The Centers for Medicare & Medicaid Services (CMS) Web site address referenced on page 1 and page 4 of the following report has changed. The new address is:

http://www.cms.hhs.gov/TherapyServices/

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 1 2006

TO: Leslie V. Norwalk
Deputy Administrator
Centers for Medicare & Medicaid Services

FROM: Brian Pattee for
Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Physical Therapy Billed by Physicians

In 2002, the Office of Inspector General (OIG) initiated work associated with Medicare payments for physical therapy. In October 2003, we reported interim results to your office detailing aberrant billing patterns by certain physicians and carrier efforts to target physicians' physical therapy claims. Since the issuance of our 2003 memorandum, we have completed the results of our medical review of claims paid by Medicare in the first 6 months of 2002 and we have updated our claims data analysis of physicians who show aberrant billing patterns for physical therapy claims.

Based on a simple random sample of 70 physical therapy line items billed by physicians and rendered in the first 6 months of 2002, we found that 91 percent of physical therapy billed by physicians and allowed by Medicare during the first 6 months of 2002 did not meet program requirements, resulting in $136 million in improper payments. In addition, we analyzed Medicare claims data from 2002 to 2004 and identified aberrances in physicians' billing patterns and unusually high volumes of claims. Finally, based on our review, we identified a number of issues associated with physical therapy billed by physicians under the "incident to" rule.

During the course of our review, the Centers for Medicare & Medicaid Services (CMS) took actions that addressed many of our findings. First, in November 2004, CMS issued a final rule to address the skill level of staff that provides physical therapy "incident to" physician services. Additionally, in May 2005, CMS issued a change request that clarifies CMS policy with respect to physical therapy services (Publication 100-02, Transmittal 36, Change Request 3648). Finally, CMS recently posted provider education materials regarding physical therapy services on its Web site (www.cms.hhs.gov/providers/therapy/). In light of these changes, we have decided not to issue a report that would include formal recommendations to CMS. Instead, we are transmitting this summary of our review in the event that the information will be useful in CMS's review of the physical therapy benefit and future considerations of the "incident to" rule.

BACKGROUND

Physical therapy is the treatment of functional limitations to prevent the onset and/or slow the progression of physical impairments after an illness or injury. Physical therapy includes: (1) examining patients with impairments, functional limitations, disabilities, or other health-related conditions to determine a diagnosis, prognosis, and intervention; (2) alleviating

impairments and functional limitations by designing, implementing, and modifying therapeutic interventions; and (3) preventing injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and quality of life.[1] Common treatments performed in physicians' offices include therapeutic procedures, manual therapy, electrical stimulation, and ultrasound therapy.

Physical therapy billed directly by physicians represented approximately $158 million out of a total of approximately $528 million for physical therapy claims billed to the Part B carriers and allowed by Medicare in the first 6 months of 2002. Medicare allows physicians to submit claims for physical therapy that they do not perform personally, as long as the services are an "integral, although incidental, part of the physicians' personal professional services in the course of diagnosis or treatment of an injury or illness."[2] 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 for more than $1 million in physical therapy has more than doubled, from 15 to 38 in the same 2-year period.

General provisions of the Social Security Act (the Act) govern Medicare reimbursement of all services, including physical therapy. Section 1862(a)(1)(A) of the Act states that ". . . no payment may be made [under the Medicare title for services that] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Specific coverage requirements for physical therapy are in section 1861(p) of the Act, which requires that:

- The patient must be under the care of a physician (a doctor of medicine, osteopathy, optometry, or podiatric medicine).

- The services must be furnished under a plan of care. The plan of care indicates the type, amount, frequency, and duration of the services.

- The plan of care must be recertified periodically by a physician.

