Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PHYSICAL THERAPY IN PHYSICIANS' OFFICES

JUNE GIBBS BROWN
Inspector General

MARCH 1994
OEI-02-90-00590

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared in the New York Regional Office under the direction of Regional Inspector General Thomas F. Tully and Deputy Regional Inspector General Alan S. Meyer. Project Staff included:

New York

Renee C. Dunn, P.T. (Project Leader)
Lucille M. Cop, R.N.
William J. Counihan
Nancy T. Harrison

Headquarters

Wayne A. Powell
Barbara R. Tedesco
Linda M. Moscoe

To obtain a copy of this report contact the New York Regional Office at (212) 264-1998

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PHYSICAL THERAPY IN PHYSICIANS' OFFICES

JUNE GIBBS BROWN
Inspector General

MARCH 1994
OEI-02-90-00590

EXECUTIVE SUMMARY

PURPOSE

To determine the nature and extent of physical therapy services provided to Medicare beneficiaries in physicians' offices and to describe carrier monitoring of these services.

BACKGROUND

Physical therapy treatment consists of a planned program to relieve symptoms, improve function and prevent further disability for individuals disabled by chronic or acute disease or injury. Treatment may include various forms of heat or cold, electrical stimulation, therapeutic exercises, ambulation training and training in functional activities.

Medicare has detailed coverage guidelines for physical therapy which apply to all outpatient settings, except physicians' offices. While no specific coverage requirements exist regarding physical therapy in physicians' offices, the services like all others, must be reasonable and necessary and not for palliation. As in any other area in Medicare, in the absence of HCFA national policy, local carriers establish their own policies.

For outpatient settings other than physicians' offices, Medicare requires the services must be restorative or for the purpose of designing and teaching a maintenance program for the patient to carry out at home. The services must also relate to an written treatment plan and be of a level of complexity that requires the judgement, knowledge and skills of a qualified physical therapist to perform and/or supervise the services. The amount, frequency and duration of the physical therapy services must be reasonable. Lastly, the services must be considered reasonable and necessary and must not be palliative in nature.

Medicare reimbursement for physical medicine services provided by physicians and independently practicing physical therapists increased by 40 percent from 1990 to 1991. Allowed charges for these services in the HCFA common procedure code index (HCPCS) went from a combined total of $144 million in 1990 to $202 million in 1991.

We selected a stratified random sample of 300 beneficiary cases who received physical therapy services (100 from independently practicing physical therapists' offices and 200 from physicians' offices) in 1991 to compare services in physicians' offices with those in another outpatient setting. We obtained the medical records of 166 of the physicians' claims and 89 of the independently practicing physical therapists'. We conducted a medical review of the records, determined the percentage of cases which would not have met Medicare coverage guidelines had they been performed outside a physician's office and those which were palliative and calculated the possible cost savings to Medicare.

The study team also interviewed, by telephone, 36 physicians, 20 physical therapists, 42 carriers and representatives of six professional associations to gather their perspectives and concerns pertaining to physical therapy services provided in physicians' offices. We also obtained and reviewed carrier documents regarding provider education, policies and screens for physical therapy services.

FINDINGS

Almost Four Out of Five Cases Reimbursed as Physical Therapy in Physicians' Offices Do Not Represent True Physical Therapy Services: $47 Million Was Inappropriately Paid in 1991

The services are not restorative or complex nor do they have treatment plans with goals or objective evaluations. Most of the questionable services are palliative, giving only temporary relief and, therefore, are not covered under section 1862 (a)(1)(A) of the Social Security Act. The great majority of independently practicing physical therapy services meet all Medicare coverage guidelines; they routinely have plans of care, goals, objective evaluations and are restorative in nature.

Carriers Have Paid Little Attention to Physical Therapy in Physicians' Offices

Two-thirds of the carriers have no policies concerning physical therapy in physicians' offices.

All Professional Associations, Some Carriers, Physician and Physical Therapy Respondents Encourage More Stringent Requirements for Physical Therapy in Physicians' Offices

Both professional physician specialty organizations and physical therapy associations agree that physical therapy in physicians' offices should be restorative and have goals set forth in a plan of care. Over a third of the carrier respondents feel there are problems with the frequency of physical therapy treatments in physicians' offices, such as overutilization and excessive services.

RECOMMENDATIONS

We recommend that HCFA take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. The HCFA can use the following approaches to achieve this goal:

- Conduct focused medical review,
- Provide physician education activities,
- Apply its existing physical therapy coverage guidelines for other settings to physicians' offices.

We estimate that implementation of this recommendation would save $235 million over five years.

COMMENTS

Comments on the draft report received from HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) concur with the general thrust and significant details of our recommendations. Suggestions for changes in wording, clarifications of the text and technical changes have, for the most part been incorporated into the final report. The actual comments received are in Appendix B.

The HCFA plans to share copies of the IG report with carriers and ask them to focus on issues identified in the report. Also, it has a work group considering alternative ways of providing appropriate physician education. The HCFA would like to analyze the results of these actions before changing coverage guideline policies. We support this approach and will, of course, be interested in the results of the analysis.

Finally, while we appreciate ASPE's desire to see a more explicit recommendation, it is our desire to allow the operating agency flexibility in addressing the concerns identified and developing corrective actions.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To determine the nature and extent of physical therapy services provided to Medicare beneficiaries in physicians' offices and to describe carrier monitoring of these services.

