

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MANY MEDICARE CLAIMS FOR
OUTPATIENT PHYSICAL
THERAPY SERVICES DID NOT
COMPLY WITH MEDICARE
REQUIREMENTS**

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**March 2018
A-05-14-00041**

Office of Inspector General

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Report in Brief

Date: March 2018

Report No. A-05-14-00041

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

For calendar year (CY) 2013, the Medicare Part B program paid approximately \$1.6 billion for outpatient physical therapy services provided to Medicare beneficiaries. Past Office of Inspector General reviews of individual physical therapy providers have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, or properly documented. We conducted this review to determine the extent to which these issues occurred nationwide.

The objective of this review was to determine whether Medicare claims for outpatient physical therapy services complied with Medicare requirements.

How OIG Did This Review

Our review covered Medicare outpatient claims for physical therapy services, totaling \$635.8 million, provided by therapists from July 1 through December 31, 2013. A claim consisted of all services provided to a beneficiary on the same date. We reviewed a stratified random sample of 300 of these claims.

Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements

What OIG Found

Sixty-one percent of Medicare claims for outpatient physical therapy services that we reviewed did not comply with Medicare medical necessity, coding, or documentation requirements. Specifically, of the 300 claims in our stratified random sample, therapists claimed \$12,741 in Medicare reimbursement on 184 claims that did not comply with Medicare requirements. Therapists properly claimed Medicare reimbursement on the remaining 116 claims.

On the basis of our sample results, we estimated that during the 6-month audit period, Medicare paid \$367 million for outpatient physical therapy services that did not comply with Medicare requirements.

These overpayments occurred because the Centers for Medicare & Medicaid Services' controls were not effective in preventing improper payments for outpatient physical therapy services.

What OIG Recommends and CMS Comments

By eliminating improper payments, Medicare could have saved an estimated \$367 million on services provided by outpatient physical therapists from July 1 through December 31, 2013. Therefore, we recommend that CMS (1) instruct the Medicare Administrative Contractors to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, (2) establish mechanisms to better monitor the appropriateness of outpatient physical therapy claims, and (3) educate providers about Medicare requirements for submitting outpatient physical therapy claims for reimbursement.

In written comments on our draft report, CMS generally disagreed with our findings and our first recommendation. CMS stated that it disagrees with some of the policy interpretations and believes further analysis of the sampled claims is warranted to determine whether the claims met Medicare requirements. CMS agreed with our second and third recommendations.

After considering CMS's comments and consulting with our independent medical reviewer, we made changes to the draft report where appropriate. However, we maintain that the remaining error determinations by our medical reviewer were correct and that all of our associated recommendations are valid and consistent with similar reviews of physical therapy services at individual providers.

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INTRODUCTION

WHY WE DID THIS REVIEW

For calendar year (CY) 2013, the Medicare Part B program paid approximately \$1.8 billion for outpatient physical therapy services provided to beneficiaries. Past Office of Inspector General (OIG) reviews of individual physical therapy providers¹ have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, or properly documented.² We conducted this review to determine the extent to which these issues occurred nation-wide.

OBJECTIVE

Our objective was to determine whether Medicare claims for outpatient physical therapy services complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B provides supplementary medical insurance for medical and other health services, including outpatient physical therapy services. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims for outpatient physical therapy services provided by therapists across the United States and its territories.

Medicare Outpatient Physical Therapy Services

Medicare Part B covers outpatient physical therapy services.³ Physical therapists evaluate and treat disorders of the musculoskeletal, lymphatic, and cardiovascular/pulmonary systems among others. The goal of physical therapy is to restore maximum functional independence to a patient by providing services that aim to restore function, improve mobility, and relieve pain.

¹ The term “providers” in this report encompasses all professionals allowed by each State under its licensure rules to provide physical therapy services to Medicare beneficiaries.

² See Appendix A for a list of related OIG reports on Medicare claims for outpatient physical therapy services.

³ The Act § 1832(a)(2)(C).

Physical therapy services are also used to maintain function and prevent or slow decline in functionality. Physical therapists provide various services that include procedures such as manual therapy, therapeutic exercise, neuromuscular re-education, and physical modalities such as electrical stimulation and ultrasound. These services are provided in a number of different settings. In private practice,⁴ the majority of Medicare payments for outpatient therapy services are for physical therapy.

For Medicare Part B to cover outpatient physical therapy services, the services must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified physical therapist⁵ and periodically reviewed by a physician, and the need for such services must be certified by a physician.⁶ Therapists bill for outpatient physical therapy services using standardized codes.⁷ For outpatient physical therapy services to be considered reasonable and necessary, each of the following conditions quoted below must be met:⁸

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or . . . under the supervision of a therapist.
- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

⁴ Private practice for purposes of this report means services provided by a therapist in an office setting.

⁵ For purposes of this report, a “qualified physical therapist” is a physical therapist that meets the qualifications in 42 CFR part 484, such as having successfully graduated from a physical therapist education program (42 CFR § 410.60(a)).

⁶ The Act §§ 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C); 42 CFR §§ 410.60 and 410.61.

