

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1370

In the case of

Claim for

Iron Run Orthopedics
(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiary)

(HIC Number)

Highmark Medicare Services
(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated January 25, 2011, which concerned an overpayment assessed against the appellant for outpatient physical therapy (PT) services furnished to twenty-two beneficiaries on the dates of service listed on Attachment A.¹ The ALJ determined that the services were not covered under Medicare Part B and that the appellant was liable for the non-covered charges and overpayment under sections 1879 and 1870 of the Social Security Act (Act). The ALJ also found that the statistical sampling and extrapolation methodology were valid and affirmed the extrapolated overpayment amount. The appellant, through counsel, has asked the Medicare Appeals Council (Council) to review this action.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

¹ To maintain privacy, the Council will refer to the beneficiaries by their initials throughout this action. Their initials and redacted HICNs, as well as the dates of service, are listed in the attachment (Attachment A) to this action.

We enter the appellant's request for review, supplemental brief, and interim correspondence between the appellant and/or its attorney and the Council into the administrative record as Exhibit (Exh.) MAC-1.²

The Council has considered the record and the appellant's exceptions. We adopt the ALJ's decision as we find no reason to disturb the ALJ's findings of non-coverage and liability, as well as the ALJ's findings upholding the statistical sampling validity, for the services at issue.

BACKGROUND

The ALJ's 66-page decision recounts the procedural history, facts, and legal authorities applicable to this case in detail. See Dec. at 1-17. The facts specific to each claim at issue are discussed individually in the beneficiary-specific analyses in Appendices 1 through 22 of the ALJ's decision. See Dec. at 23-66. The Council incorporates those portions of the ALJ's decision by reference, and will not repeat them in full here.

Briefly, the appellant seeks Medicare coverage for various outpatient PT services (CPT/HCPCS codes 97110, 97112, and 97140) provided to the beneficiaries on the dates of service listed on Attachment A. Dec. at 1-2; Exh. 12, at 256-307. Highmark Medicare Services (Highmark) paid the claims initially. Pennsylvania Benefit Integrity Support Center (PENN-BISC), the Program Safeguard Contractor (PSC), subsequently reopened the claims for post-payment review, and audited a statistically valid random sample (SVRS) of the appellant's claims for the dates of service between January 1, 2006 and April 30, 2008, which ultimately resulted in an extrapolated overpayment assessment in the amount of \$536,085.48. See *id.*; Exh. 16.³

² The Council received the appellant's request for review of the ALJ's decision after the 60-day period for appealing the ALJ's decision, issued on January 25, 2011. See 42 C.F.R. § 405.1102(a). The Council granted the appellant's request for an extension of time to file its appeal before the Council and, subsequently, granted an request to supplement its appeal. See *id.* at § 405.1102(b). All of the appellant's and the appellant's attorney's filings, including the supplemental brief, and correspondence between the Council and the appellant or the appellant's attorney are collectively admitted into the record as Exh. MAC-1.

³ The ALJ's decision and the PSC's pre-hearing submittal to the ALJ (see Exh. 16) discussed in detail the post-payment audit review. Because the appellant does not raise herein any contentions specifically related to the assessment of the overpayment, including the validity of statistical sampling

Highmark upheld the overpayment, in part, in separate redeterminations. Following the redeterminations, Highmark recalculated the overpayment and assessed the total overpayment amount as \$461,163.32. Exh. 8, at 200. Highmark later recalculated the total overpayment amount to \$461,027.21. See Exh. 13, at 316. The Qualified Independent Contractor (QIC) upheld the revised overpayment and statistical sample validity on reconsideration, also finding the appellant liable for the overpayment amount. Exh. 12, at 254-313; see also Dec. at 1-2.

ALJ Hearing and Decision

The ALJ conducted a telephone hearing on November 4, 2010. At the time of the hearing, the appellant was represented by Dr. P.S., the sole owner of Iron Run Orthopedics. D.H., the office manager of Iron Run Orthopedics, was also present. Appearing on behalf of the PSC were: L.S. (Lead Investigator), T.B. (Statistician), M.S. (Nurse Reviewer), and T.S. (Benefit Integrity Manager). The PSC was assisted by S.B., a licensed physical therapist, in its review of the claims at issue, and she testified on behalf of the PSC at the hearing. Hearing CD; see also Dec. at 2.

