste may include:

- Spending on services that lack evidence of producing better outcomes compared with less-expensive alternatives
- Failures of care coordination that result in unnecessary hospital readmissions, avoidable complications, and declines in functional status
- Ordering unnecessary tests to guard against liability in malpractice lawsuits

## REAL-WORLD EXAMPLES

- **An owner of a physical therapy clinic was charged with submitting more than \$2 million in fraudulent claims to Medicare. The owner allegedly submitted bills for physical therapy when the services, to the extent they were rendered at all, were acupuncture and other services that Medicare does not cover.**
- **A skilled nursing facility engaged in a scheme to maximize the number of days it billed to Medicare at the “ultra high” rehabilitation utilization group (RUG), which pays a higher amount than other RUGs. Therapists working in the facility were pressured to provide therapy services to patients that were not medically necessary in order to get into the “ultra high” group.**



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## 2. FRAUD AND ABUSE LAWS

*The 5 Federal fraud and abuse laws that are important for physical therapists to know are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark Law), the Exclusion Authorities, and the Civil Monetary Penalties Law. Government agencies responsible for enforcing these laws include the Centers for Medicare and Medicaid Services, the Health and Human Services Office of Inspector General (OIG), and the Department of Justice. In addition to the federal fraud and abuse laws, many states have established their own fraud and abuse laws, which govern billing relationships with private payers.*

### **FALSE CLAIMS ACT (31 U.S.C. SECTIONS 3729-3733)**

The civil False Claims Act imposes liability on any person who submits a claim to the federal government (eg, Medicare or Medicaid) that he or she knows (or should know) is false. An example may be a health care provider who submits a bill to Medicare for medical services she knows she has not provided. This could also include falsifying medical records or documentation to obtain or retain money from the federal government. No specific intent to defraud is required, because the FCA defines “knowing” as not only actual knowledge but also acting in deliberate ignorance or reckless disregard of the truth or falsity of information, such as repeatedly ignoring government bulletins and transmittals regarding billing and coverage for physical therapist services.

Under the FCA, filing false claims can result in fines of up to 3 times the programs’ loss plus \$22,000 per claim filed, so the fines can be very high. The FCA includes a whistleblower provision that allows a private individual (eg, office staff, patients, other providers) to file a lawsuit on behalf of the United States and share a percentage of the proceeds from the FCA action. The FCA provides protection to whistleblowers who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA.

In addition, there is a criminal FCA (18 U.S.C. section 278) that imposes criminal penalties, including imprisonment and fines, for submitting false claims.



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## ANTI-KICKBACK STATUTE (42 U.S.C. SECTION 1320A-7B(B))

Kickbacks can distort medical decision-making, cause overutilization, increase costs, and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. Kickbacks can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests.

The Anti-Kickback Statute (AKS) was created to counter these potential abuses in the health care system. The AKS is a criminal law that prohibits anyone from "knowingly and willfully" receiving a form of payment in return for referring a patient to another provider for services or items covered by Medicare or Medicaid. It also forbids payment in return for purchasing, leasing, or ordering any good, facility, service, or item that would be paid for by Medicare or Medicaid. Payment, referred to under the statute as "remuneration," can include anything of value, such as cash for referrals, free rent for medical offices, expensive meals, tickets to shows, and excessive compensation for medical directors. The statute covers those who offer to pay the remuneration and those who receive it. Because this is a criminal statute, each party's intent is a key element of their liability.

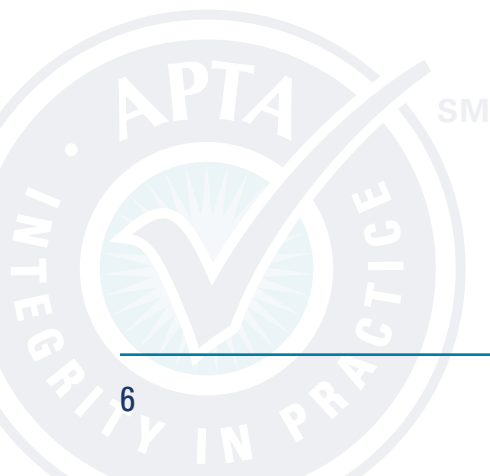
Criminal penalties and administrative sanctions for violating the AKS include fines, imprisonment, and exclusion from participation in federal health care programs. Civil penalties can be up to \$50,000 per kickback plus 3 times the amount of remuneration.