⁷ Providers use standardized codes called Healthcare Common Procedure Coding System (HCPCS) codes to report the type and units of service.

⁸ *Medicare Benefit Policy Manual*, chapter 15, § 220.2.B. (Rev. 63), which was in effect during our audit period of July 1 through December 31, 2013. These requirements apply to both rehabilitative therapy and maintenance programs.

- The amount, frequency, and duration of the services must be reasonable under acceptable standards of practice.

If a beneficiary is receiving rehabilitative therapy (rather than being on a maintenance program),⁹ physical therapy services would not be covered if the beneficiary's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve that potential.¹⁰ There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.¹¹

Additionally, Medicare payments should not be made without the information necessary to determine the amount due the provider.¹² A provider must furnish to its MAC sufficient information to determine whether payment is due and the amount of payment.¹³ These requirements are further clarified in chapter 15 of CMS's *Medicare Benefit Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04).

Under section 1128J(d) of the Social Security Act and 42 CFR part 401, subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR §§ 401.305(a)(2), and (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). The Office of the Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments.

HOW WE CONDUCTED THIS REVIEW

Our review covered all therapists' claims greater than or equal to \$25 for Medicare outpatient physical therapy services provided from July 1 through December 31, 2013. Our sampling frame consisted of 9,037,556 outpatient physical therapy service claims with a place of service code of 11 (signifying that the therapist provided the service in an office setting),¹⁴ totaling \$635,771,872, of which we reviewed a stratified random sample of 300 claims. We contracted with an independent medical review contractor that reviewed the medical records for the

⁹ A beneficiary on a maintenance program is one who is receiving physical therapy services to maintain functional status or to prevent decline in function. *Medicare Benefit Policy Manual*, chapter 15, § 220.2.D. (Rev. 63).

¹⁰ *Medicare Benefit Policy Manual*, chapter 15, § 220.2.C (Rev. 63).

¹¹ *Medicare Benefit Policy Manual*, chapter 15, § 220.2.B (Rev. 63).

¹² The Act § 1833(e).

¹³ 42 CFR § 424.5(a)(6).

¹⁴ A claim consisted of all services provided to a beneficiary on the same date.

sampled claims to determine whether the services were allowable in accordance with Medicare requirements. This medical review determined whether the services met medical necessity, coding, and documentation requirements, and each denied claim was reviewed by two reviewers, including a certified coder and a physician who is board-certified in Physical Medicine and Rehabilitation. The medical review contractor reviewed all pertinent beneficiary medical record documentation, including the beneficiary plan of care, progress reports, and notes up to the date of service for the sampled therapy visit.

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.

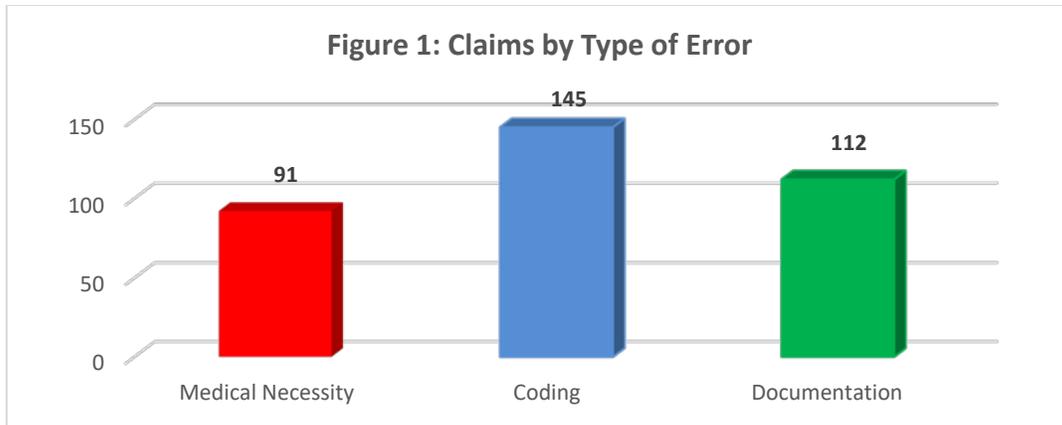
Appendix B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Sixty-one percent of Medicare claims for outpatient physical therapy services that we reviewed did not comply with one or more of the following requirements: Medicare medical necessity, coding, or documentation. Specifically, of the 300 claims in our stratified random sample, therapists claimed \$12,741 in Medicare reimbursement on 184¹⁵ claims that did not comply with Medicare requirements. Therapists properly claimed Medicare reimbursement for the remaining 116 claims.

On the basis of our sample results, we estimated that Medicare paid \$367,039,705 for outpatient physical therapy services that did not comply with Medicare requirements during the 6-month audit period. Therapists submitted claims that were not medically necessary, contained coding deficiencies, or did not meet Medicare documentation requirements. Figure 1 shows claims by type of error.

¹⁵ The total errors exceeded 184 because some claims contained more than one error.



These overpayments occurred because CMS’s controls were not effective in preventing improper payments for outpatient physical therapy services.