The ALJ subsequently issued an unfavorable decision on January 25, 2011. In a discussion applicable to all beneficiaries, the ALJ cited Highmark's Local Coverage Determination (LCD) for *Physical Therapy and Rehabilitation Services* (L4737) and Medicare Benefit Policy Manual (MBPM), Pub. 100-02, ch. 15, sections 220.2 and 220.3 in his discussion of PT documentation criteria. The ALJ found that most of the documentation, including progress and treatment notes, failed to meet Medicare documentation criteria. He found that the LCD and the MBPM require, *inter alia*, that the progress notes "are to be written by the clinician and contain the clinician's signature verifying their participation in treatment," but that the documentation in the record generally was not written by Dr. P.S. Dec. at 19. Further, the ALJ found that the records generally lacked information such as the length of time spent on each PT modality, that is required for Medicare coverage and payment. *Id.* at 20.

The ALJ also found that the appellant's records "contain little objective measurements of the beneficiaries' progress towards their goals." Dec. at 20; see also MBPM, ch. 15, § 220.3 and

methodology employed in this case, we will not include a detailed discussion of the statistical sampling or the contents of the PSC's submittal.

LCD L4737. The ALJ stated that, despite Dr. P.S.'s contention that "the patients' progress is largely subjective and cannot be judged by objective measurements," the LCD and MBPM require the use of objective measurements in PT documentation for coverage and payment of PT services. *Id.*

Further, the ALJ found that there was little evidence that the services provided to the beneficiaries required the skills of a physical therapist or qualified therapist. *See* Dec. at 20-21; *see also* MBPM, ch. 15, section 220.2. The ALJ noted S.B.'s testimony that many of the services could have been performed in a fitness gym without skilled supervision. Dec. at 20-21; Hearing CD. The ALJ stated that the records of PSC investigators indicate that there were six to seven patients receiving treatment at the facility at one time and the services seemed to be administered by the appellant's technicians, with no direct supervision by Dr. P.S. Dec. at 21. Lastly, the ALJ found that the progress and treatment notes were insufficient to establish Dr. P.S.'s supervision of the PT services because the doctor did not write or sign the notes himself. *Id.* Thus, the ALJ concluded that the PT services provided to the beneficiaries were not medically reasonable and necessary. Dec. at 17-21.

On the overpayment assessment, the ALJ upheld the statistical sampling methodology because the documentation of the methodology was "complete" and the appellant did not challenge the validity of the statistical extrapolation methodology. *Id.* at 21. The ALJ also found the appellant liable for the non-covered services and not entitled to waiver of overpayment under sections 1879 and 1870 of the Act. *Id.* at 21-22. Lastly, in beneficiary-specific appendices, the ALJ discussed the medical documentation relating to each of the 22 beneficiaries, ultimately affirming that the PT services included in the statistical sample were not reasonable and necessary and were not covered by Medicare. Dec. at 23-66.

Request for Review

In the cover letter accompanying the supplemental brief in support of the appeal, addressed to the Council, the appellant's attorney states: "This submission basically relies upon the settlement agreement in Jimmo v. Sebelius, No. 5:11-CV-17-CR (D.VT. filed Jan. 18, 2011), approved on January 24, 2013. This agreement essentially precludes the 'Improvement Standard' from serving reason given to support the denials of coverage in the

within matter are the result of the implementation of the 'Improvement Standard.'

The appellant states that Dr. P.S., a licensed orthopedic surgeon, "personally evaluates therapy needs" and "personally monitors ongoing physical therapy." He personally provided all of the services, or, the services were provided under his direct supervision. The appellant objects to the hearing testimony of S.B., and argues that the ALJ "relied heavily" on the testimony of S.B. who did not actually "witness" the therapy furnished to the beneficiaries. The appellant states that "[a] key component in denying benefit payment was [S.B.'s] determination that [Dr. P.S.] often times either failed to sign, or had utilized a signature stamp." The appellant argues that Medicare coverage should not have been denied on this basis because Dr. P.S. testified to the veracity of his patient progress notes and, according to the appellant, "a signature stamp is conterminous with an actual signature." The appellant also argues that it has fully complied with Medicare coverage guidelines, citing in particular, the MBPM provisions. Exh. MAC-1, supplemental brief and Dr. P.S.'s April 8, 2011 letter.

