Audit Report

Co-Treatment Therapy Billing

Rebound Sports and Physical Therapy

August 26, 2021
OIG Report No. AUD-21-028

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

The Texas Health and Human Service (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of co-treatment therapy billing to determine whether Rebound Sports and Physical Therapy Center (Rebound) billed correctly for co-treatment services performed in three of its locations in Texas. This audit focused on claims paid to Rebound from Superior HealthPlan and UnitedHealthcare, which totaled $5,772,369 (or 77 percent of the total amount paid to Rebound by all MCOs during the audit period).

The audit objective was to determine if Rebound performed co-treatment services and if so, billed for co-treatment services in accordance with applicable statutes, rules, and procedures. The audit scope included physical, speech, and occupational claims paid by Superior HealthPlan and UnitedHealthcare from September 1, 2018, through May 31, 2020.

WHAT THE OIG RECOMMENDS

Rebound should (a) designate a primary therapist when performing co-treatment, (b) only submit claims for the primary therapist, (c) indicate co-treatment was performed by including the U3 modifier on co-treatment claims, and (d) repay HHSC $474,783.06.

MANAGEMENT RESPONSE

OIG Audit presented audit results, issues, and recommendations to Rebound in a draft report dated July 15, 2021. Rebound provided management responses that it disagreed with the conclusions in the report. Rebound's action plan is included in the report following the issue, and the complete management response is provided in Appendix C.

For more information, contact:
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CO-TREATMENT THERAPY BILLING

Rebound Sports and Physical Therapy

WHAT THE OIG FOUND

During the audit scope, Rebound did not follow required guidelines for submitting claims for co-treatment therapy billing, although documentation for therapy sessions was otherwise available and complete. For all claims tested, Rebound maintained required documentation in the patient's medical record including detailed progress notes for all dates of services requested for selected therapy sessions.

However, Rebound did not follow all billing requirements by submitting claims for more than one therapist performing concurrent treatment without including the required modifier. The Texas Medicaid Provider Procedures Manual states when performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist. Claims for co-treatment must be submitted with the U3 modifier.

Of the 120 potential instances of co-treatment tested, 68 (57 percent) were incorrectly billed. Specifically, those therapy sessions were performed as co-treatment in which Rebound did not follow established billing requirements. Specifically, Rebound did not:

- Designate a primary therapist when performing co-treatment
- Only submit claims for the primary therapist performing co-treatment
- Indicate co-treatment was performed by including the U3 modifier on co-treatment claims

During the course of the audit, Rebound management informed OIG Audit that co-treatment occurs at its various locations occasionally, but it is not billed differently than normal sessions. Rebound management and general counsel stated they did not recall receiving communication of the change to co-treatment billing guidelines from HHSC or the MCOs when the changes were put in place in May 2016. As a result of not designating a primary therapist and both performing therapists having been paid for sessions determined to have been performed as co-treatment, Rebound received overpayments of $6,617.24 from claims not supported for payment under Medicaid rules in the sample tested.

Overpayments identified for the statistically valid sample of claims was used to calculate an error rate, which was applied to the respective MCO claims populations using extrapolation. The total extrapolated overpayment amount is $474,783.06. The estimated overpayment amount was calculated by extrapolating the dollar value of the errors across the appropriate sample population.

BACKGROUND

Co-treatment is defined as two different therapy disciplines being performed on the same client at the same time by a licensed therapist for each therapy discipline and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and State Board of Examiners for Speech-Language Pathology and Audiology.

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INTRODUCTION

The Texas Health and Human Service (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of co-treatment therapy billing to determine whether Rebound Sports and Physical Therapy (Rebound) billed correctly for co-treatment services performed in three of its locations in Texas.

Co-treatment is defined as two different therapy disciplines being performed on the same client at the same time by a licensed therapist for each therapy discipline.[1] Co-treatment therapy benefits the client when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. The therapy performed requires the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech language pathologist), to perform the therapy safely and effectively to reach the client's goals.

Current Texas Medicaid co-treatment billing guidelines were put in place in May 2016. The guidelines stipulate:

- When performing co-treatment, a primary therapist must be designated from between the two performing therapists.
- Only the primary performing therapist may bill for the therapy services rendered.
- The second therapist must not be reimbursed for assisting a designated primary performing therapist.[2]
- Claims for co-treatment services must be submitted with modifier U3, which is used to indicate in billing that the service was performed as co-treatment.[3]

This audit examined therapy claims by Rebound paid by Superior HealthPlan or UnitedHealthcare, two Medicaid managed care organizations (MCOs), for any possible instances of co-treatment. These two MCOs account for approximately

[1] Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," § 4.4 (Sept. 2018 through May 2020). See Appendix A for the full text.

[2] Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," § 4.4 (Sept. 2018 through May 2020).

[3] Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," § 5.5.6 (Sept. 2018 through May 2020).

77 percent of the total amount reimbursed to Rebound from all MCOs. Superior HealthPlan and UnitedHealthcare contract with Big Country Rehabilitation, Inc., which does business as Rebound in some locations and Steps2Strides in others, to provide services to their patients. Rebound has four locations throughout Texas, in Abilene, Denison, Paris, and Wichita Falls. This audit focused on the Denison, Paris, and Wichita Falls locations, which provide physical, speech, and occupational therapy and each conduct business under the same processor control number used to submit claims for billing.

OIG Audit selected Rebound for this audit based on analysis of encounters data designed to identify risks related to incorrectly billing co-treatment, meaning the same patient received more than one therapy discipline on the same date of service. Analysis determined Rebound had the highest percentage of the top five providers in total paid claims flagged for potential co-treatment.

A breakdown of those claims is shown in Table 1.

Table 1: Summary of All Claims Paid to Rebound During Audit Scope by MCOs

MCO	Amount Paid to Rebound	Percent of Total Paid by the MCO
Superior HealthPlan	$3,957,080	53%
UnitedHealthcare	1,815,289	24%
Other MCOs	1,680,022	23%
Total Paid by All MCOs	$7,452,391	100%

Source: Encounters Data – OIG Fraud, Waste, and Abuse Research and Analytics

Objective and Scope

The audit objective was to determine if Rebound performed co-treatment services and if so, billed for co-treatment services in accordance with applicable statutes, rules, and procedures.

The audit scope included physical, speech, and occupational claims paid by Superior HealthPlan and UnitedHealthcare to Rebound from September 1, 2018, through May 31, 2020. The audit included a review of Rebound's internal control as well as testing of controls that were significant within the context of the audit objectives.

Methodology

To accomplish its audit objectives, OIG Audit collected information through discussions and interviews with management and responsible staff at Rebound, UnitedHealthcare, Superior HealthPlan, and the Texas Health and Human Services Commission (HHSC), and through request and review of supporting documentation maintained by Rebound.

OIG Audit defined the testing population for the audit to include patients who received more than one therapy session from more than one therapy discipline on the same day between September 1, 2018, and May 31, 2020, and reviewed samples of paid claims from both MCOs provided by OIG Fraud, Waste, and Abuse Research and Analytics (FWARA). Auditors reviewed patients' progress notes through Rebound's electronic medical records system, Centricity, to determine whether a patient had been in therapy sessions for different disciplines with start or end times that overlapped.

The testing population for Rebound included 11,136 potential instances of co-treatment during the audit scope period. These instances were made up of 26,017 claims paid by Superior HealthPlan and UnitedHealthcare totaling $3,319,228.

FWARA selected a statistically valid, random sample of 60 instances per MCO, 120 total from the testing population described in Table 2:

Table 2: Testing Populations and Samples

	Population Size	Population Value	Sample Size	Sample Value
Superior HealthPlan	5,746	$1,806,506	60	$19,537
UnitedHealthcare	5,390	1,512,722	60	17,548

Source: OIG Fraud, Waste, and Abuse Research and Analytics

The claims sampled were selected based on the following characteristics:

- Patients of Rebound
- Services provided for more than one therapy discipline—physical, occupational, or speech—on the same date
- Claims paid for more than one therapy discipline—physical, occupational, or speech—on the same date

OIG Audit also reviewed Rebound's system of internal controls, including components of internal control,[4] within the context of the audit objectives.