The implementing regulations at 42 CFR §§ 410.60 and 410.61 restate these coverage requirements and further specify that the plan of care must include the diagnosis and anticipated goals of the therapy that a physician must recertify every 30 days. Section 2218 of the Medicare Carriers Manual[3] states that the plan of care must contain:

- the patient's significant past history;
- patient's diagnoses that require physical therapy;
- related physician orders;
- therapy goals and potential for achievement;

[1] For a more complete definition of physical therapy, see American Physical Therapy Association, "Model Definition of Physical Therapy for State Practice Acts in the Guide to Physical Therapy Practice," 1997, chapter 1, p. 2.
[2] Centers for Medicare & Medicaid Services, Medicare Carriers Manual, section 2050.1.
[3] Online Centers for Medicare & Medicaid Services Manual System, Publication 100-2, chapter 15, section 220.2.

- any contraindications;
- patient's awareness and understanding of diagnoses, prognosis, treatment goals; and
- when appropriate, the summary of treatment provided and results achieved during previous periods of physical therapy services.

Section 1833(e) of the Act requires that providers furnish "such information as may be necessary in order to determine the amounts due" to receive Medicare payment. Related regulations at 42 CFR §§ 411.15(k) and 424.5(a)(6) reflect these provisions of Federal law.

Section 1861(s)(2)(A) of the Act provides for Medicare coverage of services and supplies furnished "incident to" the professional services of a physician. This section defines covered medical and other health services as ". . . services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills." The implementing regulations at 42 CFR §§ 410.10(b) and 410.26 restate this language. Section 2050 of the Medicare Carriers Manual[4] provides examples of services and supplies covered under the "incident to" rule. Examples of services include taking blood pressures and temperatures, giving injections, and changing dressings. Examples of supplies include gauze, ointments, bandages, and oxygen.

The "incident to" rule allows physicians to bill for physical therapy performed by any nonphysician staff (including, but not limited to, licensed physical therapists). The rule allows physician reimbursement for physical therapy at the full physician fee schedule amount for physical therapy provided by nonphysician staff, if the services are:

- commonly furnished in a physician's office and are an integral, although incidental, part of the physician's covered services;
- included in a treatment plan for an injury or illness, where the physician personally performs the initial service and is involved actively in the course of treatment; and
- furnished under the direct supervision of a physician.[5]

Section 1862(a)(20) of the Act permits payment for therapy services furnished "incident to" a physician's professional services only if the practitioner meets the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement. Under the "incident to" rule, licensed physical therapists need not perform the services, and Medicare currently does not require licensure or certification of staff that perform "incident to" physical therapy. However, in all other settings, including nursing homes, independently practicing physical therapists' offices, and rehabilitation facilities, Medicare requires that only licensed physical therapists can render physical therapy. In addition, licensed physical therapist assistants, performing within their scope of practice, may render Medicare physical therapy under the direct supervision of a physical therapist.

---

[4] *Ibid.*, sections 60.1-60.4.

[5] Direct supervision means that the physician must be present within the office suite and immediately available to render assistance in person, if necessary. Physicians do not need to be present in the room when the services are rendered. The incident to" rule does not limit the number of services physicians can bill concurrently (42 CFR § 410.26).

Training, licensure, and direct billing for physical therapists

Physical therapists are college-educated and State-licensed health care professionals. To qualify for a State physical therapy license, candidates must have completed a post-baccalaureate professional education program from an accredited institution.[6] Generally, the education includes a 4-year college degree and at least 2 additional years of full-time study in physical therapy. Therapists must pass a State-administered national examination in order to practice. Additional requirements may vary according to individual State practice acts. For example, in California, physical therapists must complete an additional 18 weeks of clinical experience under the supervision of a licensed physical therapist to become licensed.

To bill Medicare directly, physical therapists must be licensed by the State in which they practice and must adhere to Medicare's coverage guidelines for outpatient physical therapy. Physical therapists can provide services in their own offices, a physician's office, a nursing home, a hospital, or a rehabilitation facility. When physical therapy is rendered "incident to" physicians' professional services, unlicensed individuals can render the services.

In November 2004, CMS issued a final rule to address the skill level of staff that provides physical therapy "incident to" physicians' services. CMS now requires that staff providing these services must meet the same standards and conditions as qualified therapists, with the exception of the licensing requirement. For example, unlicensed staff furnishing "incident to" physical therapy services must meet the existing training standards for licensed physical therapists. In May 2005, CMS issued a change request (Publication 100-02, Transmittal 34, Change Request 3648) that reorganizes and clarifies current CMS policy with respect to physical therapy services. The change request includes:

- clarification of conditions of coverage for physical therapy services;
- descriptions of plan of care, certification, and recertification requirements;
- description of reasonable and necessary requirements;
- description of supervision requirements for physical therapy services; and
- clarification of "incident to" physical therapy services.