BACKGROUND

Physical therapy treatment consists of a planned program to relieve symptoms, improve function and prevent further disability for individuals disabled by chronic or acute disease or injury. Any condition which requires physical rehabilitation, such as low back pain, bursitis, stroke, Parkinson's disease, or arthritis, can benefit from physical therapy.

A licensed physical therapist evaluates the patient, develops a treatment program and sets goals to meet each patient's needs. This plan may include various types of therapeutic exercise, either manual or with the assistance of a machine, to decrease pain and improve strength, endurance, coordination, range of motion and mobility. Treatment may also include such modalities as hot or cold packs, whirlpool, diathermy, ultrasound, traction and electrical stimulation. These modalities are most often used in combination with exercise. Additional physical therapy treatments include ambulation training, assessment for orthotic or prosthetic devices, and functional training activities needed for daily living.

An aging population and medical advances in the treatment of chronic disease have contributed to the need for physical therapy in recent years. The number of licensed physical therapists and the variety of settings in which they work have also increased. These settings may include acute care hospitals, outpatient clinics, home health agencies, independently practicing physical therapists' offices or physicians' office.

All States have licensing laws and specific regulations pertaining to physical therapy practice. Physical therapists must pass certain educational and examination requirements to qualify for a license. Most States require that only a person licensed or authorized under their legislation shall practice physical therapy or use the title "physical therapist."

Medicare Coverage

Medicare covers physical therapy in both inpatient and outpatient settings. Inpatient settings include institutions such as hospitals and nursing homes. Outpatient settings are independently practicing physical therapists offices', outpatient clinics, home health agencies, rehabilitation agencies, and physicians' offices.

To be reimbursed by Medicare, all provider settings, with the exception of physicians' offices, must be certified. As part of the certification process, the State surveys each facility to assure that Medicare standards are met. During these surveys, the State representative reviews personnel records of staff giving care to be sure they are qualified.

Coverage in physicians' offices

Medicare has detailed coverage guidelines for physical therapy which apply to all outpatient settings, except physicians' offices. Medicare covers physical therapy in physicians' offices as it does any other medical treatment, as incident to a physician's service. This means, according to the Medicare Carriers Manual (MCM) section 2050, the services must be: an integral part of a physician's service; commonly furnished in a physician's office; rendered without charge or included in the physician's bill; performed under the direct (rather than general) personal supervision of the physician; and performed by an employee of the physician. As any other physicians' services, according to the Social Security Act, in the section on exclusions from coverage, Section 1862 (a)(1)(A) states that,"... no payment may be made under part A or part B for any expenses incurred for items or services which,... are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." This section goes on to say that payment is prohibited for medical services that are for prevention, palliation, research, or experimentation. Palliation is generally defined as relieving or easing pain temporarily. No specific MCM coverage requirements exist regarding physical therapy in a physician's office. As in any other area in Medicare, in the absence of HCFA national policy, local carriers establish their own policies.

Coverage in outpatient settings other than physicians' offices

The MCM, section 2210, contains coverage requirements for independently practicing physical therapists. The Medicare Intermediary Manual (HIM) contains similar coverage requirements for other Part B outpatient providers of physical therapy, including approved clinics, rehabilitation agencies, participating hospitals, skilled nursing facilities, and home health agencies. The key elements in both manual sections include:

- The services must be restorative with an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time based on the assessment by the physician and qualified physical therapist; or the services of a qualified therapist may be necessary to design and teach a maintenance program for the patient to carry out at home.

- The physical therapy services must relate to an written treatment plan established by the physician after consultation with the qualified physical therapist. "The plan must relate the type, amount, frequency, and duration of the physical therapy services ... and indicate the diagnosis and anticipated

goals." The MCM states that the plan may be established by either the physician or the qualified physical therapist.

- The physical therapy service must be of a level of complexity and sophistication, or the condition of the patient must be such that requires the judgement, knowledge and skills of a qualified physical therapist to perform and/or supervise the services.

- The amount, frequency and duration of the physical therapy services must be reasonable.

To fulfill these requirements and demonstrate the patient's restoration potential, the patient's record must show objective measures of patient evaluations such as strength, balance, endurance, range of motion and activities of daily living. There must also be periodic review by the physician.

The Medicare manual physical therapy guidelines for outpatient settings, other than physicians' offices, discuss some of the more common physical therapy modalities and procedures utilized in the treatment of patients. They give examples of what would constitute Medicare covered physical therapy. For instance, simple heat treatments such as hot packs, cold packs, infra-red, and whirlpool, which do not ordinarily require the skills of a qualified physical therapist and when used alone are usually palliative (giving temporary relief), are not covered. However, such treatments may be given as a part of a more complex program and would be considered part of that physical therapy service. Also, in some cases where the patient has circulatory deficiency, areas of desensitization, open wounds or other complications, the skills and judgement of a qualified therapist may be necessary and, therefore, covered. Other more complex modalities such as ultrasound, shortwave, and microwave diathermy treatments must always be performed by or under the supervision of a qualified physical therapist, and would then constitute physical therapy.

