Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A South Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Physical Therapy Services

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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EXECUTIVE SUMMARY

A South Texas physical therapist in private practice improperly claimed at least $90,000 in Medicare reimbursement for physical therapy services for calendar years 2012 and 2013.

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about $1.9 billion in calendar year 2014. Previous Office of Inspector General reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, properly documented, and were vulnerable to fraud, waste, and abuse. As part of a nationwide effort, we selected multiple physical therapists for review, including this therapist in South Texas. Our analysis indicated that this selected therapist was among the highest Medicare physical therapy billers in Texas.

Our objective was to determine whether claims for outpatient physical therapy services provided by a South Texas physical therapist (the therapist) in private practice complied with Medicare requirements.

BACKGROUND

Federal regulations provide coverage of Medicare Part B outpatient physical therapy services. For these services to be covered, they must be medically reasonable and necessary, they must be provided in accordance with a plan of care established by a physician or qualified therapist and periodically reviewed by a physician, and the need for such services must be certified by a physician. Medicare Part B also covers outpatient physical therapy services performed by or under the direct supervision of a therapist in private practice. Federal law precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

HOW WE CONDUCTED THIS REVIEW

Our review covered 8,771 Medicare beneficiary claim days for outpatient physical therapy services, totaling $764,086, provided by a South Texas physical therapist from January 1, 2012, through December 31, 2013. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary. We reviewed a random sample of 100 of those beneficiary claim days.

WHAT WE FOUND

The therapist claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our random sample, the therapist properly claimed Medicare reimbursement on 81 beneficiary

claim days. The therapist improperly claimed Medicare reimbursement on the remaining 19 beneficiary claim days.

These deficiencies occurred because the therapist did not have a thorough understanding of the Medicare reimbursement requirements related to the appropriate length of treatment for outpatient physical therapy services or mistakenly billed too many units.

On the basis of our sample results, we estimated that the therapist improperly received at least $90,166 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that the therapist:

- refund $90,166 to the Federal Government and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services.

PHYSICAL THERAPIST COMMENTS AND OUR RESPONSE

In written comments on our draft report, the physical therapist agreed with one of the errors and provided additional information and technical comments for each of the beneficiary claim days we found to be in error. The physical therapist commented that neither complicating factors of the patients' medical conditions nor the physical therapist's judgment were considered in determining the appropriate frequency and duration of treatment provided. The physical therapist also indicated that the treatment guidelines that the medical review contractor used are not an absolute prescription for determining, for every individual, what medical care is appropriate and for how long.

The medical review contractor examined all of the medical records and documentation submitted and carefully considered this information in conjunction with Medicare requirements. After medical review of the additional information the physical therapist provided, we reduced the number of errors from 20 in our draft report to 19 and amended this report accordingly. We maintain that our remaining findings are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

In recent years, Medicare Part B outpatient physical therapy payments have increased annually with private practice physical therapists generating payments of about $1.9 billion in calendar year (CY) 2014. Previous Office of Inspector General (OIG) reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, properly documented, and were vulnerable to fraud, waste, and abuse.[1] As part of a nationwide effort, we selected multiple physical therapists for review, including this therapist in South Texas. Our analysis indicated that this selected therapist was among the highest Medicare physical therapy billers in Texas.

OBJECTIVE

Our objective was to determine whether claims for outpatient physical therapy services provided by a South Texas physical therapist (the therapist) in private practice complied with Medicare requirements.

BACKGROUND

The Medicare Program

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

Medicare Part B covers services considered medically necessary to treat a disease or condition, including outpatient therapy services. CMS contracts with Medicare contractors to process and pay Part B claims.

Medicare Outpatient Physical Therapy Services

Medicare Part B provides coverage for outpatient physical therapy services.[2] Physical therapists evaluate and treat disorders of the musculoskeletal system. The goal of physical therapy is to restore maximal functional independence to each individual patient by providing services that aim to restore function, improve mobility, and relieve pain. Modalities such as exercise, heat, cold, electricity, and massage are used. These services are provided in a number of different

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[1] *AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-13-01031), issued June 15, 2015; *An Illinois Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-05-13-00010), issued August 20, 2014; *Spectrum Rehabilitation, LLC, Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services* (A-02-11-01044), issued June 10, 2013; *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), issued December 21, 2010.