Safe harbors exist that protect certain payment and business practices that would otherwise implicate the AKS statute. An arrangement must satisfy all of the requirements of the safe harbor to be legal.

## PHYSICIAN SELF-REFERRAL LAW (42 U.S.C. SECTION 1395NN)

The Physician Self-Referral Law, also called the Stark Law, prohibits physician referrals of designated health services (DHS) for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that entity, unless an exception applies. A financial relationship includes ownership, investment interest, and compensation arrangements. The law has a list of 12 "designated health services," including physical therapy services. For example, if a physician provides physical therapy services in his office, he may not refer patients to that facility unless the facility meets certain criteria to qualify for an exception to the Stark Law. The most commonly used exception involving the provision of physical therapy in physician offices is the "in office ancillary services" exception.

There is no need to prove specific intent for this law to be violated. Penalties for physicians who violate the law include fines and exclusion from participation in federal health care programs. More information is available at the CMS website: <http://www.cms.gov/physicianselfreferral/>.







## **EXCLUSION STATUTE (42 U.S.C SECTION 1320A-7)**

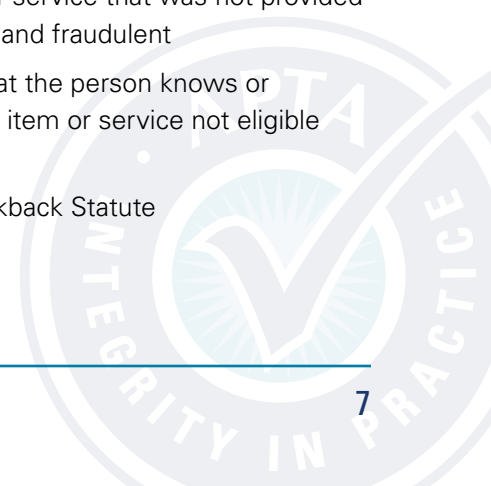
Under the Exclusion Statute, the Department of Health and Human Services is required to exclude health care providers and suppliers who have been convicted of certain crimes from participation in all federal health care programs. These programs, such as Medicare, Medicaid, TRICARE, and the Veterans Health Administration, will not pay for items or services that these excluded providers furnish, order, or prescribe. The crimes include:

- Medicare fraud
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

## **CIVIL MONETARY PENALTIES LAW (42 U.S.C. SECTION 1320A-7A)**

The OIG may seek civil monetary penalties (CMPs) for a variety of conduct, and different amounts of penalties and assessments may be authorized based on the type of violation at issue, with penalties ranging from \$10,000 to \$50,000 per violation. CMPs can also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received. Examples of CMP violations include:

- Presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false and fraudulent
- Presenting a claim that the person knows or should know is for an item or service not eligible for payment
- Violating the Anti-Kickback Statute



### 3. PHYSICAL THERAPISTS' RELATIONSHIPS WITH PAYERS

*In most instances, third-party payers cover the cost of medical bills for your patients. These payers include Medicare, Medicaid, workers compensation, automobile liability, and commercial insurers. It is important to know the coverage and payment policies of these different payers. Federal laws and regulations apply to federal programs such as Medicare, and many states have similar laws that apply to private payer programs.*

#### CODING AND BILLING FOR PHYSICAL THERAPISTS

The federal government and other payers rely on physical therapists to use their clinical judgment to provide patients with appropriate services and to submit proper claims for payment with accurate information. When you submit a claim for services for a Medicare or Medicaid beneficiary, you are attesting that you have earned the payment requested and that you are in compliance with all the billing requirements. If you knew or should have known that the claim you submitted was false, then attempting to be paid constitutes a violation of the law. Types of claims considered improper include:

- Billing for services you did not provide
- Billing for services that are not medically necessary
- Billing for physical therapy services provided by aides
- Billing for services provided by physical therapist assistants that were not properly supervised by a physical therapist
- Billing for excessive duration and frequency of services
- Using codes that pay a greater amount than the service provided (ie, upcoding)
- Billing for direct 1-on-1 services when they were provided to multiple patients at the same time with no direct 1-on-1 contact
- Billing for the incorrect level of evaluation

#### REAL-WORLD EXAMPLES

- **An aquatic therapy practice regularly billed Medicare for direct, 1-on-1 therapeutic procedures when such services were not provided. At the clinic, physical therapists and physical therapist assistants would routinely provide services to multiple patients at the same time. Nevertheless, the services provided to each patient were billed as if the physical therapist or physical therapist assistant had provided direct, 1-on-1 care.**
- **A physical therapist submitted claims to Medicare that had been “upcoded” (billed at a higher payment code than was justified). The physical therapist billed for treatments lasting 30 to 60 minutes when her actual time with patients was only 10 to 20 minutes.**





## PHYSICAL THERAPIST DOCUMENTATION

While safety and quality of care is most important when working with patients and clients, documentation throughout the episode of care is a professional responsibility and a legal requirement. Physical therapists must ensure that claims they submit for payment are supported by complete medical records and documentation. The Medicare and Medicaid programs and private payers may perform audits to review documentation to ensure the requirements are met.

While physical therapists may find documentation to be onerous, appropriate documentation of level of evaluation and services is crucial for the following reasons:

- It serves as a record of patient or client care, including a report of the individual's status, physical therapist management, and outcome of physical therapist intervention.
- It is a tool for the planning and provision of services and is a communication vehicle among providers.
- It tells others about the physical therapist's abilities, unique body of knowledge, and services provided.
- It demonstrates compliance with federal, state, payer, and local regulations.
- It provides an historical account of patient and client encounters that can be used as evidence in potential legal situations.
- It may be used to demonstrate appropriate service utilization and reimbursement for many payers.

Medicare and many third-party payers have established minimal standards for documentation. In addition, many state practice acts define what is expected of its licensees in clinical documentation. Documentation should be done at the point of care or soon afterward. A late entry, an addendum, or corrections to the medical record are legitimate occurrences in documentation of clinical services. However, it is important to make sure that the late entry or addendum bears the current date of that entry and is signed by the person making the addition or change. Falsified documentation would be considered a violation of fraud and abuse laws.



The Medicare program has identified several common issues with outpatient physical therapy documentation that result in improper payments, which include:

- Missing or incomplete plan of care/ treatment plan
- Missing physician or nonphysician practitioner (NPP) signatures and dates
- Missing total time for procedures and modalities
- Missing certification and recertification of plan of care

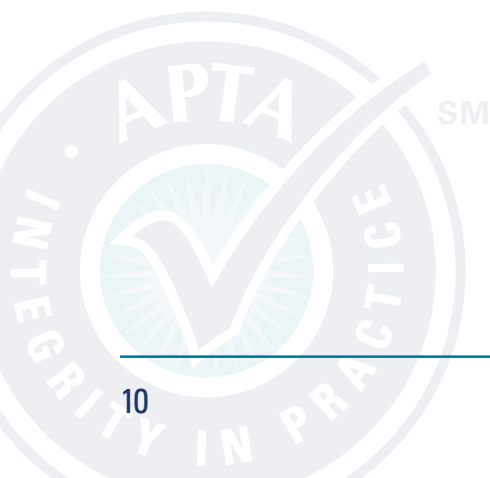


For physical therapists, it can be challenging to determine which documentation standards apply. The following resources are available:

- Medicare’s Internet-Only Manual (IOM) system that sets specific and Part A vs Part B guidelines [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html)
- Medicare Administrative Contractor’s local coverage decisions [www.cms.hhs.gov/mcd/search.asp?from2=search.asp&](http://www.cms.hhs.gov/mcd/search.asp?from2=search.asp&)
- Payer-specific websites (eg, Aetna, Blue Cross-Blue Shield, Cahaba, Noridian, Palmetto, Trailblazer, United Health, as well as others)
- State practice acts [www.apta.org/Licensure/StatePracticeActs/](http://www.apta.org/Licensure/StatePracticeActs/)
- APTA’s “Defensible Documentation for Patient/Client Management,” based on APTA’s Guidelines: Physical Therapy Documentation of Patient/Client Management (BOD G03-05-16-41) [www.apta.org/Documentation/DefensibleDocumentation/](http://www.apta.org/Documentation/DefensibleDocumentation/)
- Medicare and Medicaid Outpatient Rehabilitation Providers [www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/OutpatientRehab.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/OutpatientRehab.html)
- Medicare Fact Sheet: Complying with Medical Record Documentation Requirements [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf)

## REAL-WORLD EXAMPLES

- **A Medicare contractor informed a physical therapist that the contractor was performing an audit of the practice. The physical therapist instructed an employee to delay the audit by telling the contractor that medical records were stored at a nonexistent storage facility. The physical therapist then used the additional time provided to alter and augment patient records. Specifically, the physical therapist, and an employee at his direction, created and added patient progress notes when no notes had been created at the time of service. The notes made it appear as though Medicare beneficiaries had obtained direct, 1-on-1 services from a licensed physical therapist when, in fact, some of the services had been rendered by unlicensed auxiliary personnel.**
- **A physical therapist and physical therapist assistant created evaluations, therapy treatment notes, and other medical documentation for services to patients they did not see or treat. They knew that the documents they falsified would be used to support false claims to Medicare for home health services.**



## ENROLLING AS MEDICARE AND MEDICAID PROVIDERS WITH CMS

Physical therapists in private practice should enroll in the federal health care programs to be paid for services. (A physical therapist in an institutional setting, such as a hospital, SNF, or home health agency, does not enroll as an individual. Instead, services are billed under the institution's provider enrollment number.) To enroll as a physical therapist in private practice, a provider must first obtain an NPI, which is a unique individual identifier. You may apply for the NPI at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Next, complete the appropriate Medicare enrollment application (855B, 855i, 855R). Applications are available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. In addition, complete your state-specific Medicaid enrollment application if you choose to enroll in Medicaid.

Physical therapists in private practice are required to resubmit their enrollment approximately every 5 years, a process known as "revalidation." Physical therapists are required to keep their information updated with Medicare and must report any changes of ownership, changes in practice location, and final adverse legal actions within 30 days of the effective date of the change or action. For more information, see MLN Matters #SE1617, Timely Reporting of Provider Enrollment Information Changes at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1617.pdf>. Failure to report legal actions or changes in practice location within 30 days may result in revocation of the provider's Medicare billing privileges. Physical therapists should submit routine changes such as address updates, reassignments, additions to practice, and other changes within 90 days of the effective date of the change.

As an enrolled physical therapist you are responsible for ensuring claims submitted under your name are correct and for updating your enrollment for any changes.

## REAL-WORLD EXAMPLE

- A physical therapist assistant falsely billed for physical therapy services that were not performed or supervised by a licensed physical therapist. The physical therapist assistant owned and operated a practice and submitted reimbursement claims to Medicare for services under the name and provider number of a physical therapist who no longer worked at the practice, without the knowledge or consent of that former physical therapist employee.