To be covered by Medicare, range of motion tests must be performed by qualified therapists. Range of motion exercises require the skills of a qualified therapist only when they are a part of active treatment for a specific disease; the degree of motion lost and the degree restored must be documented. Generally, range of motion exercises which are not related to a specific loss of function, but intended for the maintenance of function, do not require the skills of a qualified therapist. However, the therapist could design a program of maintenance exercises for the patient and family to carry out, and Medicare would cover it.

Therapeutic exercises which must be performed by or under the supervision of the qualified therapist, due to the type of exercise or the condition of the patient, are also covered. Gait evaluation and training with a patient who has impaired function would require the skills of a qualified physical therapist, but would be considered physical therapy only if the patient can be reasonably expected to improve his or her ability to walk. Repetitive exercises to improve gait or maintain strength and endurance, or to

assist a feeble patient in walking, do not require the skills of a qualified physical therapist. An example would be a patient who has generalized weakness and needs assistance and encouragement to walk and to increase his/her endurance. This service could be carried out by a non-physical therapist such as a nurse or nurse's aide, but would not be considered covered physical therapy.

Medicare Reimbursement

Medicare reimbursement varies for different physical therapy providers. Medicare pays both inpatient and outpatient institutional providers on a reasonable cost basis. Physicians and independently practicing physical therapists in their offices are paid on the basis of a Medicare fee schedule. The independently practicing physical therapists are, however, subject to a yearly $750 reimbursement limitation per patient.

Medicare reimbursement for physical medicine services provided by physicians and independently practicing physical therapists increased by 40 percent from 1990 to 1991. Allowed charges for these services in the HCFA common procedure code index (HCPCS) went from a combined total of $144 million in 1990 to $202 million in 1991.

Medicare reimbursement for the three most commonly reimbursed physical therapy HCPCS codes for physicians and independently practicing physical therapists shows a 273 percent increase over the five-year period from $24.8 million in 1986 to $92.1 million in 1991. In one year, from 1990 to 1991, allowed charges for just these three codes increased 26 percent from $73.3 million to $92.1 million. The three codes are 97010, physical treatment of one area of the body with hot or cold packs; 97110, initial physical therapy treatment of therapeutic exercise in one area of the body for 30 minutes and; 97128 ultrasound treatments.

Prior Study

A 1982 HCFA Region II validation study raised certain issues. The fact that these issues remain is one factor that prompted the present inspection. The prior study noted that there were no HCFA directives addressing physical therapy services furnished by physicians in their offices and thus no requirement that the care be restorative. However, there were HCFA instructions governing the same therapy for other outpatient providers, including independently practicing physical therapists. The study also reported the absence of HCFA guidelines addressing the reimbursement of non-restorative, palliative treatment billed as physical therapy in either setting. The medical record review identified 57 percent of the total study services in physicians's offices as palliative care. The study recommended that HCFA establish uniform guidelines for the coverage and reimbursement of restorative physical therapy services. It also recommended that non-restorative services be reimbursed as a part of medical services, but not separately as physical therapy. No action was taken.

METHODOLOGY

First, we selected a stratified random sample of 300 beneficiary cases. Each case represents all physical therapy services received by a sample beneficiary from a single provider in 1991. The sample consists of the HCFA common procedure coding system (HCPCS) codes 97010 to 97799. One stratum included beneficiaries who received physical therapy services in independently practicing physical therapists' offices and the other stratum included beneficiaries who received services in physicians' offices. The independently practicing physical therapists' offices were selected as a representative of other outpatient settings with which to compare services in physicians' offices. One hundred of the beneficiaries treated by independently practicing physical therapists were chosen from the first stratum and 200 by physicians from the second stratum (see appendix A.) This sample of 300 beneficiary cases was handled by 42 Medicare carriers, whom we contacted to obtain the names of the providers in each of these claims.

Next, we asked the providers to send us copies of all of the sample patients' physical therapy medical records for the period of 1990 to the present. We received 255 (85 percent) of the 300 records requested; 166 records from physicians and 89 from independently practicing physical therapists. The study team created a review form for the medical records based on Medicare coverage guidelines for physical therapy provided in all outpatient settings other than physicians' offices (where there are no guidelines). A HCFA physical therapist reviewed the form and found it an acceptable way to determine whether the treatment would constitute covered physical therapy. A physical therapist and registered nurse from the study team reviewed the medical records to ascertain whether there was a written treatment plan with diagnosis and anticipated goals; whether the care was restorative with the expectation that the patient would improve significantly in a predictable period of time; whether a maintenance program was designed and taught; whether objective testing was done; whether the services were palliative; and whether the amount, frequency and duration of the services was reasonable. We next compared the medical records of physicians with those of independently practicing physical therapists to identify differences or similarities regarding services provided, the type of person providing them, and levels of documentation. Based on the results of this medical review, we determined the percentage of services which would have met Medicare coverage guidelines had they been performed outside a physician's office and calculated the possible cost savings to Medicare if these coverage requirements for physical therapy were applicable to that in physicians' offices.

We also selected a stratified random subsample of 60 of the 300 providers, 40 physicians and 20 independently practicing physical therapists to interview by telephone. We were able to contact 36 of these physicians and all 20 of the independently practicing physical therapists. We asked both groups how physical therapy in physicians' offices compares to that in independently practicing physical therapists' offices, and about the qualifications of the person in their office providing the service and compared their responses.

