

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Realhab, Inc.
Docket No. A-13-76
Decision No. 2542
November 19, 2013

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Realhab, Inc. (Realhab) , a supplier of outpatient physical therapy services, appeals the April 22, 2013 decision by an administrative law judge (ALJ), *Realhab, Inc.*, DAB CR2763 (2013) (ALJ Decision). The ALJ affirmed the determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Realhab's enrollment in Medicare effective December 15, 2011. The ALJ concluded that Realhab had abused its billing privileges within the meaning of 42 C.F.R. § 424.535(a)(8) by submitting multiple claims billing Medicare for more units of service than Realhab's qualified staff could possibly have furnished to beneficiaries in the hours available to the staff on particular dates.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

Section 1831 of the Social Security Act (Act) establishes the Supplementary Medical Insurance Benefits for the Aged and Disabled Program known as Medicare Part B.¹ CMS administers Medicare Part B through contractors such as First Coast Service Options (First Coast), the Medicare Part B contractor in this case. Act § 1842(a).

Medicare payments for services furnished to program beneficiaries may be made only to health care "suppliers" and "providers" that are enrolled in the program. Act §§ 1861(d), 1861(u); 1866(j); 42 C.F.R. §§ 400.202 (defining "provider" and "supplier"), 424.500, 424.505. When a physical therapy supplier files an application to enroll in Medicare, the supplier must provide the signature of an individual authorized to bind the supplier legally and financially, attesting that the supplier "is aware of, and abides by, all applicable statutes, regulations, and program instructions." 42 C.F.R. § 424.510(d)(3).

¹ The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

Once enrolled, a provider or supplier receives “billing privileges,” the right to claim and receive Medicare payment for health care services provided to beneficiaries. 42 C.F.R. §§ 424.502, 424.505.

Section 424.535 lists the circumstances under which CMS or one of its contractors may revoke a supplier’s enrollment and billing privileges. CMS may revoke a supplier’s enrollment based on “abuse of billing privileges,” among other reasons. 42 C.F.R. § 424.535(a)(8).

If CMS decides to revoke a supplier’s enrollment, the supplier may ask for reconsideration of the revocation determination. 42 C.F.R. §§ 424.545(a), 498.5(l)(1), 498.22(a). If the supplier is dissatisfied with the reconsidered determination, the supplier may request a hearing before an ALJ, and if dissatisfied with the ALJ decision, may request review of the ALJ decision by the Board. 42 C.F.R. § 498.5(l)(2), (3).

Case Background²

From January 1, 2010 through July 19, 2011, Realhab had two practitioners, a physical therapist and a physical therapist assistant, qualified to furnish outpatient physical therapy services to Medicare beneficiaries. In January 2011, a former Realhab employee reported to the Medicare Fraud Hotline that Realhab had been billing Medicare for services in excess of those actually provided. In response, CMS Program Integrity Contractor, SafeGuard Services, LLC (SGS), conducted an onsite investigation, interviews, and a document review of Realhab’s claims for calendar year 2010 and January 1, 2011 through July 19, 2011. CMS Ex. 1.

SGS concluded that Realhab had abused its billing privileges by “billing for services that could not have been provided to specific individuals on specific dates.” *Id.* at 6. According to SGS, Realhab billed hours “in excess of hours available to two providers on any given day” and “could not have been performing one-on-one therapy as required by the services billed when providing services to multiple patients.” *Id.*

Based on the investigation findings, First Coast revoked Realhab’s enrollment and billing privileges for three years effective December 15, 2011. CMS Ex. 6. Realhab requested reconsideration, and First Coast sustained the revocation. CMS Exs. 3, 5. Realhab then requested an ALJ hearing.

² The information in this section is drawn from the ALJ Decision and the record before the ALJ and is not intended to substitute for the ALJ’s findings.

The ALJ Decision

The ALJ determined that Realhab had abused its billing privileges within the meaning of section 424.535(a)(8) because it had billed for services that it had not delivered to Medicare beneficiaries.³ Section 424.535(a)(8) provides that CMS may revoke a supplier's Medicare billing privileges if the "supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." Applying Medicare billing requirements, the ALJ concluded that Realhab's physical therapist and physical therapist assistant "billed for more units of treatment than they could have delivered to beneficiaries in the hours available on specific dates." ALJ Decision at 10; *see also id.* at 12, 16. The ALJ also concluded, "The CMS revocation authority under the regulation is not limited by a requirement that CMS identify specific beneficiaries who did not receive the claimed services." ALJ Decision at 9.

In addition, the ALJ rejected Realhab's claim that section 424.535(a)(8) was void for vagueness. Moreover, he concluded, "even if [he] agreed with [Realhab] that the regulation is too vague to give [Realhab] proper notice of what is expected, [he had] no authority to find the regulation void for vagueness." *Id.* at 22.