Additionally, CMS’s education of therapists on Medicare requirements for outpatient physical therapy services may not have been effective in preventing improper payments. Even though CMS and MACs have a variety of educational materials on their websites, therapists still billed for outpatient physical therapy services that did not comply with Medicare requirements.

SERVICES WERE NOT MEDICALLY NECESSARY

For services to be payable, a beneficiary must need the physical therapy services (*Medicare Benefit Policy Manual*, chapter 15, § 220.1). For a service to be covered under Medicare Part B, the service must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (the Act § 1862(a)(1)(A) and *Medicare Benefit Policy Manual*, chapter 15, § 220.1). Services are reasonable and necessary if it is determined that services were safe and effective, of appropriate duration and frequency within accepted standards of medical practice for the particular diagnosis or treatment, and met the patient’s medical needs (*Medicare Program Integrity Manual*, chapter 3, § 3.6.2.2).

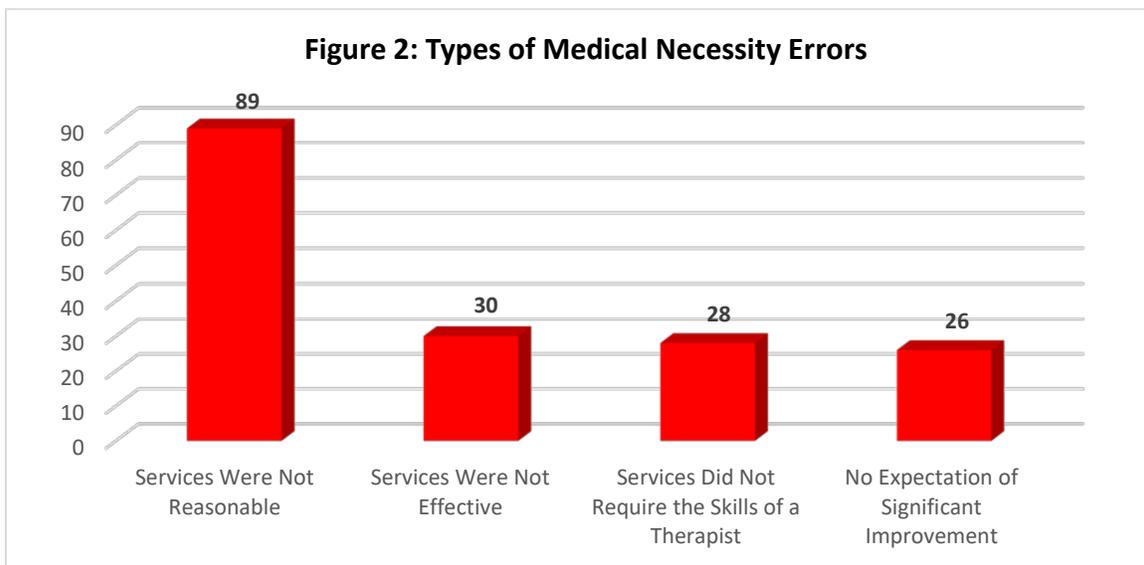
For outpatient physical therapy services to be considered reasonable and necessary, each of the following quoted conditions must be met (*Medicare Benefit Policy Manual*, chapter 15, § 220.2.B. (Rev. 63)):

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or . . . under the supervision of a therapist.

- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- The amount, frequency, and duration of the services must be reasonable under acceptable standards of practice.

If a beneficiary is receiving rehabilitative therapy (rather than being on a maintenance program), physical therapy services would not be covered if the beneficiary’s expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve that potential (*Medicare Benefit Policy Manual*, chapter 15, § 220.2.C (Rev. 63)). There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time (*Medicare Benefit Policy Manual*, chapter 15, § 220.2.B. (Rev. 63)).

For 91 claims,¹⁶ therapists received Medicare reimbursement when the beneficiaries’ medical records did not support the medical necessity of the services. The medical review contractor indicated that these services did not meet one or more of Medicare’s requirements. Figure 2 shows claims by type of medical necessity error.



Services Were Not Reasonable

For 89 claims, medical reviewers determined that the amount, frequency, and duration of the physical therapy services were not reasonable and consistent with standards of practice.

¹⁶ The total errors exceeded 91 because some claims contained more than one error.

No Evidence Services Would Be Effective

For 30 claims, we did not find any evidence that the medical records showed that the services provided would have been effective. For example, a Medicare beneficiary was receiving therapy for lumbago and spinal stenosis. However, the medical review determined that the patient had already reached a functional plateau before the date of the service reviewed.

Services Did Not Require the Skills of a Therapist

For 28 claims, the therapy services did not require the skills of a therapist. For example, a Medicare beneficiary's medical record failed to substantiate that skilled intervention by a physical therapist was necessary. The medical reviewer determined that the beneficiary was performing redundant and repetitive exercises that could have been performed as part of a home exercise program that did not require the skills of a therapist.

