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OIG Report: Physical Therapy Billed by Physicians
SUMMARY

Overview

In 2002, the Department of Health and Human Services Office of Inspector General (OIG) began reviewing Medicare payments for physical therapy services furnished in physician's offices and billed "incident to" physicians' professional services. Based on a sample random of 70 physical therapy line items billed by physicians and rendered in the first 6 months of 2002, the **OIG found that 91 percent of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in $136 million in improper payments.** In addition, **Medicare claims from 2002 to 2004 were analyzed and aberrant patterns of billing and unusually high volumes of claims were identified.** The OIG also noted that services were rendered by unskilled and/or unlicensed personnel, placing the beneficiary at risk.

Background

Physical therapy billed directly by physicians represented approximately $158 million out of a total of approximately $528 million for physical therapy claims billed to Medicare Part B carriers and allowed by Medicare in the first 6 months of 2002. Physicians may bill Medicare for physical therapy services that are "integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

The total allowed for physicians' physical therapy claims has increased from $353 million in 2002 to $509 million in 2004, and the number of physicians who billed more than $1 million in physical therapy has more than doubled in the same 2-year period.

The "incident to" rule allows physicians to bill, at the full physician fee schedule rate, for physical therapy performed by any non-physician staff if certain Medicare rules are met. In November 2004, CMS issued a final rule to address the skill level of staff that provides physical therapy under the "incident to" rule. Beginning June 2005, CMS now mandates that medical professionals rendering physical therapy services under the "incident to" rule meet the same Medicare requirements delineated for qualified physical therapists with the exception of licensure.

Methodology and Analysis

The OIG used three main methodologies to study the physician physical therapy claims: medical review of a random sample of claims, analysis of Medicare claims and billing patterns, and interviews with physicians in the sample and Medicare carrier personnel. Seventy physical therapy line items billed by physicians and rendered in the first 6 months of 2002 were originally chosen but 68 line items were reviewed. The total allowed amount in the sample was $2,176.62.

The OIG requested complete medical records from physicians for each beneficiary for the dates reflecting the physical therapy episode of care during which the claim was rendered. Other data used by the OIG, in addition to Medicare billing records were physician staff schedules for each day the beneficiary received medical services and all licenses and credentials for staff that provided services to the beneficiary. OIG contracted with licensed physical therapists to review the information.

In analyzing Medicare Part B therapy claims for 2002, 2003, 2004 and physicians' billing patterns, OIG considered: the total allowed amounts for physicians' physical therapy, the total allowed amounts for physical therapy per physician, total allowed amounts for physical therapy per beneficiary, geographic dispersion of Medicare's physical therapy, and the relationships among physicians, including physicians who share the same beneficiaries with other physicians.

Findings

- **91 percent of physical therapy billed by physicians and allowed by Medicare during the first 6 months of 2002 did meet program requirements, resulting in $136 million in improper payments.**

It was found that 26 percent (represents $33 million in payments) of the therapy during this period was not medically necessary and 34 percent (represents $49 million in payments) was not documented. Fifty-seven percent ($87 million in payments) of the services were furnished under incomplete plans of care (POC) or had no plan of care documented. All of the services that were not medically necessary also proved to be furnished under an incomplete POC or no POC.

- **Most medical records did not indicate the skill level of the individual who rendered the therapy.**

Because of the lack of documentation, the reviewers could not determine the skill level of the staff who delivered physical therapy in 32 of the 54 records. In 18 of the records PT services were performed by a PT, PTA, or physician. Four of the claims were performed by inappropriate staff such as acupuncturists, "certified disability examiners" massage therapists, and physical therapy aides.

Twenty-four out of 32 physicians reported that some or all of the physical therapy that they billed to Medicare was performed by podiatrists, chiropractors, PTs, PTAs, massage therapists, and physical therapy aides. Fourteen of the physicians reported that they personally performed some or all of the PT services, although this could not be verified by their claims data.

- **Under physician billing, 23 out 54 beneficiaries received PT without a plan of care.**

The physicians treating these beneficiaries billed physical therapy for more than 8,000 beneficiaries in 2002 for which Medicare allowed approximately $7.8 million.

Case example: A patient received 15 months of PT for lumbago and osteoarthritis, for which Medicare allowed $39,126. The physician did not document a plan of care and did not establish medical necessity. The physician billed PT to Medicare for 672 patients in 2002, an average of 27 patients per day. In 2002, Medicare allowed $752,531 for this physician's physical therapy claims.

Analysis of Physician Billing Patterns for Physical Therapy

Using 100 percent of Medicare claims data for 2002, 2003, and 2004, the OIG analyzed physicians' billing patterns for physical therapy.

They found:

- Approximately 4 percent of all physicians who submitted physical therapy claims account for more than half of all allowed claims in 2004.

- Medicare allowed between $1 million and $7.6 million in physical therapy claims for each of 15 physicians in 2002, 29 physicians in 2003, and 38 physicians in 2004.

- For an additional 992 physicians, Medicare allowed more than $100,000 each in physical therapy claims alone in 2004.

- One hundred thirty-four physicians each billed Medicare for physical therapy for more than 500 patients in 2004. In contrast, the median number of patients receiving physical therapy for the entire physician population (that rendered physical therapy in 2004) is eight. Of the 134 physicians, 97 shared at least 50 of their patients with another of the 134 physicians who also billed physical therapy for the same patient.

- The OIG identified 13,090 beneficiaries whom Medicare allowed at least $5,000 each in physical therapy billed by physicians in 2004.

- The aberrances in billing patterns cannot be explained by the specialties of providers who bill for excessive services. For example, only 4 of the 51 physicians who billed Medicare more than $1 million for physical therapy in 2002, 2003, or 2004 were physical medicine and rehabilitation or osteopathic manipulative therapy specialists.

The "Incident To" Rule

Physicians are not required to indicate on claims that services were "incident to," so it appears on the claims as if services are personally performed by the physician. Thus, it was very difficult for the OIG to discern "incident to" services and whether they were performed by a qualified therapist. Under the "incident to" rule, a physician can bill for an unlimited amount of PT services rendered at the same time as long as the physician directly supervises the staff rendering the PT services.

Although the OIG found that physicians were billing for PT services for multiple patients in one day, they could not accurately confirm that "direct supervision" was occurring. For example one physician in the sample billed Medicare for PT for an average of 51 patients per day in 2002. Additionally, because of the inadequacy of documentation, the OIG could not confirm that physicians were adhering to Medicare regulations requiring they adhere to the same standards of care as independently practicing physical therapists.

Conclusion

The OIG noted that the lack of documentation to certify that physicians were meeting the "incident to" supervision and qualified staff requirements for the delivery of PT could be the cause of so many aberrant PT billing practices by physicians, and could place patients at risk. The OIG commented that physical therapy billed "incident to" physicians' professional services and rendered by unskilled and/or unlicensed personnel represent a vulnerability that could be placing beneficiaries at risk of receiving services that do not meet professionally recognized standards of care.

The OIG concluded that the requirements for PT rendered in the physicians' offices, including licensure, should not differ with the requirements for therapy rendered in other settings, such as independently practicing physical therapists' offices and nursing homes.

In addition, the OIG concluded that CMS should consider revisions, clarifications, and further study of the "incident to" rule to ensure that Medicare beneficiaries are receiving skilled therapy services from appropriately trained and licensed staff and that the services meet professionally recognized standards of care.