We reviewed carrier documents related to physical therapy, which 40 of the 42 carriers submitted, regarding their provider education, policies and screens. We identified billing restrictions and screens or other controls, both pre-and post-payment. Also, we interviewed, by telephone, staff experienced in physical therapy coverage and reimbursement from the 42 carriers in our sample to gather their perspectives and concerns pertaining to physical therapy services provided in physicians' offices.

Lastly, we interviewed representatives of two physical therapy associations and four other medical specialty organizations to gain their views on physical therapy in physicians' offices.

FINDINGS

ALMOST FOUR OUT OF FIVE CASES (78 PERCENT) REIMBURSED AS PHYSICAL THERAPY IN PHYSICIANS' OFFICES DO NOT REPRESENT TRUE PHYSICAL THERAPY SERVICES: $47 MILLION WAS INAPPROPRIATELY PAID IN 1991

Most of the questionable services are palliative, therefore not covered under section 1862 (a)(1)(A) of the Social Security Act. They are not restorative or complex, nor do they have treatment plans with goals or objective evaluations.

The physical therapy services in physicians' offices are generally some form of palliative treatment giving only temporary relief, such as hot packs, whirlpool, ultrasound, diathermy and/or massage, often given by unlicensed people without any exercises or functional activities. Almost three-quarters of the physician medical records do not show the physical therapy services to be of a level of complexity to require the judgement, knowledge and skills of a qualified physical therapist. Only 13 percent of the cases involve exercises. When physicians were asked about the kinds of services they provide, over one-third of the physician respondents report that they only provide some type of heat. This group includes 13 of the 15 podiatrists interviewed. Only 38 percent of physicians interviewed report that they ever provide exercises.

The 1991 HCFA data show that the most frequently reimbursed physical therapy procedures in physicians' offices are hot or cold packs and ultrasound. Table A below shows the fiscal year 1991 frequency and allowed amounts for the top eight physical medicine codes in physicians' offices only. These are ranked in terms of dollars allowed.

TABLE A

HCPCS CODES	DESCRIPTION	FREQUENCY	ALLOWED AMOUNT
97128	Ultrasound	1,145,900	$20,182,800
97010	Hot or cold packs	1,111,100	$19,214,900
97110	Therapeutic exercises	811,000	$16,174,100
97014	Electrical stimulation (unattended)	464,300	$8,401,400
97022	Whirlpool	558,700	$8,279,400
97530	Kinetic activities	238,300	$6,805,400
97124	Massage	375,500	$6,384,300
97118	Electrical stimulation (manual)	298,500	$5,719,300

Most physical therapy care in physicians' offices is not restorative nor does it establish a maintenance program. Almost four out of five cases (130 out of 166) would not meet the primary Medicare guideline for physical therapy in other settings that services be restorative or for the establishment of a maintenance program. Of the 36 cases in physicians' offices meeting the guidelines 26 have restorative care and in ten a maintenance program was established.

The medical record review reveals that the physical therapy patients get in physicians' offices is usually provided too sporadically and infrequently to achieve any goals in a predictable time and is therefore not restorative. The following are examples of non-restorative care found in the medical records:

> One patient treated by a specialist in internal medicine who employs a physical therapist has osteoarthritis and pain in the knee, neck and back. She visits her physician once every month or two. She receives physical therapy once or twice a week, off and on, with a treatment of hot packs and massage and sometimes ultrasound. The physical therapist's notes generally say patient tolerated treatment well and that sometimes she feels better after treatment, and sometimes not. This care appears to be palliative with temporary relief at best; no real functional outcome can reasonably be expected.
>
> In another example, a specialist in internal medicine occasionally administers ultrasound to his patient with chronic arthritis of the right shoulder during a routine visit. The record shows no objective evaluations or plan of care or any expected functional outcome from the ultrasound treatment.

Over two-thirds (114) of the physician's medical records had no written treatment plan for physical therapy and over three-quarters (128) of the records have no physical therapy goals spelled out. Further, over two-thirds (113) of the physicians' medical records have no objective evaluations with which to measure the patient's progress. Of those that do have a treatment plan with goals, the goals include increasing function, strength and range of motion, decreasing pain, and improving ambulation. Of those with objective evaluations, the majority evaluated range of motion and/or pain.

Among different physician groups, podiatrists are least likely to provide care that is truly physical therapy.

Only two of the 47 cases from podiatrists show restorative care. Almost two-thirds of the non-restorative podiatry care was palliative. The remaining one-third was related to surgery such as whirlpool to soften the skin and nails prior to debridement or a post operative cold pack to prevent swelling. In most cases these treatments were provided once every month or six weeks when the patient routinely visited the podiatrist. Seventy-eight percent of podiatrists had no treatment plan; 82 percent had no goals, and 80 percent had no objective evaluations (see table B below.)

TABLE B

FEW SPECIALTIES WOULD MEET THE PHYSICAL THERAPY REQUIREMENTS FOR OTHER OUTPATIENT SETTINGS

	Orthopedic Surgery N=28	Physical Medicine & Rehab N=8	General Medical Practice+ N=66	Podiatry N=47	Others* N=17	Totals N=166
Has Treatment Plan	16 (57%)	8 (100%)	12 (18%)	10 (21%)	6 (35%)	52 (31%)
Has goals	18 (64%)	2 (25%)	4 (6%)	8 (17%)	6 (35%)	38 (23%)
Has objective evaluations	20 (71%)	7 (88%)	11 (16%)	9 (19%)	6 (35%)	53 (32%)
Care Either Restorative or Establishing Maintenance Program	19 (68%)	6 (75%)	6 (9%)	2 (4%)	3 (18%)	36 (22%)

The numbers within each specialty are not mutually exclusive.