OIG Audit presented audit results, issues, and recommendations to Rebound in a draft report dated July 15, 2021. Rebound provided management responses that it disagreed with the conclusions in the report. Rebound's action plan is included in the report following the issue, and the complete management response is provided in Appendix C.

[4] For more information on the components of internal control, see the United States Government Accountability Office's *Standards for Internal Control in the Federal Government* (Sept. 2014), https://www.gao.gov/assets/gao-14-704g.pdf (accessed Apr. 16, 2021).

Criteria

The OIG Audit and Inspections Division used the following criteria to evaluate the information provided:

- Texas Medicaid Provider Procedures Manual Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," §§ 4.4 and 5.5.6 (2018 through 2020)
- UnitedHealthcare Administrative Guide/Care Provider Manual (2018 through 2020)
- Superior HealthPlan Provider Manual (2018 through 2020)

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

AUDIT RESULTS

During the audit scope, Rebound did not follow required guidelines for submitting claims for co-treatment therapy billing, although documentation for therapy sessions was otherwise available and complete. As a result of submitting billing for both performing therapists, Rebound received $6,617.24 in overpayments for 68 instances of co-treatment services for which it billed the state.

For all claims tested, Rebound maintained required documentation in the patient's medical record including progress notes for all dates of services requested for selected therapy sessions. Documentation tested included patient name, patient date of birth, type of therapy discipline provided, times in and out, and number of units to bill.

Additionally, all progress notes reviewed during testing indicated therapists were taking extensive notes on patient progress to include documenting primary diagnosis, short term goals, the patient progress against the baseline, and current observations of progress.

OIG Audit tested paid claims for selected therapy services occurring on the same date, including reviewing:

- Progress notes in Rebound's electronic medical records system, Centricity, to determine times in and out of selected sessions
- Paid claims data to determine amount paid for all sessions
- Paid claims data to determine modifiers included on submitted claims

Issue 1: Co-Treatment Sessions were Billed Incorrectly

The Texas Medicaid Provider Procedures Manual (TMPPM) states when performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist.[5] Claims for co-treatment must be submitted with modifier U3 (Therapy Co-Treatment Modifier).[6]

[5] Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," § 4.4 (Sept. 2018 through May 2020).

[6] Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," § 5.5.6 (Sept. 2018 through May 2020).

Compliance staff at Superior HealthPlan and UnitedHealthcare confirmed they expect providers to follow the totality of the TMPPM Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

OIG Audit reviewed 120 potential instances of co-treatment to determine whether the claims associated with the therapy were billed correctly.[7] Of the 120 potential instances of co-treatment tested, 68 (57 percent) were incorrectly billed. Specifically, those therapy sessions were performed as co-treatment in which Rebound (a) submitted claims for both therapists and (b) billed for the sessions without including the U3 modifier.

During the course of the audit, Rebound management informed OIG Audit that co-treatment occurs at its various locations occasionally, but it is not billed differently than normal sessions. Rebound management and general counsel stated they did not recall receiving communication of the change to co-treatment billing guidelines from HHSC or the MCOs when the changes were put in place in May 2016. However, OIG Audit verified that an update for providers was posted on Texas Medicaid and Healthcare Partnership's (TMHP) website, which was communicated to TMHP by HHSC, in February 2016. That update informed providers of upcoming changes to co-treatment billing requirements.

In addition, Rebound's general counsel also stated that because Rebound operates as an Outpatient Rehabilitation Facility (ORF), their therapists do not independently bill for services. Rebound bills all therapy services for their therapists through one central billing office. The general counsel asserted that in an ORF setting, a primary and secondary designation does not occur as each therapist is treating the patient pursuant to their specific plan of care. However, OIG Audit confirmed with HHSC Medical Benefits that the billing requirements for co-treatment apply to ORFs.

As a result of not designating a primary therapist and both performing therapists having been paid for sessions determined to have been performed as co-treatment, Rebound received overpayments of $6,617.24 from claims not supported for payment under Medicaid rules in the sample tested. As it is at the provider's discretion to designate the primary therapist, the overpayment amount was calculated by assuming the higher rate of the two therapists being paid should have been paid to Rebound. Therefore, the lower rate paid for each instance of co-treatment should not have been paid and represents an overpayment.

The $6,617.24 in overpayments has been extrapolated to the respective MCO claims populations and is further explained in the "Overpayments to Rebound" report section.

[7] As some instances included patients receiving services from three different therapy disciplines on the same day, the total number of claims tested was 292.

Recommendation 1

As required by the TMPPM and MCO expectations, Rebound should:

- Designate a primary therapist when performing co-treatment
- Only submit claims for the primary therapist
- Indicate co-treatment was performed by including the U3 modifier on co-treatment claims

Additionally, Rebound should ensure changes to billing requirements, as detailed in the TMPPM and posted on the TMHP website, are identified and incorporated into its claims billing process.

Management Response[8]

Action Plan

Rebound will not perform co-treatment therapy as that term is interpreted in the Audit Report. This action, in Rebound's opinion, is against the medically necessary plan of care for its patients; however, Rebound cannot financially survive if the State refuses to pay state licensed therapists for medically necessary therapy treatment. Rebound understands that this will severely impact the access to care for the children in its areas of service, but if the State chooses to interpret the co-treatment provisions, specifically Section 4.4 and 5.5.6 of the TMHP Provider Manual, to refuse payment for medically necessary therapy services that have been provided to a child, Rebound sees no other course of action. This is a regrettable outcome for the Medicaid children in the State of Texas and, in Rebound's opinion, will result in violation of federal mandates to the state of Texas.

Responsible Manager

Rebound Administrator

Target Implementation Date

Rebound will proceed immediately to implement its action plan.

Audit Response

OIG Audit appreciates the feedback provided by Rebound Sports and Physical Therapy in its management response letter and respects Rebound's position on reported issues. OIG Audit offers the following comments regarding Rebound's management response for Issue 1.

[8] See Appendix C for Rebound's complete management response.

OIG Audit stands by its methodology for testing and the policy criteria used in this audit. OIG Audit verified its interpretation of the policy utilized for this audit with HHSC Medicaid and CHIP Services and has reviewed the work supporting the report findings. OIG Audit stands by its conclusions.

OVERPAYMENTS TO REBOUND

Overpayments identified for the statistically valid sample of claims was used to calculate an error rate, which was applied to the respective MCO claims populations using extrapolation. See Appendix B for the sampling and extrapolation methodology. The total extrapolated overpayment amount is $474,783.06. This amount includes $231,206.65 from Superior and $243,576.41 from United. The estimated overpayment amount was calculated by extrapolating the dollar value of the errors across the appropriate sample population.

Table 3: Summary of Extrapolated Overpayment Amount

MCO	Total Amount of Population Paid	Extrapolated Overpayment	Percentage of Total Paid
Superior	$1,806,506	$231,206.65	12.8%
United	1,512,722	243,576.41	16.1%
Total	$3,319,228	$474,783.06	14.3%

Source: OIG Fraud, Waste, and Abuse Research and Analytics

Extrapolation

The population included in this audit consisted of the following claims paid by selected MCOs from September 1, 2018, through May 31, 2020:

- Superior: 13,175 claims totaling $1.81 million
- United: 12,842 claims totaling $1.51 million

FWARA selected a statistically valid sample representing 120 potential instances of co-treatment, a total of 292 claims, for which MCOs paid Rebound $37,085.02. The total amount paid for claims identified as co-treatment identified for both MCOs is $17,075.56. Table 4 shows the percentage of overpayment for each MCO subject to extrapolation.