[2] Section 1832(a)(2)(C) of the Act.

settings; however, the majority of Medicare payments for outpatient therapy services are made to physical therapists practicing in an office setting.

For Medicare Part B to cover outpatient physical therapy services, the services must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified therapist, and periodically reviewed by a physician, and the need for such services must be certified by a physician.[3] Further, Medicare Part B pays for outpatient physical therapy services billed using standardized codes.[4] Services furnished by physical therapists in private practice must be performed by or under the direct supervision of a qualified physical therapist.[5] Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.[6] These requirements are further described in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04).

South Texas Physical Therapist

The selected physical therapist operates one physical therapy office located in South Texas. During CYs 2012 and 2013, the physical therapy office employed four licensed physical therapists and one physical therapist assistant.

HOW WE CONDUCTED THIS REVIEW

Our review covered the therapist's claims for Medicare Part B outpatient physical therapy services provided from January 1, 2012, through December 31, 2013. Our sampling frame consisted of 8,771 beneficiary claim days[7] of outpatient physical therapy services, totaling $764,086, of which we reviewed a random sample of 100 beneficiary claim days. An independent medical review contractor determined whether the services for the 100 sampled beneficiary claim days were provided in accordance with Medicare requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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[3] Sections 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) of the Act; 42 CFR §§ 410.60 and 410.61.

[4] Standardized codes used by providers to report units of service are called Healthcare Common Procedure Coding System (HCPCS) codes.

[5] 42 CFR § 410.60(c).

[6] Section 1833(e) of the Act.

[7] A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary.

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

FINDINGS

The therapist claimed Medicare reimbursement for outpatient physical therapy services that did not meet Medicare reimbursement requirements. Specifically, of the 100 beneficiary claim days in our random sample, the therapist properly claimed Medicare reimbursement on 81 beneficiary claim days. The therapist improperly claimed Medicare reimbursement on the remaining 19 beneficiary claim days.

Beneficiary claim days by type of error:

- 18 beneficiary claim days had therapy services that were not medically necessary and
- 1 beneficiary claim day did not meet Medicare coding requirements.

These deficiencies occurred because the therapist did not have a thorough understanding of the Medicare reimbursement requirements related to the appropriate length of treatment for outpatient physical therapy services or mistakenly billed too many units. The therapist told us that determining when to discharge a patient is difficult because patients' needs and responses to therapy vary, and discharge guidance issued by the various insurance plans can be difficult to interpret. On the basis of our sample results, we estimated that the therapist improperly received at least $90,166 in Medicare reimbursement for outpatient physical therapy services that did not comply with Medicare requirements.

SERVICES WERE NOT MEDICALLY NECESSARY

For services to be payable, a beneficiary must need physical therapy services (*Medicare Benefit Policy Manual*, chapter 15, § 220). For a service to be covered, the service must be reasonable and necessary (section 1862(a)(1)(A) of the Act and *Medicare Benefit Policy Manual*, chapter 15, § 220).

Services are reasonable and necessary if it is determined that the services were safe and effective, of appropriate duration and frequency within accepted standards of medical practice for the particular diagnosis or treatment, and met the patient's medical needs (*Medicare Program Integrity Manual*, chapter 3, § 3.6.2.2).

For 18 beneficiary claim days, the therapist received Medicare reimbursement for which the beneficiaries' medical record did not support the medical necessity of services. The results of the medical review indicated that these services did not meet one or more Medicare requirements:[8]

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[8] The total errors exceed 18 because the beneficiary claim days contained more than one error.

- The amount, frequency, and duration of services were not reasonable (18 beneficiary claim days).

- Given the patient's diagnoses, complexities, severities, and interaction of current active condition(s), the care was not appropriate (18 beneficiary claim days).

- Services did not require the skills of a physical therapist (1 beneficiary claim day).

- Services were not specific and/or an effective treatment for the patient's condition (1 beneficiary claim day).

- There was no expectation of significant improvement within a reasonable and predictable period of time (1 beneficiary claim day).