Standard of Review

We review a disputed conclusion of law to determine whether it is erroneous, and a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole. *Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, <http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html>. The Board may modify, reverse or remand an ALJ decision if, among other things, a prejudicial error of procedure (including an abuse of discretion under the law or applicable regulations) was committed. *Id.*

Analysis

I. The ALJ's decision to admit into the record summary billing data relating to the 2010-11 period is free from error.

On appeal to the Board, Realhab asserts that the ALJ admitted CMS Exhibits 15 (Billing Summary for Dates of Service February 12, 2010 and February 22, 2010) and 16 (Billing Summary by Date of Service) "over objection, during the testimony of [the] CMS

³ As an initial matter, the ALJ determined that Realhab had sufficient notice of the bases for revocation and a reasonable opportunity to respond, and was not prejudiced by the erroneous citation of 42 C.F.R. § 424.535(a)(7) in the First Coast initial and reconsideration decisions. ALJ Decision, findings of fact and conclusions of law (FFCL) 1. Realhab did not contest FFCL 1 on appeal to the Board. Accordingly, we summarily affirm FFCL 1.

investigator (TR 97, 101), despite the fact that she was unable to explain who had prepared them or how they had been prepared.” Realhab Request for Review (RR) at 4. Realhab suggests that the ALJ erred in relying on the summaries as evidence of Realhab’s billing because the exhibits lacked an adequate foundation. Realhab Reply at 4.

The record does not support Realhab’s assertions. ALJs of the Departmental Appeals Board are not bound by the Federal Rules of Evidence, though they may “apply [them] where appropriate, for example, to exclude unreliable evidence.” Civil Remedies Division Procedure (CRDP) 14, available at <http://www.hhs.gov/dab/divisions/civil/procedures/divisionprocedures.html>; 42 C.F.R. § 498.61. Here, the ALJ’s Acknowledgment and Prehearing Order advised the parties, “Any evidence will be considered admissible and true unless specific objection is made to its admissibility and accuracy.” March 12, 2012 Acknowledgment and Prehearing Order at 5. The Order stated, “Petitioner should make any objections to exhibits submitted by CMS when Petitioner files an opposition or a motion or cross-motion for summary judgment.” *Id.*

In its Prehearing Brief and Cross-Motion for Summary Judgment, Realhab argued that the billing summary reports that CMS submitted as Exhibits 1 and 16 were internally inconsistent, but Realhab did not object to the admissibility of these or any other CMS exhibits in its prehearing submission. Realhab Prehearing Brief and Cross Motion for Summary Judgment at 5.

At the outset of the in-person hearing, the ALJ asked counsel for Realhab whether Realhab had any objections to CMS’s exhibits. Tr. at 23-24. Counsel did not raise any objection to the admissibility of the 2010 billing summaries in CMS Exhibits 15 and 16. Rather, counsel stated that Realhab objected to “that portion of Exhibit 16 that refers to events that occurred in 2009” on the ground of relevancy. *Id.* at 24-25, 29. As noted in the ALJ Decision, CMS conceded that the 2009 data were not relevant; the ALJ accordingly ruled to exclude from the record the part of CMS Exhibit 16 summarizing 2009 data (pages 1-4 and the first 5 lines of page 5). ALJ Decision at 16-17, n. 10. The ALJ admitted the rest of Exhibit 16 into the record without objection by Realhab. *Id.*⁴

As further explained in the ALJ Decision and reflected in the hearing transcript, Realhab objected to the SGS investigator’s hearing testimony regarding how the billing summaries in CMS Exhibits 16, pages 5 through 9, and CMS Exhibit 1, pages 52 through

⁴ Realhab also objected to pages 9-51 of CMS Exhibit 1, consisting of statements of patients who would not be testifying. Tr. at 24-25. The ALJ determined that the patient statements in CMS Exhibit 1 were relevant and admissible, Tr. at 29-30, although he ultimately determined that they were not “sufficiently reliable” proof to support CMS’s case, and he did not rely on them in rendering his decision. ALJ Decision at 12, n. 8.

62, were compiled because she did not have direct personal knowledge of how the reports were created. ALJ Decision at 17, *citing* Tr. at 96-103. The ALJ sustained the objection to the investigator’s testimony. Tr. at 101.

The ALJ explained, however, that as specifically provided for under CRDP 10 (which uses Federal Rule of Evidence 1006 as a guideline) “a party that wants the ALJ to consider the contents of voluminous records should offer that evidence as an exhibit in the form of a chart or summary.” The ALJ noted that Federal Rule of Evidence 1006 and CRDP 10 require that the documents supporting the compilation be made available for examination or copying, and permit the judge to order the documents to be produced in court. ALJ Decision at 17. In this case, however, Realhab “did not object that the supporting documents, i.e., the bills submitted by [Realhab] from which the information was compiled, were not produced,” and Realhab did not move for an order requiring CMS to produce the underlying documentation. *Id.* Accordingly, the ALJ determined that the data compilations were properly admitted and considered reliable evidence of Realhab’s billing. *Id.*

We find no error in the ALJ’s evaluation of the admissibility and reliability of the billing summaries, and Realhab does not identify any error in the ALJ’s reasoning. We further note that Realhab offered no original source documentation to counter the billing data summarized in CMS’s reports.⁵ Realhab’s failure to provide such documentation (which should have been available to it) undercuts its assertion that the summaries are unreliable.

II. The ALJ Decision is supported by substantial evidence on the record as a whole.

A. Medicare requirements for billing and payment of outpatient physical therapy services

Medicare pays for most outpatient physical therapy services under the physician fee schedule.