Table 4: Summary of Exceptions Subject to Extrapolation

MCO	Total Amount of Co-treatment Identified	Issue 1 Overpayment	Percentage of Overpayment
Superior	$ 8,634.97	$3,257.47	37.7%
United	8,440.59	3,359.77	39.8%
Total	$17,075.56	$6,617.24	38.8%

Source: OIG Audit

By extrapolating the result of the sample to the population of claims within the scope of the audit, OIG FWARA determined that the exceptions represented an overpayment for the population of $474,783.06.

CONCLUSION

OIG Audit completed an audit of Rebound's activity for therapy services rendered from September 1, 2018, to May 31, 2020. The audit evaluated if co-treatment sessions occurred and were billed appropriately in accordance with co-treatment rules, regulations, and statutes.

Rebound maintained required documentation in patient's medical records, including documentation supporting co-treatment goals and detailing patient progress, for each therapy discipline. However, Rebound did not bill correctly for 68 of 120 (57 percent) instances of co-treatments tested. As a result of improper billing, Rebound received an overpayment of $6,617.24 for the statistically valid sample tested. When extrapolated to the populations of claims, Rebound was overpaid $474,783.06 for co-treatments, which it should return to HHSC.

These incorrect payments occurred because Rebound did not always meet all requirements from the TMPPM. Specifically, Rebound did not:

- Designate a primary therapist when performing co-treatment
- Only submit claims for the primary therapist performing co-treatment
- Indicate co-treatment was performed by including the U3 modifier on co-treatment claims

OIG Audit offered recommendations to Rebound, which, if implemented, will help to correct deficiencies in compliance with TMPPM.

OIG Audit thanks management and staff at Rebound for their cooperation and assistance during this audit.

Appendix A: Overview of Co-Treatment

The Texas Medicaid Provider Procedures Manual, Vol. 2, "Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook," (Sept. 2018 through May 2020), states:

4.4 Co-Treatment

Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist as defined in this handbook for each therapy discipline, and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and State Board of Examiners for Speech-Language Pathology and Audiology.

Co-treatment may be a benefit when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. The therapy performed requires the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech language pathologist), to perform the therapy safely and effectively to reach the client's goals as determined by the approved plan of care, signed and dated by the client's prescribing provider.

When performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist.

The following co-treatment documentation requirements must be maintained in the client's medical records as follows:

- Medical necessity for the individual therapy services must be justified before performing cotreatment.
- Documentation supports co-treatment goals and how co-treatment will help the therapist achieve the therapist's goals for the client, for each therapy discipline.
- An explanation of why the client requires and will receive multi-disciplinary team care, defined as at least two therapy disciplines (physical, occupational, or speech therapy) during the same therapy session.

Retrospective review may be performed to ensure documentation supports that the medical necessity of the co-treatment performed and that the billing was appropriate for the services provided by the designated primary-performing therapist.

Appendix B: Sampling and Extrapolation Methodology

OIG Audit examined paid therapy claims for the period from September 1, 2018, through May 31, 2020. After an initial assessment of risks and associated controls, OIG Audit performed testing on a population of paid claims for patients who received services from more than one therapy discipline on the same service date.

Testing for compliance with applicable statutes, rules, and procedures

Auditors tested a statistically valid random sample of 120 potential instances of co-treatment (292 claims total). OIG obtained separate claims populations for each MCO audited, then selected a sample of 60 from each population. The samples were designed to be representative of the respective populations; therefore, it is appropriate to project the results of the samples to the respective populations. The population sizes for each MCO were as follows:

- Superior: 13,175 claims totaling $1.81 million
- United: 12,842 claims totaling $1.51 million

The OIG identified and tested 68 instances of co-treatment being performed that indicated both performing therapists were paid for the co-treatment. Additionally, the claims were not submitted with the required U3 modifier.

Extrapolation

The estimated overpayment amount of $474,783.06 for the samples tested was calculated by extrapolating the dollar value of the errors of the sample as identified in Issue 1 across the appropriate populations. The extrapolated overpayment for the population was calculated based on a 90% percent confidence level.

Rebound was kept apprised of all aspects of the audit process and, in order to ensure audit findings were accurate, was offered multiple opportunities to provide relevant documentation and information.

The Texas Legislature has recognized HHS OIG's authority to utilize a peer-reviewed sampling and extrapolation process. HHS OIG has formally adopted RAT-STATS software as the statistical software to be utilized for the extrapolation process to be consistent with the Office of Inspector General for the United States Department of Health and Human Services.[9]

[9] 1 Tex. Admin Code § 371.35 (May 15, 2016).

Appendix C: Rebound's Management Response

Note: OIG Audit responds to Rebound's response in Issue 1 after the recommendation.

Rebound
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August 16, 2021

Mr. Patrick Smith, CIA, CRMA
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Texas Health & Human Services Commission
Office of Inspector General
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Re: Draft OIG Audit Report No. AUD-21-0XX
Co-Treatment Therapy Billing
Rebound Sports & Physical Therapy

Dear Mr. Smith:

On August 12, 2021, the Office of Inspector General ("OIG") of the Texas Health & Human Services Commission, issued a draft Audit Report ("Report") relating to co-treatment therapy billing practices of Rebound Sports and Physical Therapy ("Rebound"). Pursuant to its Report, the OIG concluded that Rebound "maintained required documentation in patient's medical records, including documentation supporting co-treatment goals and detailing patient progress, for each therapy discipline." However, the OIG further concluded that "Rebound did not bill correctly" for co-treatments tested by the OIG. Based upon the review of a purportedly statistically random sample of speech, physical, and occupational therapy claims paid by Superior HealthPlan ("Superior") and UnitedHealthcare ("United"), and the extrapolation of these results, the OIG concluded Rebound had received an overpayment from the MCOs of $474,783.06.

Based upon these findings, the OIG has recommended that Rebound:

(a) Designate a primary performing therapist when performing co-treatment;
(b) Only submit claims for the primary therapist;
(c) Indicate co-treatment was performed by including the U3 modifier on co-treatment claims; and,
(d) Repay HHSC $474,783.06.

The OIG audited "potential instances of co-treatment," being defined as instances where one patient received more than one therapy service on the same day. The OIG contends there were 11,136 potential instances of co-treatment between September 1, 2018 and May 31, 2020. The OIG sampled 120 of those 11,136 potential instances and determined that 68 (or 57 percent) of those 120 potential instances involved co-treatment therapy. Based on that finding and the OIG's

interpretation of Section 4.4 of the Texas Medicaid Provider Procedures Manual – Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook ("the Handbook"), the OIG has extrapolated a recommended repayment of $474,783.06. The OIG also offered Rebound an opportunity to submit a Management Response to its findings, conclusions, and recommendations. This letter shall serve as the Management Response from Rebound.

Rebound appreciates the professionalism by which this audit has been conducted and the information provided. However, Rebound has a fundamentally different approach to and understanding of the applicable regulations and completely disagrees with the conclusions of the OIG. Rebound is completely committed to its mission of providing services to Texas' very young and vulnerable citizens. Rebound has always taken seriously and been committed to not only providing its patients with the highest level of medically necessary care but complying with and going above the required regulations. For these reasons, Rebound is very concerned by the OIG's legal interpretations and applications as to co-therapy and is compelled to act to protect its now and future patients, itself, and similar providers from these devastating determinations.

I. With an Appreciation of the State's Obligation to Balance Both Access to Care and Prevention of Fraud, Waste, and Abuse, Rebound has Multiple Reasons Supporting its Disagreement with the Conclusions Drawn by the OIG.