In addition, CMS has posted provider education materials regarding physical therapy services on its Web site (www.cms.hhs.gov/providers/therapy/).

Previous Office of Inspector General Work

OIG began reviewing Medicare rehabilitation therapy (including physical therapy) in 1994. Our evaluations, which have focused on therapy provided in physicians' offices and nursing homes, found that significant compliance and quality of care problems persist, including overutilization, services rendered by unskilled staff, and services billed that do not meet Medicare's coverage rules.

[6] Graduates from 1960 to the present must have graduated from an institution accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). Beginning in 2002, the CAPTE limited its accreditation to only those programs offering a post-baccalaureate degree in physical therapy.

In 1994, OIG reported that approximately 78 percent of physical therapy rendered in physicians' offices did not represent true physical therapy, as defined by Medicare.[7] The services were mostly palliative in nature or did not represent the complexity required by Medicare's coverage guidelines.

In 1999, OIG issued two reports[8] addressing therapy provided to Medicare beneficiaries in skilled nursing facilities during 1998, prior to implementation of the prospective payment system. We found that while most nursing home patients were proper candidates for physical and occupational therapy, approximately 13 percent of the services were billed improperly. These improper billings represented almost $1 billion reimbursed to nursing homes in 1998.

In 2001, OIG issued two reports[9] addressing physical therapy for nursing home patients. We found that the $1,500 financial limitation on therapy in 1999 did not prevent nursing home patients from receiving necessary and appropriate services. We also found that, despite the limitation, 14 percent of the therapy (representing $28 million during the first 6 months of 1999) was not medically necessary.

METHODOLOGY

We used multiple methodologies to accomplish our objectives:

1. medical review of a random sample of claims,

2. analysis of Medicare claims and billing patterns, and

3. interviews with physicians in our sample and Medicare carrier personnel.

For this review, we selected a simple random sample of 70 physical therapy line items billed by physicians and rendered in the first 6 months of 2002. We eliminated two line items from our sample because one line item was for respiratory therapy and a physician we could not locate submitted the other. The total allowed amount in our sample of 68 line items was $2,176.62. We selected the line items from the population of all line items billed by physicians with service dates between January 1 and June 30, 2002.[10] We selected line items in order to project our findings to the total Medicare allowed amounts for physicians' physical therapy during the sample timeframe.

A line item is a single current procedural terminology (CPT) code within the claim; however, it may reflect multiple units of the same procedure. For example, CPT 97110 represents a therapeutic procedure, one or more areas, each 15 minutes. The line items ranged from one to

---

[7] Office of Inspector General, "Physical Therapy in Physicians' Offices," OEI-02-90-00590.

[8] Office of Inspector General, "Physical and Occupational Therapy in Nursing Homes: Medical Necessity and Quality of Care" (OEI-09-97-00121) and "Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings" (OEI-09-97-00122), both issued in August 1999.

[9] Office of Inspector General, "Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients: Medical Necessity, Cost, and Documentation Under the $1,500 Caps" (OEI-09-99-00560) and "Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients: Medical Necessity and Quality of Care Based on the Treatment Diagnosis" (OEI-09-99-00563), both issued in August 2001.

[10] The total population of line items is 5,669,575 representing $164.4 million.

three units each (15 to 45 minutes). Each line item, regardless of the number of units, is weighted equally when we report aggregate claim percentages. We used the actual allowed amount for each line item, which reflects the number of units for each CPT code to estimate total allowed Medicare dollars. A claim may contain multiple line items with multiple units. Throughout this report, we use the term "claim" to refer to single physical therapy line items (a single CPT code).