No Expectation of Significant Improvement

For 26 claims, all of which were for beneficiaries who were on rehabilitative programs, the medical reviewers determined that the expected rehabilitation potential was insignificant in relation to the extent and duration of the physical therapy services required to achieve that potential or that the beneficiary did not improve significantly enough in a reasonable period of time to justify continued treatment. For example, the evidence in a Medicare beneficiary's medical record (including a review of a plan of care, progress reports, and notes) showed no expectation of significant improvement to warrant that claim or further therapy.

CODING DID NOT MEET MEDICARE REQUIREMENTS

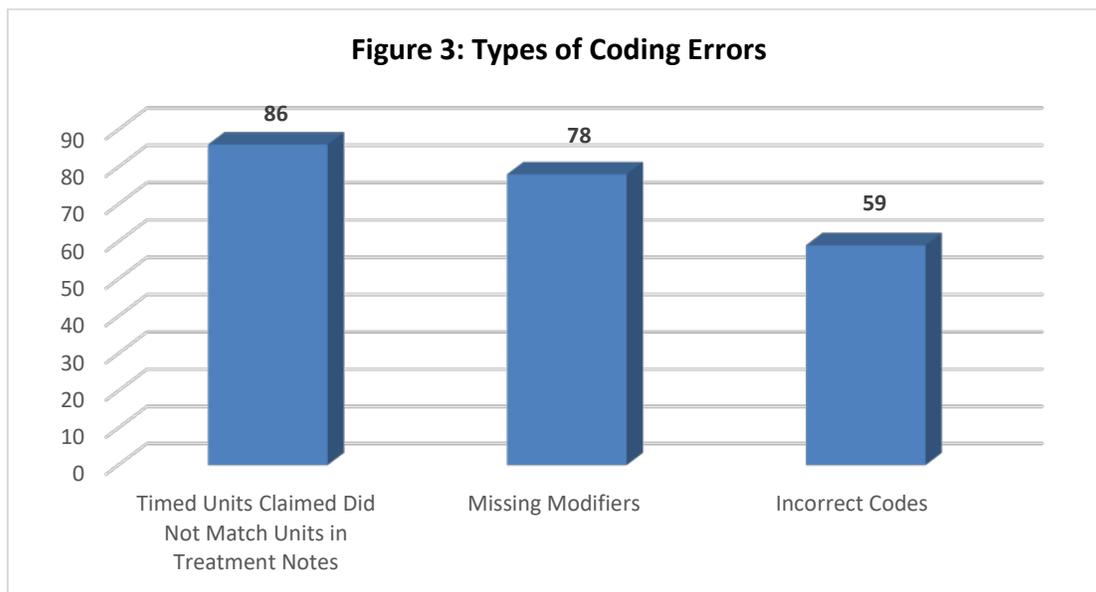
Medicare coding requirements state that outpatient therapy services are payable when the medical record and information on the provider's claim form consistently and accurately report covered services (*Medicare Benefit Policy Manual*, chapter 15, § 220.3A). For timed procedures providers report units in 15-minute intervals based on the number of times the procedure is performed. For untimed procedures, one unit of service is appropriately reported by a provider regardless of the number of minutes spent providing this service (*Medicare Claims Processing Manual*, chapter 5, § 20.2).

Additional Medicare coding requirements in effect as of January 1, 2013, require providers to use certain functional reporting codes, commonly referred to as "G-codes," and severity modifiers that provide information about the beneficiary's functional status (*Medicare Benefit Policy Manual*, chapter 15, § 220.4).¹⁷ These coding requirements are a condition of payment; without the proper functional reporting, claims should not be paid. While the *Medicare Benefit*

¹⁷ G-codes and modifiers are required on certain claims at specific intervals of a beneficiary's care. These G-codes and modifiers should also be documented in the beneficiary's medical record.

Policy Manual requires functional reporting on or after January 1, 2013, CMS allowed a testing period from January 1, 2013, through June 30, 2013, that would let providers use the new coding requirements without penalty and would ensure that CMS’s systems worked as intended. For therapy furnished on or after July 1, 2013, MACs were to return or reject claims without the required G-codes or modifiers (*Medicare Claims Processing Manual*, chapter 5, § 10.6). After our fieldwork, CMS stated that it did not enforce functional reporting on provider claims until October 1, 2013.

For 145 claims,¹⁸ therapists received Medicare reimbursement for claims that did not meet Medicare coding requirements. Figure 3 shows claims by type of coding error.



Timed Units Claimed Did Not Match Units in Treatment Notes

For 86 claims, the number of timed units claimed did not match the number of timed units documented in the treatment notes. For example, a claim for one Medicare beneficiary included three timed units of HCPCS code 97110 (therapeutic exercises¹⁹). However, the treatment notes supported two units of therapeutic exercises and one unit of HCPCS code 97116 (gait training²⁰).

¹⁸ The total errors exceeded 145 because some claims contained more than one error.

¹⁹ Therapeutic exercises (HCPCS code 97110) are a type of therapeutic procedure performed in an active, active-assisted, or passive approach.

²⁰ Gait training (HCPCS code 97116) is a type of physical therapy that specifically helps people from falling by improving their ability to stand and walk.