Rebound firmly disagrees with the findings of the OIG on key matters. These are:

1. Section 4.4 of the Handbook clearly states that co-therapy treatment is a covered Medicaid benefit under certain circumstances. Even so, the OIG has interpreted Section 4.4 in a manner inconsistent with the clear meaning and that goes against the best interest of the Medicaid children of the state of Texas. Rebound contests the OIG's interpretation of the co-treatment provision and strongly disagrees that Section 4.4 allows payment only to a designated "primary therapist" for the service of the primary therapist when providing co-treatment.

2. Rebound believes it has complied fully with the requirements of billing for co-therapy and no refund is due. However, assuming the position of the OIG is correct (which again, Rebound does not) Rebound contends that the OIG has significantly overstated the potential overpayment to Rebound by failing to fully take into account the difference in billing methodology between speech therapy and physical and occupational therapy, in instances where speech therapy overlaps with either physical or occupational therapy.

3. The OIG did not find any instance where Rebound billed for a therapy service that was not performed and provided to its patients, and the OIG found that "Rebound maintained required documentation in the patient's medical record including detailed progress notes for all dates of services requested for selected therapy sessions." Moreover, the OIG has not found that any Rebound therapist was merely assisting another therapist.

4. Finally, and as far as Rebound is concerned, most importantly, the OIG interpretation of Section 4.4 results in a cessation of access to medically necessary therapy services for the rural children of the state of Texas. Rebound cannot afford to have therapists provide services without payment, and the curtailing of services will cause harm to the youngest

> and most vulnerable Texans, without contributing to any tangible benefit to the Texas Medicaid program. If Rebound, and in fact all providers, cease to provide medically necessary treatment to Texas children, the only result is a serious access to care issue for these special-needs children. This result violates the federal mandates set forth in 42 USC §1396, *et seq*, and specifically 42 USC §1396d.

Under the interpretation provided by the OIG, Section 4.4 and Section 5.5.6 of the Handbook require speech, physical or occupational therapy, when provided at the same time to the same patient, to be billed as follows:

- When performing co-treatment, a primary therapist must be designated from between the two performing therapists.
- Only the primary performing therapist may bill for the therapy services rendered by the primary performing therapist.
- The second therapist will never be reimbursed.
- Claims for co-treatment must be submitted with modifier U3

However, this interpretation twists the plain language of Section 4.4, renders Section 5.5.6 completely superfluous, ignores Section 4.7 of the Handbook and Section 1.12 of the Texas Medicaid Provider Procedures Manual Vol. 1 (the "Manual" or "Procedure Manual") and makes the efficient and effective care of patients impracticable.

II. Section 4.4 of the Texas Medicaid Provider Procedures Manual – Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook ("the Handbook") is drafted to provide a covered benefit for co-treatment therapy. The OIG has modified the use of the word "benefit" which results in the entire remainder of this Section being all but impossible to resolve in any meaningful way.

The OIG appears to have only reviewed Section 4.4 and Section 5.5.6 of the Handbook. However, the OIG should also have considered Section 4.7 of the Handbook and Section 1.12 of the Procedure Manual in its interpretation of the rules applicable to co-treatment therapy. As will be shown, Section 4.4 clearly provides for co-therapy to be a covered Medicaid benefit and the result reached by the OIG is against the only plain meaning of the language contained in Section 4.4. Specifically, the OIG directly re-words a portion of Section 4.4 against the best interests of the Medicaid children in the state of Texas and against the great weight of the remainder of this provision.

Specifically, Section 4.4 of the Handbook states:

> **Section 4.4 Co-Treatment**
>
> Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist as defined in this handbook for each therapy discipline and

rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and State Board of Examiners for Speech-Language Pathology and Audiology.

Co-treatment may be a benefit when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. The therapy performed requires the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech-language pathologist), to perform the therapy safely and effectively to reach the client's goals as determined by the approved plan of care, signed, and dated by the client's prescribing provider.

When performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist.

The following co-treatment documentation requirements must be maintained in the client's medical records as follows:

- Medical necessity for the individual therapy services must be justified before performing cotreatment.

- Documentation supports co-treatment goals and how co-treatment will help the therapist achieve the therapist's goals for the client, for each therapy discipline.

- An explanation of why the client requires and will receive multi-disciplinary team care, defined as at least two therapy disciplines (physical, occupational, or speech therapy) during the same therapy session.

Retrospective review may be performed to ensure documentation supports that the medical necessity of the co-treatment performed and that the billing was appropriate for the services provided by the designated primary-performing therapist.

Specifically, Section 4.7 of the Handbook[1] states:

Section 4.7 Exclusions (Non-covered Services)

The following services are not a benefit of Texas Medicaid:

- Speech therapy provided in the home to adult clients who are 21 years of age and older.
- Therapy services that are provided after the client has reached the maximum level of improvement or is now functioning within normal limits.
- Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition.
- Separate reimbursement for VitalStim therapy for dysphagia. VitalStim must be a component of a comprehensive feeding treatment plan to be considered a benefit.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
- Therapy services related to activities for the general good and welfare of clients who are not considered medically necessary because they do not require the skills of a therapist, such as:

[1] Section 1.12 of the Texas Medicaid Provider Procedures Manual Vol. 1 and 2 sets forth almost 70 specific instances that are *not* covered benefits and are specifically excluded from Medicaid coverage. Co-therapy treatment is not excluded from coverage.

- General exercises to promote overall fitness and flexibility or improve athletic performance
- Activities to provide diversion or general motivation
- Supervised exercise for weight loss
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational or speech therapy program
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
- Therapy prescribed primarily as an adjunct to psychotherapy
- Treatments not supported by medically peer-reviewed literature, including but not limited to investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback, and the Wilbarger brushing protocol.
- Therapy not expected to result in practical functional improvements in the client's level of functioning
- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the client on their own or with a responsible adult's assistance)
- The therapy requested is for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist
- Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided
- Therapy services provided by a licensed therapist who is the client's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)

Auxiliary personnel (aide, orderly, student, or technician) may participate in physical therapy, occupational therapy, or speech therapy sessions when they are appropriately supervised according to each therapy discipline's scope of practice and provider licensure requirements. Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel.

Auxiliary personnel, a licensed therapy assistant, and a licensed speech-language pathology intern (Clinical Fellow) are not eligible to enroll as therapist providers in Texas Medicaid.

Specifically, Section 5.5.6 of the Handbook states:

Section 5.5.6 Therapy Co-Treatment

Claims for co-treatment services must be submitted with modifier U3:

Modifier	Description
U3	Therapy Co-Treatment Modifier

A. The OIG has Edited the Second Paragraph of Section 4.4 in a manner that wholly and completely nullifies the meaning of Section 4.4.

1. Co-Treatment is a Covered Benefit

The first sentence of paragraph one of Section 4.4 states: "Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist . . ." The OIG includes this exact language in the Audit Report and cites Section 4.4 for this proposition.

The first sentence of paragraph two of Section 4.4 states:

> "***Co-treatment may be a benefit when*** it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time."

One could simply stop there. If co-therapy treatment is medically necessary for the client to receive therapy from two different therapy disciplines at the same time, co-treatment therapy is a covered benefit under Texas Medicaid. The remainder of Section 4.4 then explains when one therapist has one plan of care and needs a skilled set of hands to assist them, a provider may not bill for the services of the assisting therapist. That makes sense. Rebound agrees.

However, the OIG *completely changes* the meaning of this provision in the Audit Report:

> "Co-treatment therapy ***benefits the client*** when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time."