We requested complete medical records from the physicians for each beneficiary for the dates reflecting the physical therapy episode of care during which the sampled claim was rendered. In addition, we requested the Medicare billing records, physician and staff schedules for each day the beneficiary received medical services, and all licenses and credentials for the staff that provided services to the beneficiary. The episodes of care varied in length and occurred from July 2001 through December 2002. We made four requests for the records. We received 54 valid responses (79 percent). The confidence intervals at the 95 percent level are in Appendix A.

We contracted with licensed physical therapists to review each service according to a standard protocol, which was based on Medicare coverage guidelines and requirements. The review instrument solicited information about the beneficiary's physical therapy as a whole and about the individual sampled service in particular. This enabled the reviewers to determine if the services billed to Medicare were covered and properly documented. This level of information would not generally be available to carriers unless they were to conduct a comprehensive medical review of a particular physician or patient.[11] After completing their review, the contractors returned the completed instruments to us for data entry. We analyzed the medical review results using the statistical software packages SAS and SUDAAN.

When we requested medical records from a physician and received no response after four requests, we considered the claim undocumented. This is consistent with 42 CFR § 424.5(a)(6), which states that Medicare providers must furnish to the Medicare carriers sufficient information to determine whether or not payment is due. In our final written request to the physicians, we informed them that if we did not receive the requested documentation, we would not be able to confirm the appropriateness of payment, and we would refer the matter to the appropriate Medicare carrier for resolution. Carriers could collect overpayments from the physicians and determine if fraud or abuse investigations are warranted.

Data Analysis and Interviews

We analyzed all physicians' Medicare Part B physical therapy claims for 2002, 2003, and 2004. We analyzed and reviewed physicians' billing patterns. Our analysis included:

- total allowed amounts for physicians' physical therapy;
- total allowed amounts for physical therapy per physician;
- total allowed amounts for physical therapy per beneficiary;
- geographic dispersion of Medicare's physical therapy; and

[11] We recognize that our methodological approach differs from that of CMS's Comprehensive Error Rate Testing (CERT) program. The CERT paid claims error rate is based on the review of a single claim, while our review elicited information about the beneficiaries' episode of physical therapy care in addition to an evaluation of the individual sampled service.

- relationships among physicians, including physicians who share the same beneficiaries with other physicians.

We interviewed, in person and by telephone, selected Medicare Part B carriers that have conducted reviews and investigations of physicians' physical therapy claims. The carriers provided summaries of their work, including the total dollar amounts for therapy that was paid inappropriately.

We conducted telephone interviews with 32 of the 54 physicians who responded to our medical record request and consented to an interview. We asked to what extent they personally render physical therapy and who on their staff render physical therapy.

2002 MEDICAL REVIEW RESULTS

Ninety-one percent of physical therapy billed by physicians and allowed by Medicare during the first 6 months of 2002 did not meet program requirements, resulting in $136 million in improper payments. During the first 6 months of 2002, Medicare allowed approximately $158 million for physical therapy billed by physicians (Table 1). Based on our medical review, 26 percent of the therapy during this period was not medically necessary, and 34 percent was undocumented. Fifty-seven percent of the services were furnished under incomplete plans of care or had no plan of care documented. All of the services that were not medically necessary also were furnished under incomplete plans of care or had no plans of care documented.

Table 1: Improper Payments for Physical Therapy Billed by Physicians

	Sample		Projected	
Type of error	Services	Allowed Amount	Services (Percent)	Allowed Amount (Millions)
Not medically necessary	**18**	**$455.65**	**26%**	**$33.0**
Undocumented:				
-Nonresponse	*14*	*466.58*	*	*
-Missing documentation	*9*	*209.56*	*	*
Total undocumented	**23**	**$676.14**	**34%**	**$49.0**
Incomplete/No plan of care:				
-Incomplete plan of care	*23*	*$802.40*	*34%*	*$58.2*
-No plan of care	*16*	*$397.50*	*24%*	*$28.8*
Total incomplete/no plan of care	**39**	**$1,199.90**	**57%**	**$87.0**
Overlapping errors *(Both not medically necessary and incomplete/no plan of care)*	***(18)***	***($455.65>***	***<26%>***	***<$33.0>***
Total	**62**	**$1,876.04**	**91%**	**$136.0**

Source: Medical Review of Physical Therapy Billed by Physicians January to June 2002.