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## 4. PHYSICAL THERAPISTS' RELATIONSHIPS WITH PHYSICIANS AND OTHER REFERRAL SOURCES

*If a health care business offers something to you for free or below fair market value, or offers to pay you cash in exchange for referrals, or offers you far above fair market value for products or services, you should question the reason. For example, if a DME supplier offers to pay you to recommend its DME items to your patients, it would most likely be a violation of anti-kickback laws.*

### RENTAL OF OFFICE SPACE FROM PHYSICIANS

Health care providers including physical therapists may rent space in the offices of physicians or other practitioners. When entering these rental arrangements, it is important for physical therapists to make sure that they are not paying for more space than necessary, or paying more than fair market value for the space, to access the physicians' potential referrals. According to

the Office of Inspector General's "Special Fraud Alert" on appropriate rental of office space from a physician, rental amounts should be at fair market value, should be fixed in advance, and should not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties. For more details, the alert is available at <https://oig.hhs.gov/fraud/docs/alertsandbulletins/office%20space.htm>.





## REAL-WORLD EXAMPLES

- **A hospital had a number of part-time employment arrangements which were found to have no more purpose than to induce referrals. In essence, the hospital paid physicians for part-time employment services that were not needed. A federal jury found the hospital guilty of violating the Stark Act for the contracts.**
- **A hospital was alleged to have provided kickbacks to physicians by providing free rent, equipment and furnishings; leases at less than fair-market-value; medical director services in excess of fair-market-value; and reimbursement at rates more than the requirements of an income-guarantee agreement.**



## GIFTS TO PHYSICIANS

Physical therapists need to be cautious about furnishing gifts to physicians who could be referral sources. Any remuneration (eg, trips, hotels, gifts, or other payments) with the intent to induce referrals for services that are paid for in whole or in part by Medicare or Medicaid is a violation of the Anti-Kickback Statute. Thus, gifts should be analyzed on a case-by-case basis. The difficult part of such an analysis is discerning the intent of the offer, as each party's intent is a key element of their liability under the statute. To be permissible, the gift must be primarily educational and cannot be given with the intent of obtaining a referral. For example, if a physician practice routinely accepts "free lunches" from a physical therapist without serious education, it is easy to prove that the intent of the lunch is to thank the physician for past purchases or to encourage future purchases. Alternatively, if a physical therapist schedules a luncheon with a physician practice, provides a modest lunch along with a genuine educational session describing the physical therapist services he provides at his practice, the "free lunch" should be acceptable.



## MEDICAL DIRECTORS

Physical therapists may hire medical directors to advise their facility. It is important to make sure that the arrangement is not structured in a way to induce referrals from that physician. The medical director must actively oversee clinical care in the facility, be involved, and be paid fair market value based on the services provided in his or her role as a medical director.

For additional information, see the July 9, 2015, OIG Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability at [https://www.acponline.org/system/files/documents/running\\_practice/payment\\_coding/medicare/fraud-alert-2015.pdf](https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/fraud-alert-2015.pdf).



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## 5. PHYSICAL THERAPISTS' RELATIONSHIPS WITH PATIENTS

*If a health care provider offers their patients gifts, provides free services, or waives deductibles and coinsurance, there is a likelihood that the federal government and private payers would question the reason.*

### GIFTS TO PATIENTS

Health care professionals may want to show their appreciation to patients through a gift. However, federal laws generally prohibit offering gifts to Medicare and Medicaid beneficiaries, because this could be seen as inducing patients to come to one practice instead of another or to use services that may not be needed. The OIG does permit inexpensive gifts to program beneficiaries as long as (1) they are not cash or cash equivalents; and (2) they have a retail value of no more than \$15 individually and \$75 in the annual aggregate per patient.

### WAIVER OF COINSURANCE AND COPAYMENTS

Providing free services to patients or waiving patient coinsurance and deductibles is generally prohibited by federal laws, because of the likelihood of influencing a patient to receive your services. However, the OIG does allow the waiver of coinsurance and deductible amounts by a person if the following conditions are met:

- The waiver is not offered as part of any advertisement or solicitation.
- The physical therapist does not routinely waive coinsurance or deductible amounts.
- The physical therapist waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need, or failing to collect coinsurance or deductible amounts after making reasonable collection requests.

However, you cannot routinely waive copayments for patients, nor can you solicit patients by advertising that you will waive copayments.

