Outpatient physical therapy has been under considerable scrutiny by Medicare for many years. Demonstrating its continued focus on therapy services, the Office of the Inspector General for the Department of Health and Human Services (OIG) released a report of an audit which found that 61% of sampled Medicare claims between July and December 2013 did not comply with rules requiring that services be medically reasonable and necessary, be submitted with proper coding, or submitted with sufficient documentation. Providers of outpatient physical therapy services should closely review the report and consider using its metrics for reviewing services billed to federal health care programs.

Medicare Part B covers outpatient physical therapy services. In order to qualify for Medicare Part B coverage, outpatient physical therapy services must be medically reasonable and necessary; provided in accordance with a plan of care established by a physician or qualified physical therapist and periodically reviewed by a physician; and the need for such services must be certified by a physician. To be deemed reasonable and necessary, physical therapy services must meet each of the following conditions:

- The services provide specific and effective treatment for the patient's condition under accepted standards of medical practice,
- The services are of such a level of complexity and sophistication or the condition of the patient is such that the services required can be safely and effectively performed only by a therapist, or under the supervision of a therapist,
- It is expected that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state, and
- The amount, frequency, and duration of the services must be reasonable under the acceptable standards of practice.

In addition, Medicare coding requirements for timed procedures include reporting units in 15-minute intervals based on the number of times the procedure is performed. For untimed procedures, one unit of service is appropriately reported by a provider regardless of the number of minutes spent providing the service. Providers also must use certain functional reporting codes (G Codes) and severity modifiers that provide information about the beneficiary's functional status. Finally, Medicare requires that outpatient physical therapy services be provided in accordance with a written care plan established before treatment begins; therapists are required to recertify the plan of care when a significant modification is needed or at least every 90 days; and therapists must create a treatment plan for each service that includes the type, amount, frequency and duration of the physical therapy services; indicate a diagnosis; and state the anticipated goals.

In its recent audit, the OIG reviewed 300 claims and found that 61% of the claims reviewed did not meet all requirements. Specifically, the OIG found:

- 91 claims where the medical record did not support the medical necessity of the services.
- 89 claims where the amount, frequency, and duration of the services were not reasonable and consistent with the standards of practice.
30 claims where there was no evidence that the services provided would have been effective.
28 claims that did not require the skills of a therapist.
86 claims where the number of timed units claims did not match the number of units documented in the treatment notes.
78 claims that were missing required functional reporting information.
59 claims were incorrectly coded.
112 claims for services that were not provided in accordance with one or more Medicare documentation requirements.

Based on the sample reviewed, the OIG estimated that Medicare overpaid therapists $367 million. As a result, the OIG recommended that the Medicare contractors notify providers that were found to be noncompliant in this study of possible overpayments. In response to this report, providers of outpatient physical therapy services should review their policies and procedures to ensure compliance with Medicare’s requirements for outpatient physical therapy providers. Providers should also keep in mind that, under the 60 day rule, upon receiving credible information of a potential overpayment, providers must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayment within 60 days of identifying the overpayment.

2 42 U.S.C. §§ 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) and 42 C.F.R. §§ 4110.60 and 410.61.
4 Medicare Benefit Policy Manual, Chapter 15, § 220.3A.
5 Medicare Claims Processing Manual, Chapter 5, § 20.2.
6 Medicare Benefit Policy Manual, Chapter 15, § 220.4 (effective 1/1/13).
7 42 C.F.R. § 410.60.
8 42 CFR § 424.24(c)(4) and Medicare Benefit Policy Manual, Chapter 15, § 220.1.3C.
9 Medicare Benefit Policy Manual, Chapter 15, § 220.3E.

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