* Indicates the n for that cell is too small to reliably project. Totals may not equal the sum of individual rows due to rounding.

Not medically necessary. Pursuant to section 1862(a)(1)(A) of the Act, services that are not reasonable and necessary are not covered by Medicare. Twenty-six percent of the physical therapy billed by physicians and allowed in the first 6 months of 2002, totaling $33 million, did not meet Medicare criteria for medical necessity. Medical reviewers found that there were no objective bases for care, no identified outcomes, and/or no change in the patients' conditions to justify ongoing therapy.

Undocumented. Physicians did not provide substantiating documentation for approximately 34 percent of the services billed to Medicare. Despite repeated requests, we did not receive the medical records related to 14 of the services in our sample. The physicians who billed for an additional nine of the services provided us with records that did not substantiate that any service was rendered on the date claimed. Based on these findings, we estimate that Medicare may have allowed approximately $49 million during the first 6 months of 2002 for undocumented physical therapy services billed by physicians. Although some cases of missing documentation may be attributable to billing errors (e.g., putting the wrong date on the claim form), others might represent services not rendered. In any case, claims for services that lack sufficient documentation to show that care was provided do not meet the requirements of section 1833(e) of the Act.

No plan/incomplete plan of care. Separate from the completely undocumented services previously discussed, 57 percent of physical therapy services were furnished without a plan of care or under an incomplete plan of care, contrary to the requirements of section 1861(p) of the Act. Approximately 24 percent of the services were furnished under no plan of care, and 34 percent were furnished under incomplete plans.[12] The incomplete plans did not contain information concerning the amount, frequency, or duration of the therapy, and/or physician certification. When projected to the national population of therapy billed by physicians, we estimate the services furnished without a plan of care or under an incomplete plan of care represent $87 million that Medicare allowed during the first 6 months of 2002.

Overlapping errors. All of the services that were not medically necessary also were furnished under incomplete plans of care or had no plans of care documented.

Because of inadequate documentation, reviewers had difficulty assessing the quality of the therapy services. Reviewers could not assess the quality of care for 33 of the 54 records they reviewed. However, 12 records contained enough documentation for the reviewers to question the quality of care and note that some services "lacked an objective basis for care." They also noted that massage therapy alone, which was the only service provided in three cases, is not considered "a skilled intervention or restorative care."

Most medical records did not indicate the skill level of the individual who rendered the therapy. The reviewers could not determine the skill level of the staff who rendered physical therapy in 32 of the 54 records. Persons with the appropriate skill levels, including physicians, physical therapists, and physical therapist assistants appear to have rendered the services in 18 of the 54 records. Persons who lacked appropriate skill levels,[13] such as an acupuncturist, a "certified

[12] These approximations total 58 percent due to rounding.
[13] According to the judgment of our medical reviewers.

disability examiner," a massage therapist, and a physical therapist aide, appear to have rendered the services for four of the claims.

Of the 32 physicians we interviewed, 24 told us that their staff render some or all of the physical therapy for which they bill Medicare. According to these physicians, therapy in their offices is rendered by:

- podiatrists,
- chiropractors,
- physical therapists,
- physical therapist assistants,
- massage therapists, and
- physical therapist aides.

Fourteen of the physicians we interviewed reported that they personally render some or all of the therapy for which they bill; however, we could not verify through Medicare claims data what proportion of the physicians' physical therapy claims were rendered personally by the physician.

Some physicians in our sample billed Medicare for extensive physical therapy without developing a plan of care. Twenty-three of the fifty-four beneficiaries in our sample received physical therapy with no plan of care. These beneficiaries received a mean average of 30 days of physical therapy in 2002 from the physicians in our sample. Medicare allowed a mean average of $2,691 for each beneficiary for physical therapy from the physicians in our sample. In total, physicians for these 23 beneficiaries billed physical therapy for more than 8,000 beneficiaries in 2002 for which Medicare allowed approximately $7.8 million.