Missing Modifiers

For 78 claims that CMS required to contain functional reporting information, the medical record or claim or both were missing the proper G-codes or modifiers. For example, a claim form for a Medicare beneficiary did not contain the required G-codes or modifiers to show the beneficiary's functional status as required at that interval of his or her treatment. Thus, the claims should not have been processed and paid.

Incorrect Codes

For 59 claims, providers incorrectly coded the services. For example, a Medicare beneficiary received four units of therapy services and had a reevaluation. Rather than billing four units of HCPCS code 97530 (therapeutic activities) and one unit of HCPCS code 97002 (reevaluation), the provider billed for five units of HCPCS code 97530.

DOCUMENTATION DID NOT MEET MEDICARE REQUIREMENTS

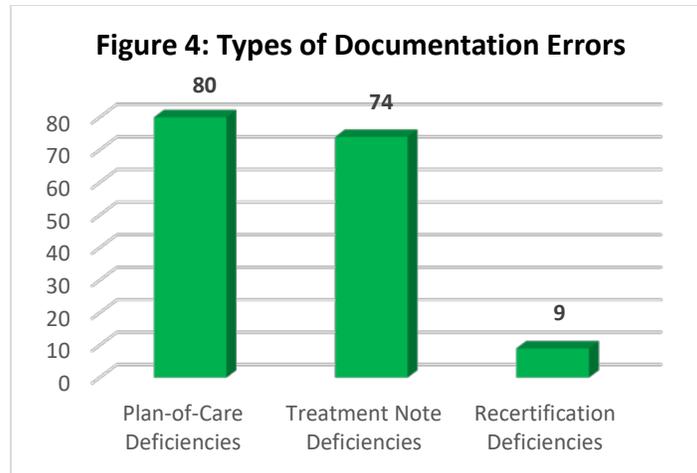
Medicare documentation requirements state that outpatient physical therapy services must be in accordance with a written plan established before treatment begins (42 CFR § 410.60). The plan must contain the type, amount, frequency, and duration of the physical therapy services to be furnished and must indicate the diagnosis and anticipated goals (42 CFR § 410.61). Goals should be measurable and pertain to identified functional impairments. In addition, the signature and professional identity of the person who established the plan and the date it was established must be recorded with the plan (*Medicare Benefit Policy Manual*, chapter 15, §§ 220.1.2A and B).

Additionally, therapists are required to recertify the plan of care when a significant modification of the plan is needed or at least every 90 days after the initial treatment (42 CFR § 424.24(c)(4) and *Medicare Benefit Policy Manual*, chapter 15, § 220.1.3C).

Therapists must also create and maintain a treatment note for each treatment day and each therapy service. The treatment note must include (1) the date of treatment, (2) each specific service provided and billed, (3) the total treatment minutes for timed codes and total minutes for the entire therapy session, and (4) the signature and professional identification of the therapist who furnished or supervised the service (*Medicare Benefit Policy Manual*, chapter 15, § 220.3E).

For 112 claims,²¹ therapists received Medicare reimbursement for services that were not provided in accordance with one or more Medicare documentation requirements. Figure 4 shows claims by type of documentation error.

²¹ The total errors exceeded 112 because some claims contained more than one error.



Plan-of-Care Deficiencies

For 80 claims, there were plan-of-care deficiencies. For example, the medical reviewer deemed a Medicare beneficiary’s plan of care to contain vague goals, to not be signed by a physician or a non-physician practitioner, and to not list the duration and frequency of the therapies.

Treatment Note Deficiencies

For 74 claims, there were treatment note deficiencies. For example, a Medicare beneficiary’s treatment notes did not contain total treatment minutes for timed codes or total minutes for the entire therapy session.

Recertification Deficiencies

For nine claims, there were recertification deficiencies. For example, a Medicare beneficiary’s medical record did not contain a recertification justifying the need for additional therapy after the initial therapy phase under the original plan of care. However, the beneficiary received the therapy anyway.

CMS’S CONTROLS AND PHYSICAL THERAPY EDUCATION WERE NOT ALWAYS EFFECTIVE IN PREVENTING PAYMENTS FOR PHYSICAL THERAPY SERVICES NOT COMPLYING WITH MEDICARE REQUIREMENTS

The overpayments occurred because CMS’s controls were not effective in preventing payments for physical therapy services that did not comply with Medicare medical necessity, coding, or documentation requirements. For example, the enforcement of the functional reporting requirements was not effective in preventing claims from being processed and paid. We noted that of the 78 claims with functional reporting issues (e.g., missing proper codes and modifiers), 38 claims (about half) were processed and paid after October 1, 2013, the date that CMS stated that it had begun enforcing this requirement.