Section 1861(p) of the Act defines “outpatient physical therapy services” to mean, subject to certain limitations, “physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with” such an entity, to an individual who “is under the care of a physician” and “with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician . . . or by a qualified physical therapist and is periodically reviewed by a

⁵ As discussed below, Realhab did submit its own summary report of its billing data for the January 4, 2010 through July 22, 2011 period for purposes of comparison. P. Ex. 7. As discussed below, this evidence, too, supports the conclusion that Realhab billed for services that it could not have furnished to Medicare beneficiaries.

physician.” Medicare Part B pays for outpatient physical therapy services furnished by a qualified physical therapist or an appropriately supervised physical therapist assistant under specified conditions. 42 C.F.R. §§ 410.10(m), 410.60, 424.24(c); *see also* Act §§ 1832(a)(2)(c) (scope of benefits) and 1834(k) (payment for outpatient therapy services). Most outpatient physical therapy services are considered “physician services” for payment purposes and paid under the Medicare physician fee schedule.⁶ Act §§ 1848(a)(1), 1848(j)(3), 1861(s)(2)(D); 42 C.F.R. § 414.2.⁷ The Act requires payments under the fee schedule to be based in part on uniform relative value units (RVUs), which reflect the resources used in furnishing each service. Act §§ 1848(b)(1)(A), 1848(c).

The Act and regulations require practitioners to use the CPT coding system when billing for outpatient physical therapy services.

Sections 1848(c)(4) and (5) of the Act authorize the Secretary to establish a uniform procedure coding system for all physician services and “ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement” the fee schedule. *See also* 42 C.F.R. § 414.40. Section 1848(i)(1)(E) of the Act prohibits administrative and judicial review of “the establishment of the system for the coding of physicians’ services” A Medicare supplier must use the applicable medical data code sets adopted by the Secretary when billing for covered services. 45 C.F.R. §§ 162.1000 and 162.1002.

CMS created the Healthcare Common Procedure Coding System (HCPCS), a compilation of definitions of physician and other health care professional services, codes for those services and payment modifiers used to process and pay Medicare claims. *See* 42 C.F.R. §§ 414.2 and 414.40; 45 C.F.R. § 162.1002. The HCPCS incorporates the Current Procedural Terminology (CPT), a coding system maintained by the American Medical Association (AMA) of descriptive terms and numeric codes used to report services and procedures furnished by physicians and other health care professionals. The AMA republishes and updates the CPT annually. CMS annually updates and publishes in the *Federal Register* the fee schedule RVUs for new and revised CPT codes based on recommendations from a committee of representatives from the AMA and national medical specialty societies (Relative Value Scale Update Committee).

⁶ Section 6102 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law No. 101-239, amended title VIII of the Act by adding a new section 1848, “Payment for Physicians’ Services,” which directed the Secretary to establish a fee schedule for the payment of physicians’ services.

⁷ When billed by an outpatient hospital department, physical therapy services are paid under the Outpatient Prospective Payment System.

A supplier may bill Medicare for timed, one-on-one physical therapy services only when a physician or therapist has provided a service requiring constant, one-on-one contact.

The CPT lists physical therapy services under several general categories: Evaluations; Supervised Modalities (the “application of a modality [i.e., physical agent applied to produce therapeutic changes to biologic tissue] that does not require direct (one-on-one) patient contact by the provider”); Constant Attendance Modalities (the “application of a modality that requires direct (one-on-one) patient contact by the provider”); and Therapeutic Procedures (which effect change “through the application of clinical skills and/or services that attempt to improve function”). CMS Exs. 8, 9 (2010 and 2011 CPT Codebooks, “Physical Medicine and Rehabilitation,” codes 97001-97546).

The CPT descriptions of each physical therapy service control whether the service must be reported based on the number of times the procedure is performed (without regard to time) or based on the amount of time (measured in 15-minute units) the practitioner spent providing the service to the patient. *Id.* For example, code 97010, listed under the “Supervised Modalities” section, is described without regard to time as the “[a]pplication of a modality to 1 or more areas; hot or cold packs.” *Id.* In contrast, code 97032, listed under the “Constant Attendance Modalities,” is described as the “[a]pplication of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes.” *Id.*

The CPT provides that therapeutic procedures generally require the physician or therapist “to have direct (one-on-one) patient contact” and are reported as timed codes. *Id.* The CPT states, however, that “group therapy procedures” must be reported when the therapist provides to a “group (2 or more individuals)” procedures that “involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist.” *Id.* Under those circumstances, the CPT directs practitioners to “[r]eport 97150 for each member of [the] group” without regard to the time spent delivering the services. *Id.*

In 1994, when the AMA revised and organized the CPT physical therapy services codes into the above-described categories, CMS (then called the Health Care Financing Administration) updated the physician fee schedule to reflect the CPT revisions. CMS explained that it “based the work RVUs for these services on the expectation **that the definition of the codes represents how the services will be furnished when billed to Medicare.**” 59 Fed. Reg. 63,451 (Dec. 8, 1994)(emphasis added). “For example,” CMS stated, “we expect that when 15 minutes of a service in the constant attendance category is billed, we may be confident that the provider furnished the 15 minutes of constant one-on-one attendance that is included in the definition of the code.” *Id.*

CMS continued, “If the provider did not furnish 15 minutes of one-on-one constant attendance, as the code is defined,” the provider “may not bill a code for 15 minutes of constant attendance.” *Id.* CMS also stated that if a “provider is overseeing the therapy of more than one patient during a period of time, he or she must bill the code for group therapy (CPT code 97150), since he or she is not furnishing constant attendance to a single patient.” *Id.* The same language was republished in the *Federal Register* in 1996. 61 Fed. Reg. 59,490, 59,542 (November 22, 1996).