One beneficiary in our sample received 15 months of physical therapy for lumbago and osteoarthritis, for which Medicare allowed $39,126. The beneficiary's physician did not document a plan of care and did not establish medical necessity for the services. The physician, a general practitioner, billed physical therapy 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

We identified aberrances in physicians' billing patterns and unusually high volumes of claims that suggest physical therapy is vulnerable to abuse. Using 100 percent of Medicare's claims data for 2002, 2003, and 2004, we analyzed physicians' billing patterns for physical therapy. The following are examples of what we found that raise questions about physicians' physical therapy billing patterns:

- Approximately 4 percent of all physicians who submitted physical therapy claims account for more than half of all allowed claims in 2004 (Table 2).
- 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. (See Appendix B.)

- 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.
- We identified 13,090 beneficiaries whom Medicare allowed at least $5,000 each in physical therapy billed by physicians in 2004. In contrast, for the entire beneficiary population, Medicare allowed a median of $305 each for physical therapy billed by physicians in 2004.
- The aberrances in billing patterns we observed 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. (See Appendix B.)

Table 2: Selected Statistics for Physical Therapy Billed by Physicians in 2004 by Categories of Medicare Allowed Amounts

Allowed per physician	*$1 to $99,999*	*$100,000 to $499,999*	*$500,000 to $999,999*	*$1 million or more*
Total physicians	23,777	885	107	38
Percent of physicians	95.85%	3.57%	0.43%	0.15%
Percent of allowed physical therapy	38.85%	34.26%	13.92%	12.97%
Median allowed per physician	$987	$163,127	$623,091	$1,419,803

Source: Office of Inspector General analysis of Medicare claims data, 2005.

THE "INCIDENT TO" RULE

Physicians are not required to indicate on their claims if services were rendered "incident to" their professional services, and thus, the claims appear as if the physician personally rendered the services. Therefore, in our medical review and our analysis of billing patterns, we could not measure the proportion of physicians' claims that were rendered "incident to" nor could we determine whether qualified therapists rendered the service.

Under the "incident to" rule, a physician can bill for an unlimited amount of physical therapy rendered at the same time, as long as the physician is "directly supervising" the staff rendering the services. However, based on the medical record documentation provided by the sampled physicians, we could not confirm that physicians directly supervised the provision of the service because they are not required to document "direct supervision" of therapy. In our analysis of billing patterns, we found that some physicians are billing physical therapy for dozens of beneficiaries daily, but we could not determine how many receive therapy at the same time, and therefore could not determine whether direct supervision for all of these services was physically possible. For example, 1 physician in our sample billed Medicare for physical therapy for an

average of 51 patients per day in 2002. Among all physicians who billed Medicare for physical therapy in 2002,[14] 110 billed at least once for more than 50 patients per day.

Finally, under Medicare, although staff that render physical therapy "incident to" physicians' services need not be licensed, they are required to adhere to the same standards of care[15] as independently practicing physical therapists. However, because physicians' medical records were documented inadequately, we could not confirm their compliance with these standards of care.

CONCLUSION AND ITEMS FOR CONSIDERATION

Under the "incident to" rule, Medicare allows physicians to bill for physical therapy that is rendered either by the physicians themselves or by their staff. Until 2005, staff who rendered physical therapy in physicians' offices did not have to be trained or licensed. In 2005, CMS implemented a regulation that requires staff who render physical therapy in physicians offices have the same training as licensed physical therapists. They still do not need to be licensed. In addition, under the "incident to" rule, there is no limit on the number of therapy staff that physicians can supervise concurrently. These conditions represent a vulnerability that could partially account for the noncovered and undocumented care described above and could be placing beneficiaries at risk of receiving services that do not meet professionally recognized standards of care. Therefore, we believe that the requirements for physical therapy rendered in 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, given the vulnerabilities identified in our medical review as well as our analysis of physician billing patterns for physical therapy, CMS should consider revisions, clarifications, and further study of the "incident to" rule to ensure that Medicare beneficiaries are receiving skilled services from appropriately trained and licensed staff and that the services meet professionally recognized standards of care. Under separate cover, we will forward information on the noncovered and undocumented services identified in our sample to CMS for appropriate action**.**

We plan to continue to monitor Medicare payments for physical therapy and will conduct additional reviews in this area as warranted.