Ironically, the OIG does ***not*** cite Section 4.4 for this complete reconstruction. Why? Because the OIG *changed the meaning of this sentence.* The Procedure Manual, which includes the Handbook, uses the word "benefit" over 1,600 times. Not once does "benefit" mean anything other than a "covered benefit" under Medicaid. Yet, the OIG twists the meaning of this commonly used term in the health care world into something entirely different. When read as a whole, "benefit" simply means a covered health care benefit. Ignoring this usage, the OIG re-writes this sentence, if not the entire Section, to say "Co-treatment is never a reimbursable benefit." Changing the wording of the sentence is something that is not allowed by the rules and guidelines of the Audit and Inspections Division of the OIG. The OIG interpretation runs afoul of a very critical and perhaps the cornerstone sentence of Section 4.4. *This one sentence changes everything.*

By limiting payment to only one therapist no matter the circumstances, the OIG has completely negated this language and co-treatment ceases to be a "benefit," even if medically necessary for the client. If this was the intended result, Section 4.4 could simply be written to state: "Co-treatment is never reimbursed" or "Even if two medically necessary therapies are provided concurrently, only one therapy will be reimbursed." It does not take an additional 263 words to

make this clear. [2] This is an unacceptable and unfortunate result for the Medicaid children in the state of Texas.

The remainder of the second paragraph of Section 4.4 and the third paragraph of Section 4.4 simply cannot be reconciled except in one result: Section 4.4 provides a covered benefit for co-therapy services when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. A provider cannot be reimbursed if one of the therapists is merely assisting the other therapist. This result is the only result that makes sense when you read the Section as a whole and when you take into consideration that this type of co-therapy is not excluded from coverage elsewhere.

Looking at the second paragraph of Section 4.4, there seems to be missing a conjunction to join the first and second sentences together or to explain why the second sentence matters. It could mean that the type of co-treatment that is a covered benefit is therapy that ***"requires*** the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech-language pathologist), to perform the therapy safely and effectively to reach the client's goals." Or, could it mean that when a second therapist is needed for safety and effectiveness, the "assisting" therapist will not be reimbursed? The latter certainly makes the most sense4 when you read Section 4.4 in its entirety. Rebound would agree that an "assisting" therapist should not be reimbursed. Rebound has never billed for a therapist that is merely assisting another therapist.

However, the better understanding is one that sees this awkwardly included sentence as one that excepts certain assistance. This second paragraph actually speaks to one therapist and one plan of care that requires the expertise of another discipline to assist in providing the therapy from the singular plan of care for that therapy to be performed safely and effectively:

> . . . to perform the therapy [singular] safely and effectively to reach the client's goals as determined by the approved plan [singular] of care, signed and dated by the client's prescribing provider.

If the OIG was to truly read the second paragraph of Section 4.4 for what is the most logical conclusion, the qualifier, or perhaps *caveat*, sentence actually describes a situation where a "primary" therapist needs a set of skilled hands from another discipline to assist in performing the therapy of the primary therapist in a safe and effective manner. This interpretation would make the language of having the primary therapist bill only for the primary service and not bill for the assistance of the secondary therapist make complete sense. However, in *every instance* the Rebound therapists in this audit were actually treating the child according to separate plans of care for each separate therapy discipline. Neither therapist was assisting the other and both were working together in a manner that helped the child better obtain the medically necessary treatment in their plans of care. Truly, this is the type of co-treatment that should be considered a covered "benefit." Consequently, unless there is a finding that one therapist was merely assisting the other therapist with a single plan of care, without making that assumption, Rebound should not owe any reimbursement whatsoever.

[2] As two examples of making instruction very clear, Oklahoma has clearly drafted language that prohibits billing for co-treatment therapy and Wisconsin goes as far as providing a very instructive flyer describing how co-treatment therapy *is* a reimbursable benefit for *both* therapists. See Attachment.

2. Primary and Secondary Therapists

Taking a closer look at the third paragraph of Section 4.4, further supports Rebound's position in coverage for co-therapy. That paragraph states:

> "When performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist."

If read in conjunction with the interpretation that the second paragraph speaks to one therapist and one plan of care requiring the expertise of another discipline to assist in providing the therapy from the singular plan of care for that therapy to be performed safely and effectively, then it makes sense to designate which therapist may bill for their services and which one will not be reimbursed for assisting. However, in every potential instance of co-treatment found by the OIG, there was always a separate, approved plan of care for each patient. In no situation was a Rebound therapist assisting another Rebound therapist to provide treatment on a singular plan of care.

However, if you read Section 4.4 to say that all therapy performed by therapists from two different disciplines at the same time (and ignore the qualifying sentence) is co-treatment, then Section 4.4 is mandating that the therapists find some unknown manner to determine which therapist would be allowed to bill for their therapy service and which one would be reduced to an assistant and not get paid when providing medically necessary treatment according to the patients' separate plan of care. This is the narrow interpretation promulgated by the OIG. *However,* this conclusion does not make sense unless you completely ignore two specific words in paragraph three: "services" and "assisting."

The OIG's interpretation may have been permissible had the OIG considered the provision to mean that the primary therapist must bill for all services, including those performed by the co-treating provider. However, it did not. The very clear language of this paragraph says that "[o]nly the primary performing therapist may bill for the therapy ***services*** rendered. The secondary therapist will not be reimbursed ***for assisting*** a designated primary performing therapist." The OIG has effectively substituted the words "his/her therapy services" for the broader "the therapy ***services***," which would encompass treatment by both providers. By limiting the payment only to the single therapist, and only for the services rendered by that single therapist, the OIG has again, rewritten Section 4.4 by not reading words in their context and not construing them according to common usage. This failure is repeated where the OIG has ignored much the wording in the last sentence of the paragraph which states the secondary therapist is not paid for "***assisting***" the primary therapist.

Our therapists can only work a limited number of hours or units per day. It does not matter whether they are working together or working alone as far as payment is concerned. At the end of the day, Rebound can only bill for the hours of the day that are actually in the day. Rebound can, and has, only billed for the therapy actually provided. Rebound has not billed for assisting. The OIG has not made a finding that our therapists were assisting, yet they are penalizing us for assuming that

is the case. Rebound is not billing "extra" hours. There is no waste, fraud, or abuse. There is simply treatment.

Standard canons of construction would provide that the exception language stating that an "assisting" therapist would not be reimbursed, implies that the actual *provision of therapy* by the "secondary" therapist *would* be reimbursed. The OIG interpretation rendered these words meaningless, which contradicts the requirement that an entire statute must be read in context and the entire statute given effect. If there is no payment at all for the secondary therapist, why is there a need to specify no payment is available to the secondary therapist for assisting? The most logical interpretation of this sentence, when it is read in whole and much of the wording is not ignored, is that it is intended to clarify that while two therapists can co-treat and be paid for the individual therapies provided, there is no payment if one of the therapists is acting solely as an assistant, rather than an independent provider.

For example, if an occupational therapist and physical therapist each concurrently provide one hour of services, but during the session, the OT spends 15 minutes holding a patient steady to allow physical therapy to be rendered, the OT could not bill for time spent assisting the physical therapist. The physical therapist could record and bill for 4 units of therapy while the occupational therapist would only be able to bill for 3 units of therapy; the remaining unit, spent assisting, would not be reimbursable. To apply Section 4.4 otherwise, again, fails to follow the requirements of the Act.

Through its interpretation of Section 4.4, the OIG has denied a Medicaid benefit to Medicaid children. The rule states that co-treatment may be a benefit if three requirements are met (a) it is medically necessary, (b) the therapy performed requires the expertise of two different disciplines, and (c) the therapies are necessary to allow the patient to reach his/her goals as set out in an approved plan of care. By ignoring this and other language contained in Section 4.4 and imposing a blanket prohibition on full payment for concurrent care, the OIG has effectively barred access to co-treatment, despite a patient's clear right to such care under Section 4.4. By barring payment to a provider for medically necessary treatment by failure to pay the providers, the OIG's interpretation is creating a very clear "access to care" issue for the children of Texas.

Rebound requests the OIG review its interpretation of Sections 4.4, 4.7, and 5.5.6, and instead, after applying the requirements of the Texas Code Construction Act to these provisions, determine multiple therapies, provided concurrently, are a benefit of the Texas Medicaid Program. This is not to the benefit of Rebound but a benefit of its patients.