In addition, CMS's education of therapists in private practice on Medicare requirements for physical therapy services may not have been effective in preventing payments for physical therapy services that did not comply with Medicare requirements. Along with Medicare policies available on CMS's website, CMS has published educational materials, such as *Medicare Learning Network Matters* articles, that include information on Medicare requirements for billing of physical therapy services. The MACs' websites have also included educational materials related to physical therapy services, such as presentation slides from web-based seminars, articles, and fact sheets. Even though controls have been in place and CMS and MACs have a variety of educational materials on their websites, therapists still billed for outpatient physical therapy services that did not comply with Medicare medical necessity, coding, or documentation requirements.

ESTIMATED OVERPAYMENT

On the basis of our sample results, we estimated that CMS paid therapists \$367,039,705 for outpatient physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

We recommend that CMS:

- instruct the MACs to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments made in accordance with this recommendation;
- establish mechanisms to better monitor the appropriateness of outpatient physical therapy claims; and
- review current educational efforts about Medicare requirements for submitting outpatient physical therapy claims for reimbursement and improve or increase these educational efforts as needed to reduce the 61-percent error rate and promote provider compliance.

CMS COMMENTS

In written comments on our draft report, CMS generally disagreed with our findings and our first recommendation. CMS agreed with our second and third recommendations.

CMS stated that it disagreed with some of the policy interpretations made by OIG's independent medical review contractor and believed further analysis of the sampled claims was warranted to determine whether the claims met Medicare requirements. Since issuance of our draft report in late October 2017, we have contacted CMS to determine the status of its review of a sample of claims. As of the end of February 2018, CMS had not completed this review.

CMS also stated that OIG inaccurately interpreted CMS's coverage policy for outpatient therapy services relative to "significant improvement," contrary to CMS policy and the court-approved settlement in *Jimmo v. Sebelius* (D. Vt.).

CMS mentioned the OIG findings and CMS policy pertaining to functional reporting codes and severity modifiers but did not expressly agree or disagree with our findings. CMS disagreed with OIG's questioning claims when the NPI on the claim was for a provider different from the person shown in the medical record to have provided the service. CMS stated that its policy did not require the NPI on a claim to match the therapist who actually furnished the therapy service in cases in which the enrolled therapist is providing direct supervision of a therapist who is not yet enrolled or whose enrollment process is not complete. Finally, CMS stated that "most of the findings identified by OIG are likely attributable to documentation errors as opposed to fraudulent activity."

CMS's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering CMS's comments and consulting with our independent medical reviewer, we made changes to the draft report where appropriate. However, we maintain that the remaining error determinations by our medical reviewer were correct and that all of our associated recommendations are valid and consistent with similar reviews of physical therapy services at individual providers (see Appendix A).

It is standard practice when we begin an audit that we work with the auditee to ensure that we are applying accurate payment criteria, and we did so with CMS on this audit. All sampled claims were reviewed by a qualified medical review contractor to determine whether the services met medical necessity, documentation, and coding requirements. Each denied claim was reviewed by two reviewers, including a certified coder and a physician who is board-certified in Physical Medicine and Rehabilitation. We stand by those determinations.

Regarding CMS's comments related to "significant improvement," our medical reviewers considered whether the Medicare beneficiary was either on a maintenance or rehabilitative therapy program and only applied the "significant improvement" standard to claims for beneficiaries receiving rehabilitative therapy. This requirement²² was in effect during our audit period. We note that even a revision issued by CMS after our audit period,²³ and following the *Jimmo v. Sebelius* settlement, contained the following requirement: "If an individual's expected rehabilitative potential is **insignificant** in relation to the extent and duration of therapy services required to achieve such potential, rehabilitation therapy is not reasonable and necessary"

²² *Medicare Benefit Policy Manual*, chapter 15, §§220.2.B and 220.2.C (rev. 63).

²³ *Medicare Benefit Policy Manual*, chapter 15, § 220.2.C (rev. 179); issued as part of Change Request 8458 (January 14, 2014) to revise certain provisions in accordance with the *Jimmo v. Sebelius* settlement.

(emphasis added). We revised our report to make it clear that we used the “significant improvement” standard only for beneficiaries receiving rehabilitative therapy.

Additionally, we applied CMS’s functional reporting requirements exactly as written in regulations and manuals. We did not state that claims lacking the required functional reporting codes should have been denied; rather, we stated that claims needing the required functional reporting codes should not have been paid (i.e., the claims should have been returned or rejected).

Additionally, regarding CMS’s comment related to claims when the NPI on the claim was for a provider different from the person shown in the medical record to have provided the service, audit verification of direct supervision to a physical therapy assistant or any other physical therapist who may not yet be enrolled or whose enrollment process is not complete can only be done on a contemporaneous basis. For this reason, we removed and did not count as errors any instances where a physical therapy assistant, or instances where a physical therapist identified in the medical record differed from the physical therapist whose NPI was listed on the claim.

Finally, we note that “documentation errors” and “fraudulent activity” are not the only causes of improper payments. Most improper payments are likely not fraud,²⁴ and education can be especially helpful in avoiding non-fraudulent activity and future errors. We expressly characterized the improper payments we identified as medical necessity, coding, or documentation errors. While 112 of the 184 claims with errors did not meet Medicare documentation requirements, claims also did not meet medical necessity (91 instances) or coding (145 instances) requirements.