If you have any questions about this summary of our review, please do not hesitate to call me or one of your staff may contact Tricia Davis, Director, Medicare and Medicaid Branch, at (410) 786-3143 or through e-mail [Tricia.Davis@oig.hhs.gov].

[14] This includes, but is not limited to, the physicians who appeared in our random sample of claims.

[15] Effective June 6, 2005, CMS requires that staff providing physical therapy "incident to" physicians' services must be graduates of a qualified program of training in physical therapy. (Online CMS Manual System, Publication 100-02, chapter 15, section 230.5. Accessed November 21, 2005.)

APPENDIX A

Confidence Intervals for Selected Statistics

			95 Percent Confidence Intervals			
Selected Statistics	***Estimates***		***Estimated Allowed Services (percent)***		***Estimated Allowed Dollars (in millions)***	
Estimates	***Point Estimate***	***Dollar Estimate (in millions)***	***Lower***	***Upper***	***Lower***	***Upper***
What Medicare allowed	**100%**	**$157.8**			**$148.5**	**$167.1**
Inappropriately paid services	**91.2%**	**$136.0**	**84.4%**	**98.0%**	**$115.8**	**$156.3**
-Not medically necessary	*26.4%*	*$33.0*	*15.9%*	*37.0%*	*$15.7*	*$50.4*
-Undocumented services	*33.8%*	*$49.0*	*22.5%*	*45.2%*	*$29.2*	*$68.8*
-Incomplete or no plan of care	*57.4%*	*$87.0*	*45.5%*	*69.2%*	*$64.2*	*$109.8*

Source: Office of Inspector General analysis of Medicare claims data, 2005.

APPENDIX B

Physician Profiles: Physicians Allowed More Than $1 Million for Physical Therapy Claims in 2001 and 2002

Physician		Total Part B Allowed Physical Therapy Claims			Part B Beneficiary Statistics (2004)	
No.	Specialty	2002	2003	2004	Total Beneficiaries Who Received Physical Therapy	Average Allowed Physical Therapy Claims Per Beneficiary
1	Internal Medicine	$ 1,876,782	$ 2,067,335	$ 3,901,621	389	$ 10,030
2	Osteopathic Manipulative Therapy	$ 163	$ 1,727,941	$ 3,873,463	221	$ 17,527
3	Pediatric Medicine	$ -	$ 260,663	$ 3,569,459	138	$ 25,866
4	Family Practice	$ 378,670	$ 742,025	$ 3,160,019	328	$ 9,634
5	Internal Medicine	$ 137,437	$ 2,355,194	$ 2,991,062	251	$ 11,917
6	Internal Medicine	$ 174,925	$ 1,379,520	$ 2,770,288	198	$ 13,991
7	Family Practice	$ 414,089	$ 2,943,860	$ 2,745,495	131	$ 20,958
8	Obstetrics/Gynecology	$ -	$ -	$ 2,304,814	185	$ 12,458
9	Family Practice	$ 1,282,524	$ 7,629,540	$ 2,021,617	456	$ 4,433
10	Internal Medicine	$ 1,414,012	$ 1,698,609	$ 1,775,549	400	$ 4,439
11	Internal Medicine	$ -	$ -	$ 1,765,782	103	$ 17,144
12	Physical Medicine and Rehabilitation	$ 377,629	$ 1,328,291	$ 1,683,338	699	$ 2,408
13	Family Practice	$ -	$ 549,832	$ 1,675,719	980	$ 1,710
14	General Practice	$ -	$ 152,757	$ 1,671,809	899	$ 1,860
15	Family Practice	$ 5,395	$ 6,368	$ 1,620,016	577	$ 2,808
16	Family Practice	$ 809,255	$ 150,485	$ 1,604,205	717	$ 2,237
17	General Practice	$ 421,882	$ 610,184	$ 1,578,111	751	$ 2,101
18	Internal Medicine	$ 638,291	$ 1,609,510	$ 1,496,640	278	$ 5,384
19	Family Practice	$ 1,354,725	$ 2,237,009	$ 1,445,758	112	$ 12,909
20	Internal Medicine	$ 519,960	$ 1,010,853	$ 1,393,847	62	$ 22,481
21	Internal Medicine	$ 2,016,524	$ 1,631,839	$ 1,338,885	510	$ 2,625
22	Family Practice	$ 945,352	$ 1,665,354	$ 1,319,578	1564	$ 844
23	General Practice	$ 452,046	$ 1,183,474	$ 1,278,525	742	$ 1,723
24	Physical Medicine and Rehabilitation	$ 99,221	$ -	$ 1,273,308	622	$ 2,047
25	Internal Medicine	$ 327,561	$ 1,068,519	$ 1,247,487	585	$ 2,132
26	General Surgery	$ 290,313	$ 755,328	$ 1,234,159	841	$ 1,467
27	Family Practice	$ 1,170,425	$ 1,234,733	$ 1,222,831	663	$ 1,844
28	Family Practice	$ 1,432,369	$ 1,762,887	$ 1,214,077	925	$ 1,313
29	General Practice	$ -	$ 51,062	$ 1,149,140	464	$ 2,477
30	Family Practice	$ -	$ 3,613	$ 1,122,661	869	$ 1,292
31	Internal Medicine	$ 1,097,949	$ 1,110,347	$ 1,116,834	311	$ 3,591