In the supplemental brief the appellant again discusses the *Jimmo v. Sebelius* settlement, arguing that "most of [Dr. P.S.'s] Medicare patients' claims were denied predicated upon the 'Improvement Standard.'" The appellant argues that this standard should not have been applied to the claims at issue. The appellant states that the "claims were denied, to a large extent due to a beneficiary's lack of restoration potential, even though the beneficiary did receive [a] requisite level of skilled care to prevent, or at least slow deterioration." The appellant states that the *Jimmo v. Sebelius* settlement agreement "should compel" a "revisit" and "re-review" of each denied claim "under the maintenance coverage standard," which the appellant asserts would result in a reversal of each denial.

AUTHORITIES

For Medicare coverage of any service or item, the service or item must be reasonable and necessary for the diagnosis and treatment of a beneficiary's specific illness or injury or to improve the functioning of a malformed body member. See Act, § 1862(a)(1)(A). In addition, section 1833(e) of the Act, also applicable to all services and items, prohibits payment "to any provider of services or other person" unless "there has been furnished such information as may be necessary in order to

determine the amounts due." The regulations also make clear that it is the responsibility of the appellant to furnish sufficient information to enable reviewers to determine whether payment is due for a particular service or item and the amount of the payment. 42 C.F.R. § 424.5(a)(6).

The regulations at 42 C.F.R. section 410.60 state the conditions for Part B coverage of outpatient physical therapy, including the requirement that the services be provided to the beneficiary pursuant to a plan of care, containing certain information. See 42 C.F.R. § 410.61.

The MBPM provides guidance relevant to the coverage of outpatient physical therapy. It sets forth criteria, discussed in the ALJ's decisions, for assessing whether therapy services meet the medically reasonable and necessary standard. See MBPM, ch. 15, § 220.2(B). Relevant here, the MBPM states that the services must, among other criteria, be provided with an expectation that the beneficiary's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. See *id.*

The MBPM also identifies the type of documentation required to demonstrate the medical necessity of therapy services, such as an initial evaluation, plan of care, progress reports, and treatment notes, and explains the type of information that such documentation should contain. See MBPM, ch. 15, § 220.3(B); see also *id.* § 220.1.2 (discussing the plan of care requirements). The MBPM explains that the documentation must be legible, relevant, and sufficient, in order to document medical necessity. See *id.* § 220.3(A).

The MBPM also explains the distinction between rehabilitative therapy and therapy provided as part of a maintenance program, and provides guidance on evaluating the medical necessity of each type of therapy. It states that rehabilitative therapy is necessary to improve an impairment or functional limitation and, if possible, restore a previous level of function. Therefore, progress reports for such therapy should contain and describe "objective measurements" that, when compared, show "improvements in function, or decrease in severity, or rationalization for an optimistic outlook to justify continued treatment." See MBPM, § 220.2(C). The purpose of maintenance therapy, in contrast, is

to maintain a functional status or to prevent a decline in function. See *id.* § 220.2(D).

LCD L4737 also discusses the criteria for coverage of therapy services. LCD L4737 discusses the therapeutic procedures (CPT/HCPCS codes 97110, 97112, and 97140) that are at issue, stating, in relevant part:

Therapeutic procedures are treatments that attempt to reduce impairments and improve function through the application of clinical skills and/or services. Use of these procedures requires that the therapist have direct (one-on-one) patient contact. Common components included as part of the therapeutic procedures include chart reviews for treatment, set up of activities and the equipment area, and review of previous documentation as needed. Also included is communication with other health care professionals, discussions with family, and calls to the referring physician for additional information and clarification. Subsequent to providing the therapeutic service, the treatment is recorded, and typically the progress is documented.

Therapeutic exercise and neuromuscular reeducation are examples of therapeutic interventions. The expected goals must be documented in the treatment plan, and affected by the use of each of these procedures, in order to define whether these procedures are reasonable and necessary. Therefore, since only one, or a combination of more than one of these modalities may be used in the treatment plan, documentation must support the use of each treatment or modality as it relates to a specific therapeutic goal.

DISCUSSION

The Council notes, first, that the appellant does not dispute the issues related to the assessment of the overpayment, including the statistical sampling method employed, the extrapolation of the overpayment, the ALJ's analysis of the liability question under section 1879 of the Act, and the ALJ's analysis of waiver of recovery of the overpayment under section 1870(b) of the Act. We therefore need not further discuss these issues herein.