\+ General Medical Practice includes 29 family practitioners, 28 general practitioners, and 9 internists.

* Others include 4 general surgeons, 2 cardiovascular specialists, 2 clinics, 2 unknowns, 2 osteopaths, an anesthesiologist, a dermatologist, a plastic surgeon, a radiologist, and a pediatrician.

Physical therapy services in the offices of orthopedic surgeons and physical medicine and rehabilitation specialists are more likely to be restorative or for the establishment of a maintenance program than to be palliative. The medical records of more than two-thirds (19 of 28) of the orthopedic surgeons' and three-quarters (6 of 8) of the physical medicine and rehabilitation specialists' show restorative care or the establishment of a maintenance program (see table B above.) This compares to only four percent of the podiatrists, nine percent of those in general medical practice (including internists) and 18 percent of the other specialties.

The physical therapy services are also more likely to be performed by a licensed physical therapist or occupational therapist in the offices of orthopedic surgeons and

physical medicine and rehabilitation specialists than in other physicians' offices. All of the 28 orthopedic surgeons had licensed professionals providing the physical therapy services, 25 had physical therapists and three occupational therapists. Of the eight physiatrists, three had physical therapists, two physical therapy assistants and the remaining performed the physical therapy service themselves. None of the podiatrists, only eight percent (5 of 66) of those in general medical practice and 18 percent (3 of 17) of the other specialties had licensed physical therapists or occupational therapists performing the services.

Nine out of ten cases in independently practicing physical therapists' offices meet all Medicare coverage guidelines; they routinely have plans of care, goals and are restorative in nature.

The great majority (88 percent) of the independently practicing physical therapists' medical records document medically necessary restorative care or the establishment of a maintenance program. The services are always provided by a licensed physical therapist or, in one case, a licensed physical therapy assistant. The remaining care appears to be palliative.

Almost all independently practicing physical therapists' medical records have a written treatment plan (92 percent) with goals established (81 percent). Over three-quarters (79 percent) of the patients with goals met these goals in a predictable period of time. Almost all independently practicing physical therapists' records had objective evaluations to measure the patient's progress. These evaluations include range of motion, muscle strength, pain, gait, posture, sensation, functional activities, and activities of daily living.

Most of their physical therapy treatments are complex. In over three-quarters of the independently practicing physical therapists' records, the patient was either evaluated or performed exercises or functional activities, all of which are complex activities. All independently practicing physical therapist respondents reported that they provide a whole range of services, usually including exercises or functional training in conjunction with modalities such as heat or electrical stimulation.

CARRIERS HAVE PAID LITTLE ATTENTION TO PHYSICAL THERAPY IN PHYSICIANS' OFFICES

Four-fifths of the carriers have no policies concerning the restorative nature of physical therapy in physicians' offices.

Although each carrier is expected to establish local policy where no national HCFA policy exists, twenty-four of the 42 carriers have no policy for physical therapy in physicians' offices. Carrier documentation and interview responses by carriers and physicians reveal that most carriers require little information other than what is on the initial claim form. One, however, requires that a plan of treatment for services by physicians be attached to claims for physical therapy. Another requires a physician note on the claim that there is a treatment plan available for physical therapy services.

In contrast, all carriers require some sort of documentation by independently practicing physical therapists that a treatment plan is available. Some require the treatment plan itself and others require a notation on the claim saying that the treatment plan is available.

Ten carriers have policies such as not reimbursing physical therapy on the same day as an office visit without a separate diagnosis or only reimbursing specific HCPCS codes. These policies do not relate to the restorative nature of physical therapy services.

Eight carriers in their instructions indicate physical therapy must be restorative; however, no enforcement is apparent.

Eight carriers have policies relating to the restorative nature of physical therapy services. Six of them have sent newsletters or bulletins to physicians mentioning the need for physical therapy services to be restorative. One restricts this policy to physiatrists. One of these eight carriers has a screen dealing with the restorative nature of the physical therapy services. A review of the medical records from claims reimbursed by these carriers, however, shows that they are not enforcing these restrictive policies. They approved the same percentage of non-restorative care as other carriers in our sample.

PROFESSIONAL ASSOCIATIONS, AS WELL AS SOME CARRIERS, PHYSICIANS AND PHYSICAL THERAPISTS, ENCOURAGE MORE STRINGENT REQUIREMENTS FOR PHYSICAL THERAPY IN PHYSICIANS' OFFICES

Professional associations contacted agree that physical therapy in physicians' offices should be restorative.

Physician specialty organizations such as the American Academy of Physical Medicine and Rehabilitation, the American Osteopathic Association, the American Academy of Orthopedic Surgeons and the American Podiatric Medical Association and professional physical therapy associations, the American Physical Therapy Association and an organization of Independent Private Practitioners all agree that physical therapy in physicians' offices should be restorative and should have goals set forth in a plan of care. The representative from the osteopathic society says, "It should not go on indefinitely. It should not be done indiscriminately." The response from the Academy of Physical Medicine and Rehabilitation was that, "PT should also maintain function and prevent complications, PT may be instructional for the development of home maintenance therapy programs. Modifications to maintenance programs are frequently necessary, ... guidelines are needed to prevent abuse." The American Academy of Orthopedic Surgeons expresses similar feelings, "Physical therapy in a physician's office should follow the same guidelines and requirements as therapy performed in a free standing physical therapy office."