Private payers also have concerns with waiving copayments and coinsurance. When insurers set a copay (eg, \$15 per visit) or a coinsurance rate (eg, 20% of the billed amount or the allowed amount), they count on these patient financial responsibilities to lead to a certain pattern of behavior. They expect when patients share the expense of their medical care, they have an incentive to limit their care. When you agree with the patient to defeat this incentive, at least statistically you increase the amount of care to the patient and the cost to the insurer. The money you receive might be considered as fraudulently obtained.

### REAL-WORLD EXAMPLE

- **A large retail store offered illegal remunerations in the form of gift cards, gift checks and other similar promotions to Medicare and Medicaid beneficiaries in order to induce them to transfer their prescriptions from other pharmacies to their pharmacy. They were charged with violating the Antikickback statute and negotiated a large monetary settlement agreement with the government.**





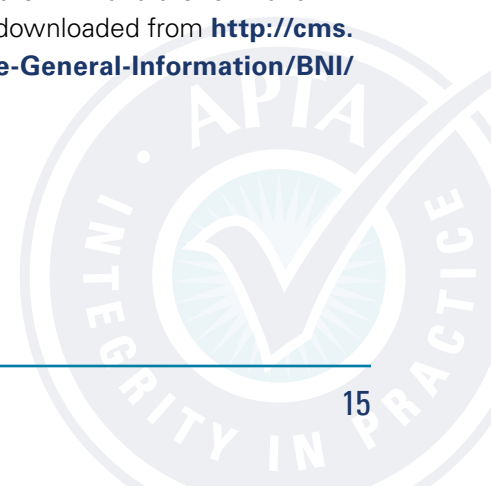
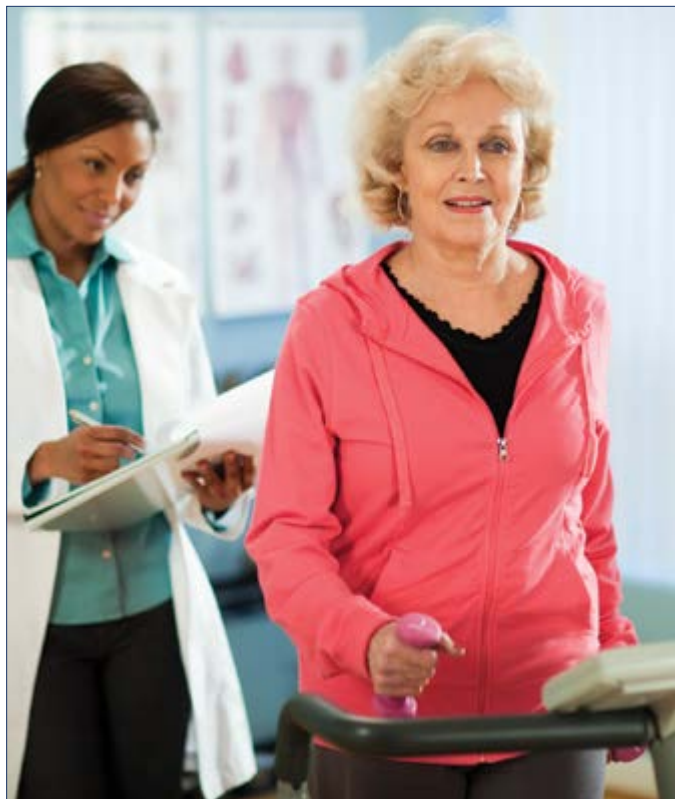
For example, if you bill \$50 for a physical therapy visit, and the patient's coinsurance is 20%, the patient should pay you \$10. If you accept the \$40 that the insurer pays you but do not pursue collection of the patient's portion, what you are really doing is saying that \$40 satisfies you in full. If that is the case, however, then the insurer's view is that it really should have paid you only 80 percent of \$40, or \$32.