Also, as noted earlier, the ALJ issued a 66-page decision, the first 22 pages of which included a lengthy section on the law, regulations, and coverage policy and guidance applicable to these cases. The appellant does not specifically identify any legal error concerning the statutory or regulatory provisions cited or quoted in that section, or the non-binding coverage policy or guidance materials as summarized or quoted therein. The appellant does not state that the ALJ should have addressed, but did not address, any other coverage authority or guidance it believes would support its case. Nor does the appellant raise any beneficiary-specific contentions concerning the ALJ's assessment of the evidence in each beneficiary case, as set out in detail in appendices 1 through 21 of the ALJ's decision. Dec. at 23-66. The Council confines our analysis herein to the contentions the appellant raises before the Council.

Dr. P.S. states that the ALJ "relied too heavily" on one witness's hearing testimony (referring to S.B.'s testimony) and objects to the ALJ's consideration of S.B.'s testimony. The Council does not find that the ALJ relied on any particular individual's hearing testimony over another's, or even on any one form of evidence over another (testimony over written documentation). We note, also, that the fact that S.B.'s testimony included a discussion of certain manual guidelines does not itself mean that the ALJ erred in considering S.B.'s statements or those manual guidelines. Hearing CD. It is well within the ALJ's authority to determine that the manual provisions that were the subject of S.B.'s statements are authorities applicable to this case and, based on the contents of the ALJ's decision, the ALJ did make such a determination and considered the manual provisions, among other authorities, to render his decision. Also, that the information concerning the contents of manual provisions were communicated to the ALJ orally by an individual who appeared on behalf of the PSC does not necessarily mean that the ALJ was inclined to rely on, or did rely on, that individual's hearing testimony as evidence more persuasive than other evidence that was before the ALJ. The appellant's contention concerning the ALJ's reliance on S.B.'s hearing testimony has no merit.

The appellant's submittals to the Council also suggest that Dr. P.S. believes that the *chief* basis for the ALJ's denial was the ALJ's finding that the documentation submitted in support of the claims did not comply with certain guidelines concerning the authentication of documents. That is not how the Council reads the ALJ's decision. The ALJ did discuss the doctor's signatures

on "most" of the documents, and the use of signature stamps on some of the documents. See Dec. at 19. However, that discussion was brief; it was only one small part of the ALJ's rationale for upholding the coverage denials. We note, again, that a full two-third of the ALJ's 66-page decision was devoted to beneficiary-specific analysis of the evidence offered in support of each beneficiary claim. The appellant does not specifically dispute the contents of that analysis.⁴

The appellant also contends that the claims at issue were denied coverage based on the application of an "improvement standard." The appellant relies upon the settlement in *Jimmo v. Sebelius* as authority supporting its position.

In the case of *Glenda Jimmo, et al. v. Sebelius*, the plaintiffs-beneficiaries brought a class action lawsuit in the U.S. District Court for the District of Vermont, arguing that Medicare claim reviewers were inappropriately applying a rule-of-thumb "Improvement Standard" to summarily deny coverage for skilled care (skilled nursing facility, home health, and outpatient therapy benefits) for lack of restoration potential. The court did not rule on the merits of the "Improvement Standard" allegations underlying the *Jimmo* class action lawsuit. The parties to the *Jimmo* action reached, and the court approved, a settlement agreement. In accordance with the settlement agreement, the Secretary (through CMS) must take various actions, which would include a revision of CMS manual provisions to clarify the agency's longstanding policy that coverage for skilled services is not predicated on a beneficiary's restoration potential, but on his or her need for skilled care.

The appellant's reliance on the *Jimmo* settlement agreement is unavailing. In accordance with the agreement, an individual's lack of restoration potential may not, by itself, be the basis for denying coverage for skilled care without an individualized assessment of the beneficiary's medical condition(s) and the

⁴ As for the appellant's contention that a signature stamp on the medical documents is sufficient to meet the signature requirements specified in the MBPM and the applicable LCD, we agree with the ALJ that the appellant did not comply with documentation requirements for progress notes provided in the MBPM. The MBPM provides that progress reports are written and signed by a clinician who provides or supervises the services. See MBPM, § 220.3. Dr. P.S. acknowledged during the hearing that he does not personally write the progress notes, but that he does occasionally dictate a progress note. Hearing CD. With respect to the records which Dr. P.S. did not personally write or dictate the progress notes, and sign the progress notes, the records do not comport with Medicare policy in the MBPM.

reasonableness and necessity of the care in question. However, to be clear, the *Jimmo* settlement does *not* represent an expansion of coverage. The settlement clearly specified: "Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."