Some carriers, physicians and physical therapists have concerns about physical therapy services provided in physicians' offices.

Over a third of the carrier respondents feel there are problems with the frequency of physical therapy treatments in physicians' offices, such as overutilization and excessive services. One carrier, concerned about possible overutilization of physical therapy modalities by physicians, requested an opinion from its State Society of Physical Medicine and Rehabilitation. Some of the features included in its guidelines, developed as a result of the Society's opinion, follow the Medicare guidelines for independently practicing physical therapists. The State society opinion also states "There is limited justification for treating multiple areas with modalities... The use of modalities on a sporadic basis concurrent with routine office visits is not justified".

Other carriers agree physicians are billing for too many physical therapy services. One respondent suggests, "HCFA should have better guidelines. We should rebundle therapy, heat treatment is a part of several modalities. A lot of services are being given, I feel, that are unnecessary." One carrier noted that they had 25 doctors on their Provider Audit List (PAL) who billed for too many physical therapy services, too many times with no documented medical necessity.

Physical therapy in podiatrists' offices is of particular concern to several carriers. One carrier reported that prior to 1992 it denied physical therapy for podiatrists since the services were considered to be part of a visit code. However, evaluation and management codes do not contain physical therapy, so the carrier now pays for both. Some carriers express the need to monitor podiatry services more closely. A number agree that whirlpool which is used to soften nails or tissues prior to debridement is not really physical therapy. One podiatrist supports this by saying, "We have found it (physical therapy) beneficial for patients. We use it frequently following a procedure, but not usually on its own when the patient is not in the office for another reason." In contrast, another podiatrist states, "It should be done every other day or every third day for several weeks and evaluated, not just every few months when the patient comes in. Then it's a foot washing."

Physical therapists also voice concerns about the frequency and care in physicians' offices. One therapist says, "We have had complaints by patients who have got physical therapy in a physician's office. They said they got too many treatments that were not necessary."

The use of licensed professionals to provide physical therapy services is encouraged by some.

The American Academy of Orthopedic Surgeons in an advisory statement dated December 1989 said, "Quality of care considerations dictate that the patient receives physical therapy services which meet the highest professional standards. Only properly trained and certified physical therapists should be involved in the patient's treatment." The American Physical Therapy Association in its Qualifications for Persons Providing

Physical Therapy Services says, "Protection of the public interest requires that physical therapy be provided only by persons who have successfully completed specialized education in that field and whose practice complies with well-defined regulations." The association also suggests in its response that providers of physical therapy services in a physician's office should be required to put their State professional license number on the billing forms.

Some carriers have concerns about who is giving the care. One carrier respondent voices the concern of others when she says, "Lesser qualified people are used by physicians to give physical therapy, they are not using physical therapists." Another adds, "We have no way of knowing who is giving physical therapy in a physician's office... the physician should explain who did it and why on the claim itself." Another respondent says, "I would like HCFA to state that a physician cannot hire a person to do physical therapy unless that person is licensed."

Some physicians also had concerns about who provides the care. An orthopedist voices the concerns of others when he says, "If doctors are billing for physical therapy by other than a therapist, it should be stopped. Having a nurse put hot packs on is not physical therapy." All physical therapists agree that physical therapy should be performed by a physical therapist. One therapist says, "Physical therapy should be given by a licensed physical therapist, technicians have no idea why we do what we do, or the physiological ideas behind therapy."

RECOMMENDATIONS

We recommend that HCFA take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. The HCFA can use the following approaches to achieve this goal:

- Conduct focused medical review,
- Provide physician education activities,
- Apply its existing physical therapy coverage guidelines for other settings to physicians' offices.

We estimate that implementation of this recommendation would save $235 million over five years. This figure was calculated by multiplying $47 million per year by five years.

COMMENTS

Comments on the draft report received from HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) concur with the general thrust and significant details of our recommendations. Suggestions for changes in wording, clarifications of the text and technical changes have, for the most part been incorporated into the final report. The actual comments received are in Appendix B.

The HCFA plans an alternative course of action to the IG suggestion to conduct focused medical review. It plans to share copies of the IG report with carriers and ask them to focus on issues identified in the report. In response to the suggestion that HCFA provide physician education activities, it has a work group considering alternative ways of providing appropriate physician education. The HCFA would like to analyze the results of these actions before changing coverage guideline policies. We support this approach and will, of course, be interested in the results of the analysis.

The HCFA also raised several technical comments. Noting that our sample consisted of HCFA common procedure coding system (HCPCS) physical medicine codes, HCFA was concerned that services other than physical therapy may have been included in our sample. We confirmed that the service was actually physical therapy through review of actual services in the medical record. The HCFA also noted increases in reimbursement and asked for further information. We focused on coverage in this study and do not have sufficient information to determine why there has been a 40 percent increase in reimbursement for physical therapy codes.