## COLLECTING CASH FROM MEDICARE BENEFICIARIES

Some physical therapists would prefer to collect out-of-pocket payments from Medicare beneficiaries rather than submit bills for reimbursement. However, Medicare requires providers, including physical therapists, to submit claims for covered services. The only exception is for physicians who have "opted" out of the Medicare program for 2 years in accordance with section 1802(b) of the Social Security Act. Physical therapists are not included in the group of providers who may "opt out" of the Medicare program for 2 years.

Therefore, a physical therapist may not collect out-of-pocket payment from a Medicare beneficiary for a Medicare-covered service. It is possible for a physical therapist to receive cash payment from a Medicare beneficiary for a service that is not covered by Medicare. For example, Medicare does not pay for wellness and prevention services, and the physical therapist could collect out-of-pocket payment from the Medicare beneficiary for those services. If the services would not be covered by Medicare because they are not considered "medically reasonable and necessary," the provider must have the patient sign an Advanced Beneficiary Notice (ABN) prior to providing the therapy services to the patient in order to collect out of pocket payment. Information on the ABN and the form and form instructions can be downloaded from <http://cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

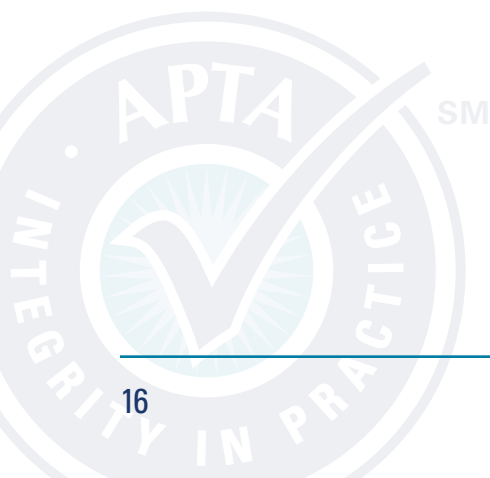


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## 6. EVIDENCE-BASED PRACTICE AND ETHICS/ PROFESSIONALISM

*To protect against the risk of fraud, abuse, and waste physical therapists should incorporate clinical practice guidelines that have been systematically developed to assist practitioner and evidence-based patient care decisions about appropriate health care for specific clinical conditions. Such practice guidelines are intended to improve the effectiveness, safety, outcomes, and efficiency of health care. Information on clinical practice guidelines is available at <http://www.ptnow.org/Default.aspx>.*

It is also important for physical therapists and physical therapist assistants to strive to apply principles of altruism, excellence, caring, ethics, respect, communication, and accountability in working together with other professionals to achieve optimal health and wellness in individuals and communities. Resources are available from APTA that outline core ethics for the physical therapy profession and practical application of the concepts. These resources are available at: <http://www.apta.org/EthicsProfessionalism/>.



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## 7. COMPLIANCE PROGRAMS

*Prior to the Affordable Care Act (ACA), the government recommended that providers voluntarily establish compliance programs to prevent violations of Medicare and Medicaid regulations. To better protect federal programs from fraud, waste, and abuse, the ACA mandates such compliance programs for Medicare and Medicaid providers. It also requires the Secretary of the Department of Health and Human Services, in consultation with the OIG, to establish core elements for compliance programs. However, an enforcement date for provider compliance plans has not been issued, and, therefore, as of the date of this publication compliance programs remain voluntary.*

The OIG has identified 7 core elements that provide a solid basis upon which you can develop a compliance program and are likely to serve as the foundation of the new compliance program requirement:

1. Develop and distribute written policies, procedures, and standards to prevent and detect inappropriate conduct
2. Designate a compliance officer or contact person
3. Conduct effective compliance education and training programs
4. Develop open lines of communication, including a process to receive complaints (a “hotline”); adopting procedures to protect the anonymity of those reporting compliance concerns/issues; and implementing a nonretaliation policy for those reporting compliance issues and violations
5. Perform ongoing internal evaluation through monitoring and auditing processes
6. Enforce compliance standards through well-publicized disciplinary guidelines
7. Respond appropriately to detected and reported compliance issues/violations

The OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, individual and small group physician practices, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor compliance with statutes, regulations, and program requirements. The documents provide principles to follow when developing a compliance program that best suits an organization’s needs. They are available at the following website:

**<https://oig.hhs.gov/compliance/compliance-guidance/index.asp>**

See also CMS’s Affordable Care Act Provider Compliance Programs: Getting Started Webinar at **[www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/MLN-Compliance-Webinar.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/MLN-Compliance-Webinar.pdf)**.