CMS guidance on billing for timed physical therapy codes

Restating the requirements established under the Medicare regulations and coding system, the Medicare Benefit Policy Manual (MBPM) provides that a practitioner must use group therapy code 97150 when billing for therapy services furnished concurrently to two or more individuals. CMS Pub. 100-02, Ch. 15, § 230.A. The MBPM states:

Contractors pay for outpatient physical therapy services . . . provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

Id. The same language also appears in First Coast Local Coverage Determination (LCD) L29289, effective February 2, 2009.⁸ CMS Ex. 10, at 4.

The Medicare Claims Processing Manual (MCPM) includes the following detailed instructions on billing for timed physical therapy code services:

Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of 15-minute units of service.

* * *

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the

⁸ “Local coverage determination” is defined in section 1869(f)(2)(B) of the Act as “a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).”

duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units Number of Minutes

1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 minutes

CMS Pub. 100-04, Ch. 5, § 20.2 (emphasis in original). The manual explains that a supplier may aggregate timed codes performed for less than 8 minutes, subject to certain limitations. The manual makes clear, however, that **if a practitioner bills Medicare for more than one timed code for “a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.”** *Id.* (emphasis added).

Consistent with CMS’s statements in the preamble to the 1995 physician fee schedule rule, the MCPM states that suppliers must “report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services.” *Id.* at § 20.3. Thus, the MCPM directs suppliers not to count “pre- and post-delivery services” when counting treatment service time. *Id.* “In other words,” the MCPM provides, “the time counted as ‘intra-service care’ begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services.” *Id.*

B. Realhab argued that the CMS guidance permitted a supplier to bill up to 7.5 units of one-on-one services per hour for each practitioner.

As the ALJ explained, Realhab argued that the Medicare guidance on billing for timed physical therapy codes provides for “services described by a 15-minute timed CPT code [to] be billed as a unit even though the service is delivered in eight minutes.” ALJ Decision at 17-18; P. Prehearing Br. at 6, citing P. Ex. 7, at 1-3. Therefore, Realhab asserted, it was permitted to bill for up to 7.5 units of timed, one-on-one physical therapy

services per hour, per practitioner.⁹ (As discussed later, Realhab argued that “each of its two professionals competently delivered approximately 7.5 units of one-on-one services per hour and . . . worked enough hours to perform the number of units billed.” *Id.*) The ALJ accepted Realhab’s interpretation of the Medicare physical therapy billing requirements for the purpose of analyzing whether Realhab abused its billing privileges, and we find no error in his doing so in the context of this case. We note, however, that the guidance which Realhab says allows it to bill 7.5 units of one-on-one services per hour permits the practitioner to bill no more than one 8-minute unit of any type of one-on-one service per patient, per day. CMS Ex. 13, at 5-6; *see also* CMS Pub. 100-04, Ch. 5, § 20.2. To bill for two units of any one-on-one service for a patient on the same day, the practitioner must have furnished at least 23 minutes (*i.e.* 15 minutes for the first unit and at least 8 minutes for the second unit) of any timed, one-on-one service to the patient. *Id.*

The ALJ developed the table below, which lists the maximum units of one-on-one services (*i.e.*, timed services requiring one-on-one patient contact by the therapist) that Realhab’s two practitioners could have delivered on any single day of service in the number of hours available, assuming each unit represented only eight minutes of service.

UNITS OF ONE-ON-ONE SERVICE POSSIBLE BY TWO SUPPLIERS	HOURS
15	1
30	2
45	3
60	4
75	5
150	10
180	12
225	15
270	18
300	20
360	24

ALJ Decision at 18. Based on Realhab’s interpretation of the billing guidance, the ALJ reasoned, for any treatment day that Realhab billed for more than 360 units of services, “an inference is triggered” that the excess units claimed were for services that Realhab could not have furnished “to a specific individual on the date of service.” *Id.*

⁹ The ALJ did not “opine as to the practicality of consistently billing 7 to 7.5 units per hour,” but noted that the MCPM instructs Medicare contractors to investigate suppliers “who have a consistent practice of providing 15-minute services in less than 15 minutes.” ALJ Decision at 17-18.

C. Substantial evidence in the record as a whole supports the finding that Realhab billed Medicare for services that it could not have furnished.