The ASPE raised several technical points regarding the basis of overpayments, the projection of our results, and the intent of our recommendations. The basis for our determination that overpayments were made is the nature of the services, rather than the individual providing them. Our method of sampling allows us to project our results (see appendix A for further details). Finally, while we appreciate ASPE's desire to see a more explicit recommendation, it is our desire to allow the operating agency flexibility in addressing the concerns identified and developing corrective actions.

APPENDIX A

SAMPLE SELECTION AND PROJECTIONS

We extracted all Physical Therapy services (HCPCS 97010-97799) from a 1% Part B Common Working File (CWF) sample of 1991. There were 123,950 services for 8,562 beneficiaries which totalled approximately $1,800,000. The file was sorted by beneficiary and date of service to facilitate categorizing beneficiaries by the specialty of the provider.

The two provider categories were independent physical therapists (IPT) and all types of physicians. We used the first occurrence of each beneficiary's service to determine the provider category. Therefore, if the beneficiary had services from more than one provider, only one provider was sampled. There were 2,078 beneficiaries in the IPT group and 6,484 in the physician group. Simple random sampling was used to select services within each category of provider. The sample consists of 100 IPT services and 200 physician services.

Beneficiary medical records were requested for the sample 300 cases, however, 45 beneficiary records were not sent. From the sample of 100 beneficiaries who received services from IPTs, 89 were sent and from the 200 beneficiaries requested from physicians offices, 166 were sent. After reviewing a beneficiary's record, it was determined whether or not the care given was restorative or for the establishment of a maintenance program. If it did not fit either of these categories, we determined them to be "non-covered." If the decision was that the care was non-covered, all physical therapy services for the beneficiary/provider combination in 1991 were assumed to be non-covered and the estimated savings was based on the amount for the non-covered services. If the beneficiary was treated by more than one provider, only data from the sampled beneficiary/provider combination was used to estimate the savings. Separate estimates were calculated for physicians and IPTs. Standard statistical formulas were used to estimate the total savings and to compute a confidence interval around the estimate. The table below shows the distribution of beneficiaries and allowed charges from the one-percent Part B Common Working File for 1991.

1% Part B Common Working File in 1991

	Beneficiaries in Universe	Allowed amount in universe	Beneficiaries in Sample	Allowed Amount In Sample
IPT	2,078	$733,488	100	$37,876
PHYSICIAN	6,484	$1,075,992	200	$25,005

The table below shows the covered and non-covered status of allowed charges based on the result of the medical record review for physicians and IPTs.

	Physicians		IPTs	
Result of Review	Number of Beneficiaries in Sample	Allowed Charges in Sample	Number of Beneficiaries in Sample	Allowed Charges in Sample
Covered	36	$5,733	78	$30,496
Non-covered	130	$14,512	11	$5,192
No Records Received	34	$4,760	11	$2,188
Total	200	$25,005	100	$37,876

Nearly 20 percent of the medical records from physicians' offices were not received and approximately 6 percent of the medical records from IPTs were not received and therefore not reviewed. Of the received records, the percent of dollars for non-covered cases in physicians' offices is about 72 percent ($14,512/$20,245). Projected to the Medicare population the $14,512 is estimated to be approximately $47 million. The 95 percent confidence interval for the estimated $47 million is $27.7 million to $66.4 million. This estimate was computed by multiplying the unweighted amount by the inverse of the probability of selection (6,484/200) and then by 100 to weight from the 1 percent file to the population. By comparison, the estimated amount for non-covered care provided by IPTs was only about 15 percent (5,192/35,688) of the total of covered and non-covered amounts. The unweighted amount of non-covered care in IPTs' offices was projected in the same manner to obtain the estimate of $10.8 million.

APPENDIX B

COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date FEB 24 1994

From Bruce C. Vladeck
Administrator

Subject: Office of Inspector General (OIG) Draft Report: "Physical Therapy in Physicians' Offices" (OEI-02-90-00590)

To
June Gibbs Brown
Inspector General

We have reviewed the above-referenced draft report which examines the nature and extent of physical therapy services provided to Medicare beneficiaries in physicians' offices, and describes carrier monitoring for these services.

Based on the findings, OIG recommended that the Health Care Financing Administration take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. These steps could include focused medical review, physician education activities, and applying existing physical therapy coverage guidelines for other settings to physicians' offices. OIG estimates that implementation of this recommendation would save $235 million over 5 years. We concur with the overall recommendation. We agree with the first two options, but disagree with the third. Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you wish to discuss our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the Office of Inspector General (OIG) Draft Report: "Physical Therapy in Physicians' Offices" (OEI-02-90-00590)

Recommendation

We recommend that HCFA take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. HCFA can use the following approaches to achieve this goal:

Option 1

Conduct focused medical review.

HCFA Response

We concur with this option, but propose an alternative course of action than focused medical review specifically. We would like to distribute copies of OIG's report to the carriers with a cover note asking them to review it and focus on the issues identified in the report. We will ask the carriers to publish pertinent information presented in OIG's report concerning appropriate billing of physical therapy services in their quarterly bulletins to providers. For example, carriers could list common palliative services that may be performed in offices, but that are not covered regardless of where the services are delivered.

Option 2

Provide physician education activities.

HCFA Response

There is currently a work group within HCFA's Bureau of Policy Development comprised of carrier physicians and physical therapists that is focusing on physical therapy in general. This existing work group is considering alternative ways of providing appropriate physician education on administering physical therapy in physician offices.