3. The OIG has Completely Ignored Handbook Section 4.7: Exclusions (Non-covered Services) and the Provider Manual Section 1.12.

Both Section 4.4 of the Handbook, and Section 1.12 of the Texas Medicaid Provider Procedures Manual Vol. 1 (the "Manual" or "Procedure Manual"), provide very detailed lists of Medicaid benefits that are ***not*** covered services. Neither Section 4.7 of the Handbook, which is specific to therapy services, nor Section 1.12 of the Manual identify co-treatment therapy as being excluded as a covered benefit. The drafters of the Handbook and Manual have shown awareness of and ability to exclude certain items from covered services. Yet, they chose not to list co-treatment therapy as an excluded benefit.

Under the Texas Code Construction Act[3] ("Act"), words are read in context and construed according to grammar and common usage. Further, when reviewing a statute, it is presumed the entire statute in intended to be effective, that a just and reasonable result is intended, that a result feasible of execution is intended, and that public interest is favored over private interest. In its interpretation (if considered at all) of Handbook Section 4.4 and Manual Section 1.12, the OIG has violated these Code Construction Act principals. The omission of co-treatment in these sections further supports the proposition that the drafters actually intended for co-treatment to be a covered, reimbursable, benefit.

4. The requirement of a U3 modifier for co-treatment claims is effectively useless.

The interpretation applied by the OIG additionally imposes meaningless requirements on providers, including the use of a modifier and designation of a primary therapist. Section 5.5.6 states that a U3 modifier must be utilized if there is co-treatment. However, it must be asked, why? If there is no payment for the secondary therapist's services, why would it be necessary to know if co-treatment occurred? It is not a situation where partial payment is available and thus, co-treatment v individual treatment might have specific implications. If only one therapist can be paid, there is no need to identify the participation of a second therapist. The same argument applies to the need to designate a primary therapist. For providers fully cognizant of the reimbursement limitations being placed on co-treatment, only claims for one therapist would be submitted. It would be illogical to take the time to designate a primary therapist and add a modifier when it would be easiest to simply bill one therapist.

In actuality, the addition of the U3 modifier is superfluous when added to claims submitted to both United and Superior. As shown by the attached examples (See, Attachment A), even when a U3 modifier is added to the claims submitted, both MCOs are paying these claims in full, as a benefit to the patients. In other words, the claims are paid the same way with or without a U3 modifier. Apparently, the MCOs interpret Section 4.4 in the same manner as Rebound: co-treatment claims (identified by a U3 modifier) are covered benefits and should be paid.

Additionally, as is evident on the United claims, United, with apparent assumed knowledge of the required U3 modifier, has instead, mandated all same-day treatments to have a 59 modifier; a modifier not required by TMHP. Not once has a state contracted MCO provided any guidance on the U3 modifier, but rather, at least one MCO has required Rebound to submit the claims with a completely different modifier and has even instructed Rebound as to which claims the 59 modifier must attach. Again, never a word on the U3. As the MCO's are charged by the State to oversee the claims process, Rebound cannot understand why the claims paid by the MCOs are now required to be returned to the state. Again, not once has Rebound submitted a claim for services not provided and supported.

The OIG has been unable to identify whether the inclusion of the U3 modifier indicates to the MCO simply that there was a co-treatment therapy provided by the primary therapist and the claim should be paid (if so, what is the purpose of the modifier?) or whether the U3 modifier gets attached to the claim for services by the second therapist that won't be reimbursed (if so, then why submit the claim for reimbursement?) or whether both claims get submitted and the U3 modifier gets

[3] Tex. Govt Code §311.001 et seq.

attached to the primary therapist and not the secondary. If the latter is the purpose and instruction, the MCO will not be able to determine which of three claims to pay if the patient received three services in one day but only two of them were co-treatment. The use of the U3 modifier is a mystery.

Additionally, the billing modifier "U3" is problematic as that modifier traditionally has many different uses. It is typically grouped with "other commonly used modifiers" without explanation. This is true even in the National Correct Coding Initiative for Medicaid. It was traditionally used for nutritional products, enteral supplies, vitamin and mineral products, bath lifts, gestation/delivery, lodging and transportation, and skilled nursing for third visits per day on a given situation not related to co-treatment. It is confusing at best. When the "U3" modifier had never been required prior to June 2016, and no notice was made of the dramatic change in both procedure and billing, the State and the MCOs have failed in proper training, clear drafting, and interpretation regarding this provision if it is interpreted to apply in some other manner than what the MCOs have been approving for years. However, it is quite possible, as shown by the practice of the MCOs, that the MCOs actually interpret Section 4.4 in the same manner as Rebound: co-treatment therapy that is medically necessary is a covered benefit in the state of Texas. The OIG has offered nothing other than a blanket statement that a banner message was posted on the HHSC website at some time prior to May 2016. No proof of such message has been shown and Rebound has absolutely no recollection of notice of such a drastic change in therapy billing rules.

III. Rebound Contests the Manner in Which the OIG has Calculated the Recoupment Amount as it Relates to OIG Findings of Co-Treatment Regarding the Differential in Billing Between Speech Therapy and Physical and Occupational Therapy.

Again, Rebound strongly contests the OIG's interpretation of Section 4.4. However, if the OIG's interpretation stands, Rebound believes the OIG has misapplied the payment limitations when speech therapy is one of the treatments at issue. See, Attachment A.

As all are aware, there is a significant difference in the methodology utilized to reimburse speech therapy versus either physical or occupational therapy. Speech therapy is reimbursed based upon a per visit methodology. Thus, whether a speech therapist spends thirty minutes or an hour with a patient, the reimbursement for each such visit remains the same. However, reimbursement for physical and occupational therapy is time based and paid utilizing 15-minute units. Thus, unlike speech therapy, the actual length of time spent with a patient (1 to 4 units) by a physical or occupational therapist would each produce significantly different reimbursement. The OIG has failed to take this discrepancy in reimbursement methodology into account in determining any overpayment due by Rebound.

Where the OIG found speech therapy to overlap by only 30 minutes with OT and/or PT (meaning the patients received 30 minutes of ST and one hour, or 4 units, of PT or OT), the OIG considered the speech therapy paid appropriately and identified the overpayment as one-half of the units (2 units) of OT and PT. But, where the OIG found speech therapy to overlap time by the full session (meaning the patient received one hour of ST and one hour, or 4 units, of PT or OT), the OIG identified the overpayment as to the full session of the lowest paid claim. As a result, in such instances, the entire payment for either physical or occupational therapy was considered an

overpayment. This outcome is arbitrary and capricious and should not stand. In fact, "[a]ccording to the ASHA Leader, "Because SLPs usually bill treatment codes that represent a session (rather than an amount of time), and because Medicare has no published minimum/maximum session length, the SLP would bill for one untimed session." The OT or PT would then bill "the timed treatment codes for the occupational or physical therapy."" In other words, both therapists should be paid when co-treatment is a combination between speech therapy and either physical or occupational therapy. See The Rehab Therapist's Guide to Co-Treatment Under Medicare, https://www.webpt.com/blog/rehab-therapists-guide-co-treatment-under-medicare/.

On a single claim basis, the difference in how the OIG has treated the sessions overlapping with speech therapy, the recoupment amount is not a large number. However, when it is extrapolated over thousands of claims, the amount at issue becomes significant. For this reason, Rebound believes that in instances in which speech therapy overlaps with other services, speech therapy should be treated as a thirty-minute session, no matter the documented time. This interpretation causes no windfall to Rebound as it received no additional funds for speech therapy services lasting over thirty minutes. Plus, it avoids the inappropriate result of punishing Rebound for going the extra mile for its patients. In these hour sessions, Rebound has already forgone the time and energy of its therapists by conducting longer sessions for no additional compensation. The OIG should not then punish Rebound for these good deeds by subjecting it to increased recoupment liability. Furthermore, because of the differential between billing by the unit or by the visit between the therapy disciplines, Rebound should not be required to reimburse any monies for these sessions.