On review of the documentation and testimony, we conclude that substantial evidence in the record as a whole supports the ALJ's finding that Realhab billed in excess of 360 units of timed, one-on-one physical therapy services for two dates of service in February 2010. ALJ Decision at 18-19, *citing* CMS Ex. 1, at 52-62; CMS Ex. 16, at 5-9. As discussed above, the record includes two "Date of Service Summary Reports" of compiled Realhab Medicare billing data for 2010 and 2011. The first report, CMS Exhibit 1, pages 52 through 62, summarizes by date of service the number of hours of services billed by Realhab, the number of beneficiaries claimed to have been treated, the total units of services billed, and the amounts billed, allowed, and paid for the period January 4, 2010 through July 22, 2011. The second report, CMS Exhibit 16, pages 5 through 9, summarizes by date of service the number of beneficiaries claimed to have been treated, the total units of services claimed, and the total amounts charged, allowed, and paid from January 4, 2010 through December 24, 2010. The record also includes a more detailed "Date of Service" report showing Realhab's billing for services furnished on February 12, 2010 and February 22, 2010, which lists the beneficiaries (identified by Medicare beneficiary identification code) for whom services were claimed, the CPT codes and units of services billed by Realhab for each beneficiary, and the amounts charged, allowed and paid by Medicare for each service. CMS Ex. 15. All three of these reports show that Realhab billed Medicare for more than 360 units of timed, one-on-one physical therapy services for February 12, 2010, and February 22, 2010. CMS Ex. 1, at 52-53; CMS Ex. 16, at 5-9; CMS Ex. 15. We agree with the ALJ that these exhibits establish that Realhab billed for services that it could not have furnished to specific individuals on two dates of service.

We also concur in the ALJ's finding that the Date of Service Summary Reports list 23 dates of service between January 4, 2010 through July 22, 2011 on which Realhab claimed that each of its practitioners furnished (on average) at least 20 hours of one-on-one services, and 125 days on which Realhab claimed that each of its practitioners furnished (on average) at least 15 hours of one-on-one services. ALJ Decision at 19; CMS Ex. 1, at 52-62; CMS Ex. 16, at 5-9.

Yet, as the ALJ noted, the hearing testimony of Realhab's own witnesses supports a finding that Realhab's physical therapist and physical therapist assistant did not deliver one-on-one patient services for 15 to 20 hours on any day. ALJ Decision at 19-20, *citing* Tr. at 148, 159-170, 174-177, 193-198. According to the testimony of G.R., Realhab's President, owner, and physical therapist, she and her staff generally worked from 6:30 a.m. to 7:00 p.m. each weekday. Tr. at 172, 179-180. G.R. testified, however, that patient appointments were generally scheduled for between 7:30 a.m. and 2:30 p.m., with the last patient leaving by 5:00 or 5:30 p.m. Tr. at 180. Thus, G.R. confirmed that

Realhab’s practitioners could have furnished no more than 10 hours of patient services per date of service, when patients were present. Tr. at 179-181. Although G.R. testified that she worked additional hours performing administrative tasks in the evenings and on weekends, that work did not include providing billable Medicare patient services. Tr. at 180-182.

Furthermore, we agree with the ALJ that Realhab’s own Exhibit 7, summarizing its Medicare billing data for 2010 and 2011, shows that it billed for more units of one-on-one services than its two practitioners could have provided. ALJ Decision at 21. Assuming that Realhab was authorized to bill for each practitioner up to 7.5 units of one-on-one patient services per hour, and each practitioner provided patient services ten hours per date of service, Realhab theoretically was capable of providing a maximum of 150 units of one-on-one services per day, and 750 units per five-day period. Yet, the data in Realhab’s date of service summary report, reprinted below, show that Realhab routinely billed Medicare for one-on-one services far exceeding that maximum:

DATES OF SERVICE	BILLED UNITS
January 4-8, 2010 [5 days]	1118
February 8-12, 2010 [5 days]	1387
March 22-26, 2010 [5 days]	1317
April 26-30, 2010 [5 days]	1057
May 3-7, 2010 [5 days]	1176
June 7-11, 2010 [5 days]	1028
July 19-23, 2010 [5 days]	932
August 23-27, 2010 [5 days]	796
September 6-10, 2010 [5 days]	791
October 11-15, 2010 [5 days]	1192
November 22-24, 2010 [3 days]	714
December 27-31, 2010 [5 days]	804
January 3-7, 2011 [5 days]	846
February 7-11, 2011 [5 days]	1057
March 7-11, 2011 [5 days]	976
April 18-22, 2011 [5 days]	1049
May 2-6, 2011 [5 days]	964
June 6-10, 2011 [5 days]	1076
July 18-22, 2011 [5 days]	801

P. Ex. 7, at 2-3. Realhab’s own evidence thus shows that it “billed for units of service that could not have been provided by [G.R.] and her physical therapist assistant to any Medicare beneficiary.” ALJ Decision at 21. Moreover, when questioned by the ALJ about Exhibit 7, G.R. stated that the exhibit reflected “what we had on our billing” and

that the calculations were made by the “billing officer.” Tr. at 229-37. While concurring in the conclusion that she and her assistant together could have provided no more than 750 units of one-on-one-services per work week, G.R. was unable to explain why Realhab’s exhibit showed that it had billed for services exceeding that limit. Tr. at 229-37.