APPENDIX B

Physician Profiles: Physicians Allowed More Than $1 Million for Physical Therapy Claims in 2001 and 2002 (continued)

Physician		Total Part B Allowed Physical Therapy Claims			Part B Beneficiary Statistics (2004)	
No.	Specialty	2002	2003	2004	Total Beneficiaries Who Received Physical Therapy	Average Allowed Physical Therapy Claims Per Beneficiary
32	General Practice	$ -	$ 2,252	$ 1,110,650	702	$ 1,582
33	General Practice	$ 160,478	$ 56,733	$ 1,099,092	527	$ 2,086
34	General Practice	$ 756,197	$ 1,004,757	$ 1,072,267	648	$ 1,655
35	Osteopathic Manipulative Therapy	$ 108	$ 360,466	$ 1,043,992	84	$ 12,428
36	Internal Medicine	$ 109,675	$ 477,074	$ 1,039,833	331	$ 3,141
37	Ophthalmology	$ 652,059	$ 1,097,927	$ 1,022,585	267	$ 3,830
38	Internal Medicine	$ 50,956	$ 287,431	$ 1,003,409	670	$ 1,498
39	Internal Medicine	$ 1,167,398	$ 1,201,513	$ 939,284	450	$ 2,087
40	Internal Medicine	$ 115,999	$ 1,029,026	$ 873,985	341	$ 2,563
41	Internal Medicine	$ 1,073,827	$ 514,978	$ 563,536	386	$ 1,460
42	General Practice	$ 921,636	$ 1,090,810	$ 525,272	565	$ 930
43	Internal Medicine	$ 1,203,828	$ 2,056,425	$ 301,632	343	$ 879
44	Family Practice	$ 407,647	$ 2,124,714	$ 300,544	217	$ 1,385
45	Internal Medicine	$ 1,283,553	$ 230,010	$ 100,357	129	$ 778
46	General Practice	$ 1,725,638	$ 1,318,579	$ 80,004	711	$ 113
47	General Practice	$ 732,566	$ 1,165,387	$ 52,367	55	$ 952
48	Internal Medicine	$ 1,088,169	$ 808	$ 5,368	12	$ 447
49	Family Practice	$ 589,697	$ 1,382,912	$ 131	1	$ 131
50	General Practice	$ 1,878,761	$ -	$ -	0	$ -
51	Internal Medicine	$ 2,362	$ 1,605,499	$ -	0	$ -
	Averages	*$ 595,510*	*$ 1,055,442*	*$ 1,315,178*	439	$ 5,129
	Totals	*$ 31,562,055*	*$ 55,938,437*	*$ 69,704,410*	18,887	

Source: Office of Inspector General analysis of Medicare claims data, 2005.