The last paragraph of Section 4.4 allows for "retrospective review" with regard to any co-treatment therapy and the billing for that therapy. If the OIG interpretation of Section 4.4 stands, Rebound should be allowed the retrospective opportunity to only bill for thirty minutes of speech therapy, even when there was an overlap of one hour, resulting in payment being applied as described above.

Based upon its review of the sessions for which speech therapy overlapped with either occupational or physical therapy and utilizing a uniform thirty-minute session time for speech therapy, Rebound has identified a reduced overpayment amount of $1,417.14 as to the 120 audited claims (see Attachment A). Rebound understands OIG has refused to utilize this revised amount in its extrapolation of the potential amounts due from Rebound. Should the language be read that co-treatment is a covered benefit, the recoupment amount for all claims should be zero.

IV. The OIG interpretation of Section 4.4 results in a cessation of access to medically necessary therapy services for the rural children of the state of Texas.

Rebound lists this factor last in this list but only because it is not a legal or audit argument. However, Rebound considers it to be its strongest argument against the OIG's interpretations and applications of the rules. Rebound was founded with the intent of providing quality therapy services to children in rural areas of Texas where such treatment is scarce. Rebound always has, and will continue, to place the interest of the child first. However, no matter how desperately needed these services are, or how much Rebound desires to continue to implement its goal of providing quality healthcare to those most in need, it cannot do so if it is not being reimbursed for its services.

Under the OIG interpretation of Section 4.4, there is no payment for co-treatment. There is only payment for one component of any co-therapy session. The practical result of this, is that Rebound will be forced to cease all co-therapy sessions. Going forward, therapy may be provided consecutively, but never concurrently. Rebound cannot afford to do otherwise. This also results in a nonsensical result of a loss of services for patients without a recovery of money by the State.

The interpretation of Section 4.4 of the Handbook, as set forth in the Audit Report, is devastating to the children of the State of Texas, regardless of whether Rebound must return monies earned for therapy services Rebound provided. We understand that the State has a challenging task to balance between Federal mandates to ensure beneficiaries have access to medically necessary services and Federal mandates to safeguard against fraud, waste, and abuse. However, the result of the State's interpretation, in actuality, conflicts with the actual letter of Section 4.4 and bars access to medically necessary services, in defiance of Federal mandates.

This result also renders services that a child needs to receive, a complete impossibility. When a determination of medical necessity is made, there are many situations where it is medically necessary to have two sets of skilled hands, i.e., two licensed therapists from two different disciplines, to effectively perform the therapies that the child needs at the same time. If the state refuses payment for medically necessary co-therapy, there is no way forward to provide the child access to the service. As set forth in the Audit Report, the OIG's interpretation takes away access to care that is medically necessary. This interpretation, applied to real-life scenarios, cannot possibly be the intent of the drafters of Section 4.4.

Unfortunately, this new reality will cause real harm to many Rebound patients. For those who are especially young, or especially fragile, prolonged therapy can be difficult, if not impossible. These children have multiple medical issues and often lack attention span or stamina and it is important to provide as many services as required in as short a period of time. While it may be argued that fragile patients can receive the same therapy but through shorter stacked sessions or on multiple days, this is not a workable solution, and in situations where two sets of skilled hands are necessary, consecutive sessions do NOT give the child the same necessary treatment. Many families are already overwhelmed with the needs of their child. Accommodating extra time or extra sessions will be impossible for many of them. Parents frequently juggle multiple jobs and have other children to care for. Their financial resources are always scarce and even the cost of the extra gas money can be beyond the means for some. These parents are already stretched thin and imposing additional burdens on them to secure the care needed for their children is inappropriate.

Rebound does not make any extra money by providing co-treatment to children. A single therapist may only see a set number of children per day. Whether the therapist is working in concert with another to care for a single child or whether each therapist is treating separate children, at the end of the day, one therapist can only bill for the number of hours they provided services – it matters not whether they worked alone or together with another therapist. The only benefit is to the child, in that the child is able to receive the benefit of special therapy services that may only be provided when performed by two sets of skilled hands at the same time. The OIG interpretation renders a complete inability for the child to receive the benefit of a service that will help that child reach the goals of their treatment plan.

Finally, as noted in the draft audit report, all of the claims that were billed by Rebound were for services that were actually performed. The OIG has stated that all appropriate records to substantiate the therapy services billed were complete. Not one instance of a claim being filed without the therapy service being provided has been identified.

V. Both the State and the MCO's have Failed in Proper Instruction as to Co-Therapy Billing Pursuant to State Law.

Rebound is one of only a few Outpatient Rehabilitation Facilities (ORFs), or even CORFs, remaining in Texas that survived the Medicaid rate cut frenzy of recent years. Through those years, we have experienced many changes in the Medicaid system, but the co-treatment billing change is quite intriguing in how it was implemented and put (or not) into effect. Typically, HHSC, TMHP, CMS, or the MCOs will provide bulletins, news releases, notices, e-mails, or some other type of notice to inform providers when billing changes or procedural changes are anticipated. These notices usually come to us weeks or months before the effective date of the change. Typically, we are never caught by surprise on any major billing or procedural changes. Although the OIG claims a banner massage was posted on the HHSC website, Rebound has no recollection, nor has it seen proof, that such a message was ever posted. The archives on the HHSC website do include reference to such messages in 2016. Rebound contends that at no time, ***before or since*** the co-treatment changes were made in 2016, was notice provided to Rebound. Moreover, pursuant to Texas law, HHSC and the MCOs are required to have training programs in place to make sure that providers are informed and knowledgeable about these very types of issues. This simply did not happen.

A review of the archives of the Texas Medicaid Provider Procedures Manual shows one consistency: it changes constantly and many times, monthly. In June 2016, the instructions for ORFs and CORFs regarding therapy services were removed completely from the traditional location in the Nursing and Therapy Services Provider Handbook and grouped together with all therapy services in the PT, OT, and ST Services Handbook. However, any specific instruction for ORFs and CORFs were completely left out of the transfer of information to the new location. The main issue with such a substantive change, is that it appears that these changes were made without any valuable consideration of how the language in the co-treatment instruction would apply to an ORF like Rebound and is quite unclear even to an individual therapist who submits their own billing. Rebound bills all therapy services through one central billing office as an ORF facility. Our therapists do not independently bill for their services. As an ORF, Rebound is able to provide an environment where kids can receive the therapies they need in the most effective manner possible. That finding has been recognized by the state of Texas in past findings. Failure to allow the therapists to do their job, and be paid for it, is an injustice to the Medicaid children in our State. We implore the OIG to recognize this valuable Medicaid benefit and not remove it from the children of Texas.

As set forth in the discovery documents shared during the course of the audit, both MCOs had newsletters and similar notices regarding many "important" changes to their respective procedures or the procedures or rules from Medicaid, HHSC, TMHP, etc. There was never one single notice about changes to documentation, procedures, or billing relating to co-treatment.

Rebound has made what seems to be an exhaustive search of the Texas Statutes and Codes and Administrative Guidelines and have found nothing that gives the State the authority to bar payment when a licensed professional provides a medically necessary service. Conversely, there is statutory language in Title 8 of the Texas Code with regard to ECI services stating as follows:

> A health benefit plan that provides coverage for rehabilitative and habilitative therapies under this subchapter *may not prohibit or restrict payment for covered services* provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

Tex. Insurance Code §1367.205(a).[4] Although specifically applied to ECI services, the same theory and logic should apply to a denial of medically necessary therapy benefits to Medicaid children.