²⁴ The OIG Office of Audit Services (OAS) does not make findings of fraud and refers suspicions of fraud to the OIG Office of Investigations or other law enforcement entities or both.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Missouri Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Physical Therapy Services</i>	<u>A-07-14-01147</u>	05/05/2017
<i>A Southern California Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-09-15-02015</u>	12/27/2016
<i>A Northern California Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-09-14-02040</u>	11/01/2016
<i>A Kansas Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-07-14-01146</u>	08/22/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07054</u>	06/30/2016
<i>A South Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-06-14-00064</u>	06/14/2016
<i>A Florida Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Some Outpatient Therapy Services</i>	<u>A-04-15-07055</u>	04/22/2016
<i>A Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-06-14-00065</u>	03/17/2016
<i>Boulevard Health Care, Inc., Improperly Claimed Medicare Reimbursement for Outpatient Physical Therapy Services</i>	<u>A-02-14-01004</u>	10/29/2015
<i>AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	<u>A-02-13-01031</u>	06/15/2015

Report Title	Report Number	Date Issued
<i>An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	A-05-13-00010	08/20/2014
<i>Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services</i>	A-02-11-01044	06/10/2013

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 9,037,556 Medicare claims for outpatient physical therapy services, totaling \$635,771,872, provided by outpatient physical therapists practicing in an office setting from July 1 through December 31, 2013. A claim consisted of all services provided to a beneficiary on the same date. These claims were extracted from CMS's National Claims History (NCH) file. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the completeness of the file. We limited our review of internal controls to those applicable to our objective.

We conducted our audit from June 2014 through April 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to obtain an understanding of the Medicare requirements related to outpatient physical therapy services;
- extracted from CMS's NCH file a sampling frame of 9,037,556 outpatient physical therapy claims with a place of service code of 11 (signifying that the therapist provided the service in an office setting) of greater than or equal to \$25, totaling \$635,771,872, for services provided from July 1 through December 31, 2013;
- selected a stratified random sample of 300 outpatient physical therapy service claims from the sampling frame (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted, considered any refunded payment a nonerror for statistical estimates, and—if a claim had been adjusted in the Common Working File—used the adjusted paid amount for statistical estimates;
- obtained and reviewed medical records documentation from therapists for the 300 sampled claims to determine whether the services were provided in accordance with Medicare documentation and coding requirements;
- provided the medical records documentation for all 300 sampled claims to an independent medical review contractor to determine whether the services were medically necessary and claimed in accordance with Medicare coding and documentation requirements;

- used the results of our sample to estimate unallowable Medicare reimbursement paid to the therapists (Appendix D); and
- discussed the results of our review with CMS officials.

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.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of all Medicare Part B outpatient physical therapy service claims for services provided by therapists from July 1 through December 31, 2013.

SAMPLING FRAME

The sampling frame was an Access database containing 9,037,556 Medicare Part B outpatient physical therapy service claims, totaling \$635,771,872, for services provided by therapists from July 1 through December 31, 2013. We limited our review to claims with payment amounts greater than or equal to \$25. We extracted the claims data from CMS's NCH file.

SAMPLE UNIT

The sample unit was an outpatient physical therapy service claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into three strata: (1) claims from \$25.00 to \$49.99, (2) claims from \$50.00 to \$99.99, and (3) claims from \$100.00 to \$626.46.²⁵

Table 1: Claims by Stratum

Stratum	Number of Claims	Amount of Payments
1	1,559,697	\$65,487,044
2	6,817,738	494,239,568
3	660,121	76,045,259
Total	9,037,556	\$635,771,872²⁶

SAMPLE SIZE

We selected a random sample of 100 outpatient physical therapy service claims from each stratum, resulting in a total of 300 sample claims.

²⁵ Claims ranged in price of greater than or equal to \$100.00 and up to and including \$626.46.

²⁶ Payment amounts do not sum to the column total because of rounding.

SOURCE OF THE RANDOM NUMBERS

We used the OIG/OAS statistical software to generate the random numbers.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the three strata of the sampling frame. After generating 100 random numbers for each of the three strata, we selected the corresponding frame items in each stratum.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to analyze the sample results. We estimated the total amount of Medicare payments for unallowable outpatient physical therapy services made to therapists.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
1	100	\$4,208	59	\$2,446
2	100	7,100	61	4,238
3	100	11,584	64	6,057
Total	300	\$22,892	184	\$12,741

Table 3: Estimated Value of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$367,039,705
Lower limit	\$325,979,412
Upper limit	\$408,099,998

APPENDIX E: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: OCT 27 2017

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma 
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: Hundreds of Millions in Medicare Payments for Outpatient Physical Therapy Services Did Not Comply with Medicare Requirements (A-05-14-00041)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on Medicare payments for outpatient physical therapy services.