Realhab’s witnesses’ testimony also confirms that Realhab billed Medicare for multiple units of timed, constant attendance modalities requiring direct, one-on-one contact by the practitioner, when it furnished supervised modalities (untimed codes not requiring constant attendance by the practitioner). For example, G.R. testified that when Realhab provided electrical stimulation, Realhab billed the service under constant attendance modality code 97032. Tr. at 162-165. G.R. and Realhab’s physical therapist assistant, T. E., testified that to administer the service, the practitioner applies the electrodes to the patient, turns on and calibrates the electrical stimulation machine, places and drapes the patient in the proper position, gives the patient instructions, and starts the machine and timer. Tr. at 163-64; 175-177, 308. G.R. testified that the practitioner then usually leaves that patient’s treatment area, “do[ing] a couple of check-ins here and there to make sure the computer is working properly and that there’s no problem,” and later returns to remove the patient from the machine. Tr. at 163-65. Both witnesses testified that during treatment, the patient has a bell to ring to notify the practitioners if the patient needs immediate assistance. Tr. at 163-64, 308.

The electrical stimulation service described by G.R. and T.E. does not meet the CPT definition for code 97032, however, which involves the “**manual**” application of a modality by a practitioner, requiring the practitioner’s **constant attendance**. CMS Exs. 8, at 3; 9, at 3 (emphasis added). Rather, G.R.’s and T.E.’s description meets the definition of supervised modality code 97014, defined by the CPT as “electrical stimulation (unattended),” which requires supervision but not constant, one-on-one patient-practitioner contact and is not billed on the basis of time. *Id.*

Realhab’s witnesses’ testimony also shows that Realhab billed Medicare for more time in furnishing one-on-one therapeutic procedures than its practitioners furnished. G.R. testified that Realhab uses “state of the art equipment,” including “Biodex, gait trainers, a balance machine, . . . joint retrainers . . . electric[al] stim[ulation] and ultrasound” equipment. Tr. at 154-159. She stated that part of the “personal/professional time” she devotes to “deliver[ing] an individual a CPT code” includes between four and six minutes to prepare the equipment for each client, instruct the client and begin the task. Tr. at 160-161. She testified that she spends between four and eight minutes to print the report of the therapy provided and enter it into a patient’s record. *Id.*

G.R. and T.E. further testified that if they leave a patient using a machine to perform another task or to work with another patient, they consider the first patient still to be receiving timed, “one-on-one care.” Tr. at 160-161, 301-306. G.R. stated that the

number of machines available limits the number of patients who may concurrently receive “one-on-one care.” Tr. at 161-165. She testified that the facility has “two Biodex joint range of motion machines,” “one balance machine, and one gait trainer.” *Id.* She stated that at times she provided therapeutic procedures to a patient in one area and electrical stimulation to another patient in a second area, while the physical therapist assistant would be working with a third patient in another area. *Id.* In those circumstances, she considered all three patients to be receiving one-on-one services and billed Medicare accordingly. Tr. at 161-165, 301-306; *see also* RR at 3. Indeed, Realhab argues that it provided “medically necessary, individually tailored one-on-one care to more than one beneficiary at a time, using efficiencies and advanced technology” that were not available when the “CPT guidance regarding minutes-per-unit” was last revised. RR at 3; Realhab Reply at 3. Realhab asserts that “neither the CPT nor Medicare guidelines are binding on the ALJ where the evidence demonstrates that a medically necessary covered service has been provided in a way that varies from the guidance source.” Realhab Reply at 3.

We conclude that the testimony of Realhab’s witnesses supports the conclusion that Realhab routinely billed for more time in delivering one-on-one services to individual patients than its practitioners provided. Under the CPT definitions, a supplier may report only the time when the therapist had “direct (one-on-one) patient contact” when billing for a one-on-one therapeutic procedure. CMS Ex. 8 at 3-4; CMS Ex. 9, at 3-4. Thus, while a therapist may provide direct one-on-one minutes to a patient in episodes, time during which only the machine had “one-on-one” contact with the patient may not be included.

Furthermore, Realhab’s characterization of the CPT is incorrect. As discussed above, the CPT codes and descriptions of physical therapy services are not simply “guidance” that an ALJ may set aside on review of a supplier revocation. Rather, the Act and applicable regulations require suppliers to use the CPT codes and descriptions when billing for outpatient physical therapy services. Moreover, the Secretary explicitly advised suppliers in the *Federal Register* notice updating the 1995 physician fee schedule that suppliers must bill for services based on their CPT definitions, and that a supplier may bill for 15 minutes of a service in the constant attendance category only when the supplier has provided “the 15 minutes of constant one-on-one attendance that is included in the definition of the code.” 59 Fed. Reg. 63,451. Thus, while evidence of Realhab’s technologically advanced equipment shows that Realhab may have been able to use this equipment to deliver individually tailored therapy services to multiple beneficiaries simultaneously, the services Realhab provided were “simply not billable as units of one-on-one therapy no matter how effectively or efficiently the therapy [was] delivered.” ALJ Decision at 22.

Accordingly, we conclude that substantial evidence in the record as a whole supports the ALJ's finding that Realhab in multiple instances billed Medicare for services that it could not possibly have furnished as billed.

III. The ALJ's conclusion that CMS properly revoked Realhab's billing privileges based on 42 C.F.R. § 424.535(a)(8) is free from error.