We do not agree with the appellant's position that the prior reviewers held the appellant to an "improvement standard" to deny these claims. We observe, also, that the appellant does nothing more than aver that the reviewers applied an impermissible "improvement standard" to deny the claims, but does not identify any specific examples, referring to any contractor decision or the ALJ's discussion, to support this argument. It does not point to any prior action in the 22 beneficiary cases to demonstrate that the claim(s) was (were) denied because based specifically - and solely - on the lack of restoration potential.

The ALJ, the QIC and the contractor found that the appellant's documentation did not substantiate coverage in accordance with applicable authorities, in effect when the services were provided. We, too, find that the documentation in the beneficiaries' records does not meet Medicare requirements, including, specifically, documentation criteria for PT services as specified by the MBPM and the LCD.

After reviewing the record, the Council agrees with the ALJ that many of the daily treatment notes found in the beneficiaries' records do not appear to indicate the length of time spent on each physical therapy modality. See Dec. at 19-20. The MBPM states that documentation of each treatment must include "[t]otal timed code treatment minutes and total treatment time in minutes." MBPM, ch. 15, § 220.3(E). Further, "total treatment time includes the minutes for timed code treatment and untimed code treatment." *Id.* Even though many of the daily progress notes include a "time in" and a "time out" for the beneficiary's therapy session, there is generally no indication in the progress notes or the treatment notes/flow sheet of times relating to the specific code denoting the type of treatment. See, e.g., P.E. Claim File at 57-65.

We also agree with the ALJ that the plan of care for many of the beneficiaries at issue does not document the long term goals. See, e.g., Dec. at 32. The MBPM provides that the plan of care or plan of treatment must contain the diagnoses, long term

treatment goals, and the type, amount, duration and frequency of therapy services. MBPM, ch. 15, § 220.1.2(B). For most of the beneficiaries at issue, the plan of care is combined with the physician's evaluations. See, e.g., P.E. Claim File at 70-71. In the "Plan" section of the plan of care, Dr. P.S. summarizes his strategy for treating the beneficiary and a schedule of treatment, but there are no long term goals identified in this section or any other part of the plan of care. *Id.*

Another reason the ALJ found that the appellant's documentation failed to meet Medicare PT coverage criteria is that it generally lacked documentation of objective measurements. See, e.g., Dec. at 20; see also MBPM, §§ 220.2(C) and 220.3(C). The Council agrees with the ALJ that the appellant's plans of care, PT progress, and treatment notes for many of the individual beneficiaries contains little or no objective measurements of the beneficiaries' progress. See, e.g., P.E. Claim File at 57-70; A.C.1 Claim File at 41-57. The plan of care for most beneficiaries includes a general summary of what the treatment plan will be for the respective beneficiary, but the plan does not give any objective benchmarks of functionality at the time the plan of care was established. See, e.g., A.C.1 Claim File at 42-43. There are generally no indications of the extent of time each type of PT service were to be furnished. Moreover, there are generally no objective measurements in the appellant's records showing that significant progress, in fact, occurred.

Lastly, we agree with the ALJ that aside from insufficient documentation supporting coverage for the PT services, there is a question as to whether the services were skilled in nature and if they were repetitive. The MBPM provides that "unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed." MBPM, § 220.2(A). The MBPM also provides:

The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy . . . by or under the supervision of a therapist.

MBPM, § 220.2(B).

Dr. P.S. acknowledged at the hearing that most of the therapy that he provided involved the use of exercise equipment that can be found at a fitness center. In fact, the doctor indicated that a majority of the beneficiaries that he treats go to a fitness facility to use its exercise equipment because it is more convenient than traveling to the appellant's facility. Hearing CD (11:04 a.m.). Moreover, in responding to the ALJ's question about whether a beneficiary who actively plays golf would still need to be under the supervision of a skilled therapist, Dr. P.S. stated that the beneficiaries under his care want to stay as active as possible and when they stop being active, they rapidly get worse. Hearing CD (11:06 a.m.). After reviewing the record and considering the testimony given at the hearing, we find that many of the beneficiaries did not require the skills of a physical therapist.

Based on the foregoing, the Council concludes that there is no cause for changing the ALJ's decision. The Council summarily adopts the ALJ's findings on the denial of coverage for the PT at issue, the validity of the statistical sampling and extrapolation methodology, liability for the non-covered charges, and waiver of recovery of the overpayment.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: September 27, 2013