## 8. TAKING ACTION IF THERE IS A PROBLEM

*Below is a list of potential resources that can help you if you have concerns about engaging in a particular billing practice, business arrangement, or other relationship.*

- Experienced health care lawyers
- Your state physical therapy board  
<http://www.fsbpt.org/FreeResources/LicensingAuthoritiesContactInformation.aspx>
- APTA resources on specific risk areas  
<http://www.apta.org/Compliance/>
- CMS local Medicare Administrative Contractors  
<https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html>
- Office of Inspector General <http://oig.hhs.gov/compliance/compliance-guidance/index.asp>

If you are engaged in or have witnessed a relationship or billing practice that you think is problematic, consider taking the following steps:

- Contact the compliance officer if there is one in the facility.
- Immediately stop submitting the problematic bills.
- Seek knowledgeable legal counsel.
- Determine whether there are any overpayments that need to be returned.
- Disentangle yourself from the problematic relationship.
- When appropriate, consider reporting information to OIG or CMS, particularly in cases in which the compliance officer has not responded appropriately.



OIG has a hotline for reporting fraud anonymously:

Phone: 800-HHS-TIPS (1-800-447-8477)

Fax: 800-223-8164

E-mail: [HHSTIPS@oig.hhs.gov](mailto:HHSTIPS@oig.hhs.gov)

TTY: 800-377-4950

Mail: Office of Inspector General  
Department of Health and Human Services  
Attn: Hotline  
PO Box 23489  
Washington, DC 20026

Web: <https://forms.oig.hhs.gov/hotlineoperations/nothhsemployeeen.aspx>





## MEDICARE RESOURCES

CMS INTERNET-ONLY MANUALS (IOMS). IOMs provide detailed descriptions of Medicare requirements for outpatient rehabilitation therapy services. Policies concerning providers and suppliers of outpatient rehabilitation therapy services are located in many places throughout the IOMs. Relevant IOM sections that may be of interest are listed below.

- Medicare Benefit Policy Manual (Publication 100-02), chapter 15, sections 220 and 230
- Medicare Claims Processing Manual (Publication 100-04), chapter 5.

For more information, visit <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

LOCAL COVERAGE DETERMINATIONS. Comprehensive knowledge of the policies that apply to outpatient rehabilitation therapy services cannot be obtained through the IOMs alone. The most definitive policies are Local Coverage Determinations found in the Medicare Coverage Database, available at <https://www.cms.gov/medicare-coverage-database>.

MEDICARE CONTRACTORS: For a list of Medicare Contractors, visit <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html>.

MEDICARE THERAPY SERVICES RESOURCES PAGE: For specific therapy information, visit <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/therapyservices>.

The screenshot shows the Medicare.gov website interface. At the top, the logo "Medicare.gov" is displayed with the tagline "The Official U.S. Government Site for Medicare". A search bar is located in the top right corner. Below the logo is a navigation menu with buttons for "Sign Up / Change Plans", "Your Medicare Costs", "What Medicare Covers", "Drug Coverage (Part D)", "Supplements & Other Insurance", "Claims & Appeals", "Manage Your Health", and "Forms, Help, & Resources". The main content area features a large banner with the text "Is my test, item, or service covered?" and a search input field. Below the banner are three green buttons: "Find health & drug plans", "Apply for Medicare", and "Get started with Medicare". At the bottom, there are three yellow boxes with links: "Impacted by hurricanes? Get health care and prescription drugs in a disaster or emergency. Learn more", "New—find hospice care. Learn more", and three blue boxes with "Go" buttons for "Address change/Medicare card issue?", "Information for my situation", and "Find someone to talk to".