Option 3

Apply existing physical therapy coverage guidelines for other settings to physicians' offices.

HCFA Response

We would like to implement and analyze the results of the first two options before changing coverage guideline policies for physician office services.

As OIG correctly points out, physical medicine services furnished in physicians' offices are covered under the "incident to" provision of Medicare. Under the incident to provision, a physician may employ auxiliary personnel to assist in rendering services. The physician includes the charges for such auxiliary personnel services in his own bills.

Although there are no detailed coverage guidelines for physical therapy in physician offices, the Social Security Act requires the services to be reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member. As pointed out in the report, payment is prohibited for medical services for prevention, palliation, research, or experimentation. Carriers establish their own policies to interpret and impose these requirements on physician services. We believe that implementing the first two options will provide guidance to the local carriers, as well as to physicians, on what services are deemed reasonable and necessary to restore functioning under the existing incident to provision.

Technical Comments

OIG's sample consisted of the HCFA common procedure coding system (HCPCS) codes 97010 to 97799. We would like to point out that these codes are for physical medicine, which may have been used to report services other than physical therapy. Therefore, OIG's emphasis on whether these services represent "true physical therapy" may be overstated. The selection of this set of codes may affect the validity of the finding that almost four out of five cases reimbursed as physical therapy in physicians' offices do not represent true physical therapy services. We would be interested on OIG's feedback on this point.

The report states that there was a $40 million increase from 1990 to 1991 in Medicare reimbursement for physical medicine services. It would be useful to know whether this increase was caused by claims from physicians abusing the system, as opposed to physical therapists, the legislated increase from $500 to $750 in the cap on charges for physical and occupational therapy services, or some other cause. This information would help us evaluate whether the recommendations would solve the problem of increases in this area, or if abuse by physicians is a small piece of a much larger problem.

On page A-2, the paragraph following the table, sixth line down should read:

> The 95-percent confidence interval for the estimated $47 million is $27.7 million to $66.4 million (rather than $6.4 million).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

IG	
PDIG	
DIG-AS	
DIG-EI	✓
DIG-OI	
AIG-MP	
OGC/IG	
EX SEC	✓
DATE SENT	8/24

AUG 23 1993

RECEIVED
OFFICE OF INSPECTOR GENERAL
1993 AUG 24 PM 4:47

TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Physical Therapy in Physicians' Offices" -- CONCURRENCE WITH COMMENTS
OEI-02-90-00590

This report examines the nature and extent of physical therapy services provided to Medicare beneficiaries in physicians' offices, and also describes carrier monitoring of these services. In brief, ASPE recommends that OIG: 1.) clarify which cause of inappropriate payments is examined in the data, 2.) discuss the appropriateness of generalizing the study's results; 3.) make the recommendations more explicit, and 4.) make minor editorial changes.

1. Clarify which cause of inappropriate payments is examined in the data We believe that this report identifies two distinct reasons why many PT services provided in physicians' offices would not be reimbursed if provided in any other outpatient setting. These causes (which are not mutually exclusive) are:

1.) that the nature of the services was inappropriate (i.e. was palliative, non-complex, or not related to a treatment plan with goals or objective evaluations). This cause is discussed on pages 6-9.

2.) that the individual providing the services was not appropriately qualified. This cause is discussed in qualitative terms on pages 11-12.

Upon first reading this report, we were uncertain if it was addressing one or both issues. Upon closer inspection, we recognized that claims had been inspected to determine only if the nature of the services was appropriate, not the providers. We thus realized that the quantitative findings refer only to the first of the two potential causes of inappropriate payments.

Given that claims forms do not indicate who provided "PT" services, we understand that this study was not able to determine the extent of inappropriate payments due to unqualified providers. However, to avoid confusion, we recommend that OIG:

1.) distinguish between the two potential causes of inappropriate payments early in the report, and explain that due to data limitations the quantitative aspects of the report address only the first.

2.) state that, because of the possibility of unqualified persons providing services of an appropriate nature, the incidence of inappropriate payments may be higher than the findings indicate.

2. Discuss the appropriateness of generalizing the study's results The conclusions of this study are based on a sample which is relatively small and which is also subject to non-response bias. Due to these limitations, we recommend that the report explicitly discuss whether the results are simply suggestive or if they are considered to be generalizable to the entire Medicare population.

3. Make the recommendations more explicit We suggest that the recommendations be expanded as follows:

"Conduct focused medical review" - This recommendation should include the answers to the following issues: Review of what? For what purpose? Would this require collecting any data beyond what is collected at present?

"Provide physician education activities" - Some specific examples of education activities would be helpful here. Also, given that on page 10 the report suggests that education without enforcement is not effective, this recommendation should mention that enforcement measures may also be necessary if education efforts are to have their desired effect.

Also, the report should explicitly state that the figure of $235 million of savings was calculated by multiplying $47 million per year by five years.

4. Make minor editorial changes

p.9 - In the fourth paragraph, second sentence, there should not be a comma after the word "goals".

p.11 - In the third full paragraph, last sentence, "may" should read "many".

p.A2 - In the second paragraph, fourth sentence, the upper limit of the confidence interval should not be $6.4 million.

David T. Ellwood

Prepared by: C. Prentice/rg 690-7994