Texas Government Code § 531.003 identifies goals of the HHSC to include improving access to health and human services at the local level and to foster the development of responsible, productive, and self-sufficient citizens by increasing support services for people with disabilities, increasing services to help people with disabilities maintain or increase their independence and to improve the coordination and delivery of children's services. The OIG's interpretation of Section 4.4 does not comply with the goals of the HHSC regarding co-treatment therapy for special-need children.

The changes made in 2016 directly affect the ability to deliver services that are deemed medically necessary for Texas children. If a determination is made that both treating therapists will not be paid for the therapy services they provide, many children simply will not receive their care in the most effective manner, if at all. Individual therapists cannot afford to co-treat patients and not be paid for the service they provide. Moreover, ORFs and CORFs have the same financial barrier if they are not reimbursed for services provided by licensed therapists that are employed by the ORF/CORF.

The Texas Government Code also governs the responsibilities of the Managed Care Organization system. Part of that law requires MCO's to provide an education program that educates its providers in providing services and proper procedures to follow. Specifically:

> MANAGED CARE MEDICAID PROGRAM: RULES; EDUCATION PROGRAMS. (a) In adopting rules to implement a managed care Medicaid program, the executive commissioner shall establish guidelines for, *and require managed care organizations to provide, education programs for providers* and clients using a variety of techniques and mediums.
>
> (b) A provider education program must include information on:
>
> *(1) Medicaid policies, procedures, eligibility standards, and benefits.*

[4] It is relevant to note that the only protections in this regard given specifically by Texas law are for the ECI system that has little oversight in billing regulations.

Tex. Government Code § 531.0211 (emphasis added). As mentioned above, for Section 4.4 to result in such a drastic change in billing procedures, surly the MCOs would have proffered instruction, education, and guidance as to these "changes." Rebound asserts the reason is that the MCOs still understand medically necessary co-treatment to be a covered service and that only assistant claims are barred from reimbursement. This makes sense. For instance, United has always acknowledged multiple claims in one day and requires Rebound to use modifier 59 on the second (and if third) therapy on the same day. United gave instruction and training on how this is to be done. Rebound complied. This is yet another reason why the recoupment sought by the OIG should not be as stated, particularly as to United.

Another key factor in full disclosure and in a program or rule that relates to payment, is to ensure proper access to care. As indicated above, there are very few ORF/CORF entities still serving rural Texas and its' children. *Any* rule that mandates a professional to work for free when providing *medically necessary* and *physician-prescribed* treatment for a child with disabilities, in such an environment as has been created by the Texas Government, is simply untenable and a further threat to the access to care issue facing so many Texas children already in violation of state and federal mandates.

Although we certainly understand the need to fully optimize Medicaid financing, that process must also ensure the financial stability of the available and approved providers. The Texas Code provides that HHSC *shall* ensure that the Medicaid finance system is optimized to both "increase and retain providers in the system to maintain an adequate provider network [and . . . to]encourage the improvement of the quality of care. Tex. Government Code § 531.02113 (emphasis added). A system or rule that eliminates payment for *medically necessary* treatment is not one established to meet that objective.

Further, Section 531.113 places obligations on the State-contracted MCO's to establish its own procedures for investigating potential fraud or abuse by recipients or providers. Rebound has never received one complaint or investigative request relating to any potential fraud or abuse. Rather, our office has worked hand-in-hand with the MCOs to ensure that all billing submitted to the MCOs is done in accordance with the instruction of the MCOs.

Moreover, the Provider Protection Plan contained in Section 533.0055 of the Texas Government Code states as follows:

> (a) The commission shall develop and implement a provider protection plan that is designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model . . . and to ensure efficiency in provider . . . reimbursement. The commission shall incorporate the measures identified in the plan, to the greatest extent possible, into each contract between a managed care organization and the commission for the provision of health care services to recipients.
>
> (b) The provider protection plan required under this section must provide for:
>
> (1) prompt payment and proper reimbursement of providers by managed care organizations;

(2) prompt and accurate adjudication of claims through:

(A) *provider education on the proper submission of clean claims . . .*

***

[and]

(9) any other provision that the commission determines *will ensure efficiency or reduce administrative burdens on providers* participating in a Medicaid managed care model or arrangement.

See Texas Government Code §533.0055 (emphasis added).

At no time since the changes put in place in 2016, has either the HHSC, CMS, Superior, United, or any other MCO taken any action to instruct Rebound as to an interpretation of Section 4.4 that meant anything other than this: Co-treatment therapy is a covered benefit when it is medically necessary to co-treat and where both therapists are actually performing therapy and not merely assisting the other therapist. In fact, after the initiation of this audit, Rebound started submitting co-treatment claims with the U3 modifier and all claims were paid exactly the same as before. Apparently, even the MCOs interpret Section 4.4 differently than the OIG.

VI. Rebound requests that the OIG reconsider its interpretation of Section 4.4 and waive any recoupment of alleged overpayment.

As discussed above, Rebound requests the OIG review its findings and (i) re-evaluate its interpretation of Section 4.4 in light of the requirements of the Code Construction Act, and find that co-treatment and payments to secondary therapists are permissible (ii) reconsider how potential overpayments are calculated when speech therapy sessions for more than 30 minutes overlap with occupational or physical therapy, and (iii) consider the hardship on patients through the imposition of an interpretation of Section 4.4 that effectively denies access to medically necessary benefits under Medicaid.

VII. Rebound Submits the Following Responses to Specific Requests by the OIG.

In addition to any objections or corrections to its Audit Report, the OIG also requested that Rebound provide information regarding a proposed action plan, identify its responsible manager, and set out a target implementation data. In response to these three requests, Rebound submits the following:

Action Plan - Rebound will not perform co-treatment therapy as that term is interpreted in the Audit Report. This action, in Rebound's opinion, is against the medically necessary plan of care for its patients; however, Rebound cannot financially survive if the State refuses to pay state-licensed therapists for medically necessary therapy treatment. Rebound understands that this will severely impact the access to care for the children in its areas of service, but if the State chooses to interpret the co-treatment provisions, specifically Section 4.4 and 5.5.6 of the TMHP Provider Manual, to refuse payment for medically necessary therapy services that have been provided to a

child, Rebound sees no other course of action. This is a regrettable outcome for the Medicaid children in the State of Texas and, in Rebound's opinion, will result in violation of federal mandates to the state of Texas.

Responsible Manager - Charles Blake Smith is the Administrator of Rebound's clinics and is the individual responsible for oversight of all operations.

Target Implementation Date - Rebound will proceed immediately to implement its action plan.

In conclusion, Rebound is unable to reconcile either the numbers proffered by the OIG in support of the alleged overpayment or the OIG's policy rationale. Regardless, the State's children will be injured and the State's coffers will not correspondingly benefit from the OIG's interpretation and application of the rules as discussed above.

Rebound appreciates the professionalism with which this audit has been conducted and the opportunity to receive and give additional information. Rebound thanks the auditors for their consideration and welcomes any questions or requests for additional information.

Sincerely,

Blake Smith

Charles Blake Smith
Administrator

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy J. VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Patrick Smith, CIA, CRMA, Audit Project Manager
- Louis Holley, CFE, Staff Auditor
- Eniola Bankole, Staff Auditor
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Report Distribution

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- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
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- Emily Zalkovsky, Deputy State Medicaid Director, Medicaid and CHIP Services
- Leslie Smart, Medical Benefits Policy Manager, Medicaid and CHIP Services
- Christine Maas, Therapy Policy Analyst, Medicaid and CHIP Services
- Shannon Kelley, Associate Commissioner for Managed Care, Medicaid and CHIP Services

Rebound Sports and Physical Therapy

- Charles Blake Smith, Administrator
- Lisa Watson Whitman, General Counsel

Appendix E: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
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