Realhab further argues that the ALJ erred in concluding that section 424.535(a)(8) supports the revocation of its billing privileges. Section 424.535(a)(8) provides:

- (a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

* * *

(8) Abuse of billing privileges. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. **These instances include but are not limited to** situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(Emphasis added.) According to Realhab, the regulation requires CMS to identify by name at least one beneficiary who could not have received the services claimed on a particular date of service. RR at 1-2. Here, Realhab asserts, the revocation notice "did not identify any **specific named beneficiary** alleged not to have received a specific service on any challenged service date." RR at 2 (emphasis in original). Realhab also contends that all of the examples of billing abuse in the regulation "address claims for services that *could not possibly* have [been] delivered because the beneficiary was dead, the clinic was closed, or [the] supplier was out of town." RR at 2. Realhab argues that "the record does not contain evidence of any of the kinds of abuses cited" in the regulation. *Id.* Realhab asserts that the ALJ's interpretation of the regulation is "overbroad" and "would make all innocent coding errors a basis for revocation because, although a Medicare service was provided to a specific beneficiary on a specific day, the claimed Medicare service was not provided." *Id.*

Realhab's arguments are unpersuasive. The evidence in the record includes documentation showing that Realhab billed Medicare for services that it could not have furnished to specific individuals on particular dates of service. Most notably, the Date of Service billing report for February 12, 2010 and February 22, 2010 identifies by Medicare beneficiary identification code the specific individuals to whom Realhab claimed to have furnished services and the types and amounts of services billed by

Realhab for each individual, on each date. CMS Ex. 15. That document shows that Realhab claimed to have furnished (among other things) two units of timed, one-on-one electrical stimulation services (CPT Code 97032) to 29 individuals on each date of service. Based on the testimony of Realhab's own witnesses, these services could not have been provided as billed because Realhab's practitioners did not furnish constant attendance, manual, one-on-one, electrical stimulation to Realhab patients. Rather, as discussed above, Realhab furnished supervised but unattended electrical stimulation to its patients, an untimed code. Tr. at 163-65, 175-177, 308; CMS Exs. 8, 9.

In addition, the Date of Service billing report for February 12, 2010 and 22, 2010 shows that Realhab typically billed two units, and occasionally billed three units, of each type of timed, one-on-one service that it claimed to have furnished to each patient. CMS Ex. 15. As noted, in order to bill Medicare for two units of any one-on-one service, a qualified practitioner must have furnished at least 23 minutes of the service, and to bill for three units, the practitioner must have furnished at least 38 minutes of the service. CMS Pub. 100-04, Ch. 5, § 20.2. Based on those requirements, the report shows that Realhab billed Medicare for more than 69 hours of one-on-one services for February 12, 2010 and more than 67 hours of one-on-one services for February 22, 2010. Limited by the total number of its qualified practitioners (2) and the hours available in each date of service (24), Realhab simply could not have furnished all of the services billed to the identified beneficiaries.

Furthermore, we reject Realhab's arguments about the limited applicability of section 424.535(a)(8). While section 424.535(a)(8) provides that "abuse of billing privileges" involves submitting a claim or claims "that could not have been furnished to a specific individual on the date of service," the purpose of the phrase "to a specific individual" is to cover situations where a practitioner was available and had the necessary equipment to furnish a service, but could not have furnished the service to the identified beneficiary given that beneficiary's status or location. As reflected in the regulatory language and the preamble to the final rule, the Secretary promulgated section 424.535(a)(8) to authorize revocation of Medicare billing privileges "when a provider or supplier submits a claim or claims for services that could not have been furnished to a beneficiary." 73 Fed. Reg. 36,448, 36,450, 36,455 (June 27, 2008). Moreover, the preamble states, it is "both appropriate and necessary that [CMS] have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier." *Id.* In addition, while the Secretary included in the regulation examples of circumstances wherein "a provider has billed the Medicare program for services which were not provided and has submitted Medicare claims for services to a beneficiary who could not have received the service which was billed," the wording in the regulation ("These instances include but are not limited to . . .") shows that the examples were not intended to represent an exhaustive

or exclusive list of abusive billing practices. *Id.* In light of the language and history of the regulation, we conclude that the ALJ did not err in construing section 424.535(a)(8) as a basis for revocation where a supplier in multiple instances billed Medicare for services it “could not have . . . furnished to any beneficiary.” ALJ Decision at 9-10.

In addition, as discussed above, the Date of Service Summary Reports show that for multiple dates of service in 2010 and 2011, Realhab billed Medicare collectively for more units of one-on-one services than its practitioners could have furnished in the hours available on those dates. CMS Ex. 1, at 52-62; CMS Ex. 16, at 5-9. While these documents do not include beneficiary identification codes or specify which beneficiaries did not receive the services that were billed but not furnished, the underlying billing documents necessarily would have identified the beneficiaries who allegedly received the services. *See* 42 C.F.R. § 424.30 *et seq.* We therefore conclude that the summary documents are sufficient to establish that on multiple dates of service, Realhab billed for services in excess of what its practitioners could have possibly furnished to specific beneficiaries. We agree with the ALJ, moreover, that to require CMS to identify with any greater specificity which beneficiaries did not receive the excess billed services “would prevent CMS from stopping abusive billing in a case such as this simply because CMS cannot tell which among many beneficiaries could not have received services on a specific day.” ALJ Decision at 10. Thus, we conclude that the ALJ did not err in sustaining the revocation of Realhab’s billing privileges based on section 424.535(a)(8).