CMS is committed to ensuring that outpatient physical therapy claims from providers comply with Medicare requirements. CMS sets forth guidelines for coverage and payment of physical therapy services specified in Medicare regulations, the Medicare Benefit Policy Manual (MBPM) and the Medicare Claims Processing Manual (MCPM). For Medicare to cover outpatient physical therapy services, the services must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified physical therapist and periodically reviewed by a physician, and the need for such services must be certified by a physician.¹ Providers bill for outpatient physical therapy services using applicable Healthcare Common Procedure Coding System codes on claims which are processed by CMS contractors. CMS communicates any policy changes regarding outpatient physical therapy payments to providers through such means as Medicare Learning Network Matters articles, fact sheets, and provider compliance newsletters. CMS also conducts medical review on certain claims and collects any potential overpayments on improper claims through CMS contractors.

OIG noted in its draft report that sixty-four percent of Medicare claims in a selected sample did not comply with one or more of the requirements regarding Medicare medical necessity, coding, or documentation. As explained below, CMS disagrees with some of the policy interpretations made by the OIG's independent medical review contractor and believes further analysis of the medical records that were utilized is needed to determine whether the claims met Medicare requirements.

For physical therapy services to be covered by Medicare, the service must be reasonable and necessary for the diagnosis or treatment of illness or injury or used to improve the functioning of a malformed body member.² CMS's coverage policy for outpatient therapy services makes clear that coverage turns on the beneficiary's need for skilled therapy services, and such skilled therapy services may be necessary to improve a patient's current condition, to maintain the

¹ 42 CFR 410.60 and 410.61

² Medicare Benefit Policy Manual, chapter 15, section 220.1

patient's current condition, or to prevent or slow further deterioration of the patient's condition. The OIG, however, has interpreted CMS's policy as allowing coverage only when there is an expectation that the patient's condition will improve significantly. This is an inaccurate interpretation of CMS's coverage policy for outpatient therapy services, and it is contrary to the court-approved settlement in *Jimmo v. Sebelius* (D. Vt.). Further, while CMS's coverage of rehabilitative therapy is designed to address the patient's recovery or improvement in function, it does not require "significant improvement" in the progress they make towards their individualized plan of care goals.³

The OIG also found that some claims did not include functional reporting codes, referred to as "G-codes" and severity modifiers that provide information about the beneficiary's applicable functional status. However, because CMS only requires certain prescribed claims to contain this functional reporting information, claims with missing G-codes and severity modifiers where they are not required cannot be denied.⁴ During CY 2013 rulemaking⁵, CMS clarified its policy that the collection of this data, although required to receive payment for therapy services, was not intended to adversely affect the beneficiary's coverage of therapy services and thereby instructed the CMS contractor to return claims without the required prescribed functional reporting data to the provider for correction and resubmission, rather than deny them for Medicare payment.

The OIG also classified claims as overpayments if the provider's National Provider Identifier identified on the claim was different from the therapist's National Provider Identifier in the beneficiary's medical record. However, per CMS payment policy, the National Provider Identifier of the private practice therapist on a claim does not have to match the name of the therapist who actually furnished the therapy service in cases where the enrolled therapist is providing direct supervision of the therapist who is not yet enrolled or whose enrollment process is not complete.⁶

CMS is committed to ensuring that outpatient physical therapy services meet Medicare coverage and payment requirements. However, several of the findings identified in the OIG's draft report do not appear to align with Medicare outpatient physical therapy payment policy. CMS will conduct a further analysis to ensure that Medicare payment policy was interpreted correctly. The OIG's recommendations and CMS' responses are below.

OIG Recommendation

Instruct the MACs to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments made in accordance with this recommendation.

CMS Response

CMS non-concurs with this recommendation. As stated above, CMS does not concur with the determinations made by the OIG's independent medical review contractor that the sample of physical therapy claims reviewed did not comply with Medicare coverage and payment requirements. CMS will review a sample of medical records from the OIG before determining whether potential overpayments need to be investigated and returned in accordance with the 60-day rule.

³ Medicare Benefit Policy Manual, Chapter 15, Section 220.2

⁴ Medicare Claims Processing Manual, Chapter 5, Section 10.6

⁵ 77 FR 68959 - 68974

⁶ Medicare Benefit Policy Manual, Chapter 15, Section 230.4

OIG Recommendation

Establish mechanisms to better monitor the appropriateness of outpatient physical therapy claims.

CMS Response

CMS concurs with OIG's recommendation. CMS is in the process of establishing mechanisms to better monitor the appropriateness of outpatient physical therapy claims.

OIG Recommendation

Review current educational efforts about Medicare requirements for submitting outpatient physical therapy claims for reimbursement and improve or increase these educational efforts as needed to reduce the sixty-four percent error rate and promote provider compliance.

CMS Response

CMS concurs with OIG's recommendation. CMS undertakes a number of educational efforts aimed at providing information on how to comply with Medicare claims and payment policies. These efforts include Medicare Learning Network Matters articles, fact sheets, and provider compliance newsletters around Medicare requirements for submitting outpatient physical therapy claims. However, CMS notes that most of the findings identified by OIG are likely attributable to documentation errors as opposed to fraudulent activity.

CMS thanks OIG for its efforts on this issue and looks forward to working with OIG on this and other issues in the future.