We also find no merit in Realhab’s suggestion that its repeated “overbilling” was based on an “innocent coding error.” RR at 2. As discussed above, the Act and applicable regulations require Medicare suppliers of outpatient physical therapy services to report and bill for services based on the codes and definitions established under the CPT. In addition, Medicare program manuals provide detailed guidance on how to report outpatient physical therapy services billed on the basis of time. Section 424.510(d)(3) of the regulations, moreover, requires a supplier to be “aware of, and abide[] by, all applicable statutes, regulations, and program instructions.” Here, substantial evidence in the record shows that Realhab engaged in abusive billing practices that were plainly inconsistent with the applicable coding system and reporting requirements. Whether Realhab believed Medicare coding and guidance have not kept pace with advances in the delivery of physical therapy services, as Realhab asserts, or Realhab deliberately ignored the requirements is irrelevant under section 424.510(d)(3).

Realhab also contends that “revocation is not a remedy for claims, or patterns of claims, that Medicare feels are not eligible for payment . . . [and] should not apply to situations in which suppliers do in fact provide services but, because of a correct or incorrect policy interpretation . . . submit claims for those services which are later denied as not covered.”

RR at 2. In that type of situation, Realhab asserts, “CMS can deny the claims subject to appellate review, or it can seek appropriate intermediate sanctions.” *Id.* “To hold otherwise,” Realhab argues, “would render moot the processes and protections of the claims review process.” *Id.*

We reject these arguments. Revocation of enrollment is a remedy intended to protect the integrity of the Medicare program by precluding certain suppliers or providers from billing for any services they furnish. CMS revoked Realhab’s billing privileges because Realhab billed for multiple services that Realhab could not have possibly furnished as claimed. Limiting the term “abuse of billing” in the context of revocation to situations in which **no** services could possibly have been furnished, as Realhab suggests (RR at 2), would not adequately protect the integrity of the Medicare program. Claiming for higher paid services than could possibly have been furnished as claimed, as Realhab did, has a detrimental effect on program finances and integrity just as if no services at all had been furnished. Mere denial of individual claims simply would not be as effective a means for protecting Medicare funds. To the extent that CMS has denied payment of any of the claims at issue, moreover, and Realhab has timely appealed the denial, the “processes and protections” of the claims review process are available to Realhab, and are not rendered moot by the revocation, which was not effective until after Realhab had billed for these services.

Accordingly, we conclude that the ALJ’s determination that CMS properly revoked Realhab’s billing privileges based on 42 C.F.R. § 424.535(a)(8) is free from error.¹⁰

IV. The ALJ did not err in rejecting Realhab’s argument that he should declare 42 C.F.R. § 424.535(a)(8) void and unenforceable for vagueness.

Realhab argued before the ALJ that he should declare section 424.535(a)(8) void for vagueness. P. Posthearing Br. at 5-6. The ALJ rejected that argument, concluding that the regulation “clearly authorizes CMS to revoke the Medicare billing privileges and the enrollment of a supplier for submitting claims for services that could not have been provided to specific beneficiaries on the dates of service.” ALJ Decision at 22. The ALJ further stated that even if he agreed that the regulation is too vague to have given Realhab “proper notice of what is expected,” he had “no authority to find the regulation void for vagueness.” *Id.*

¹⁰ We note that, in reaching this determination, the ALJ also concluded that a revocation of billing privileges under section 424.535(a)(8) must be based upon a pattern of abusive billing and requires a showing that one or more beneficiaries could not have received the services billed. We need not decide here whether these conclusions about what the regulation requires are correct. The evidence discussed above establishes that any such requirements are met by the circumstances of this case.

On appeal to the Board, Realhab asserts that the “ALJ incorrectly concluded that he did not have the authority to consider whether [section 424.535(a)(8)] was too vague to be applied to the set of facts at bar.” RR at 3. Citing the Board’s decision in a prior case, Realhab asserts that an ALJ may “consider constitutional claims challenging the manner in which a statute or regulation is interpreted or applied in a particular case.” RR at 3-4, *citing Experts Are Us, Inc.*, DAB No. 2322 (2010).

Realhab does not present any specific argument to dispute the ALJ’s finding that section 424.535(a)(8) was sufficiently clear to put Realhab on notice that billing for services that could not have been provided to beneficiaries on particular dates of service constitutes an abuse of billing privileges under the revocation regulations. Furthermore, Realhab does not articulate a constitutional claim to challenge the manner in which the regulation was applied in this case. Accordingly, we conclude that the ALJ did not err in rejecting Realhab’s argument that he should declare section 424.535(a)(8) void and unenforceable for vagueness.

Conclusion

For the reasons explained above, we sustain the ALJ Decision.

_____/s/
Sheila Ann Hegy

_____/s/
Leslie A. Sussan

_____/s/
Judith A. Ballard
Presiding Board Member