For example, the therapist received payment for the 25th physical therapy session provided to a 79-year-old Medicare beneficiary. The medical review contractor determined that the therapy service did not meet Medicare coverage requirements because the medical records showed that the patient was no longer having pain and was independently performing a home exercise program. In addition, the number of treatment sessions was deemed excessive and yet ongoing physical therapy was planned.

CODING DID NOT MEET MEDICARE REQUIREMENTS

Outpatient therapy services are payable when the medical record and information on the provider's claim form consistently and accurately report covered services (*Medicare Benefit Policy Manual,* chapter 15, § 220.3A). Providers must include the National Provider Identifier[9] on claims for the rendering therapist providing the services (*Medicare Claims Processing Manual*, chapter 26, § 10.4). In addition, providers must also report the number of units for outpatient rehabilitation services based on the procedures or services provided. For timed procedures, units are reported in 15-minute intervals. For untimed procedures, units are reported based on the number of times the procedure is performed (*Medicare Claims Processing Manual,* chapter 5, § 20.2).

For 1 beneficiary claim day, the therapist received Medicare reimbursement for which the timed units did not match the beneficiary's treatment notes.

The therapist received payment for physical therapy provided under HCPCS code 97110 to a 75-year-old Medicare beneficiary. The therapist provided treatment notes stating that therapeutic exercises were applied for 30 minutes; therefore, the provider should have billed HCPCS code 97110 for two units of service rather than the three units for which the provider billed.

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[9] A National Provider Identifier is a unique identification number for health care providers.

CONCLUSION

On the basis of our sample results, we estimated that the therapist improperly received at least $90,166 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

RECOMMENDATIONS

We recommend that the therapist:

- refund $90,166 to the Federal Government and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services.

PHYSICAL THERAPIST COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the physical therapist agreed with one of the errors and provided additional information and technical comments for each of the beneficiary claim days we found to be in error. The physical therapist commented that neither complicating factors of the patients' medical conditions nor the physical therapist's judgment were considered in determining the appropriate frequency and duration of treatment provided. The physical therapist also indicated that the treatment guidelines that the medical review contractor used are not an absolute prescription for determining, for every individual, what medical care is appropriate and for how long. The physical therapist's comments, excluding medical record information, are included as Appendix D.

The medical review contractor examined all of the medical records and documentation submitted and carefully considered this information in conjunction with Medicare requirements. After medical review of the additional information the physical therapist provided, we reduced the number of errors from 20 in our draft report to 19 and amended this report accordingly. We maintain that our remaining findings are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered a therapist's claims for Medicare outpatient physical therapy services provided from January 1, 2012, through December 31, 2013. Our sampling frame consisted of 8,771 beneficiary claim days of outpatient physical therapy services, totaling $764,086, of which we reviewed a sample of 100 beneficiary claim days. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary. These claims were extracted from CMS's National Claims History (NCH) file.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the therapist's policies and procedures for documenting and billing Medicare for outpatient therapy services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data, but we did not assess the completeness of the file.

We conducted our audit work from October 2014 through July 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- extracted from CMS's NCH file a sampling frame of 8,771 beneficiary claim days, totaling $764,086, from January 1, 2012, through December 31, 2013;
- selected a random sample of 100 beneficiary claim days from the sampling frame (Appendixes B and C);
- obtained medical records documentation from the therapist for the 100 sampled beneficiary claim days and provided them to an independent medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- used the results of the sample review to calculate the estimated unallowable Medicare reimbursement paid to the therapist (Appendix C); and
- discussed the results of our review with the auditee.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part B outpatient therapy service claims paid to the therapist from January 1, 2012, through December 31, 2013.

SAMPLING FRAME

The sampling frame was an Access database containing 8,771 beneficiary claim days of outpatient therapy services, totaling $764,086, provided by the therapist from January 1, 2012, through December 31, 2013. The claims data were extracted from CMS's NCH file.

SAMPLE UNIT

The sample unit was an outpatient therapy service beneficiary claim day. A beneficiary claim day consisted of all outpatient therapy services provided on a specific date of service on the same claim for a specific beneficiary. The beneficiary claim days were limited to payment amounts greater than or equal to $50.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 outpatient therapy service beneficiary claim days.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items. We then created a list of the 100 sampled items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to appraise the sample results. We estimated the total amount of inappropriate Medicare payments for unallowable outpatient therapy services made to the therapist at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

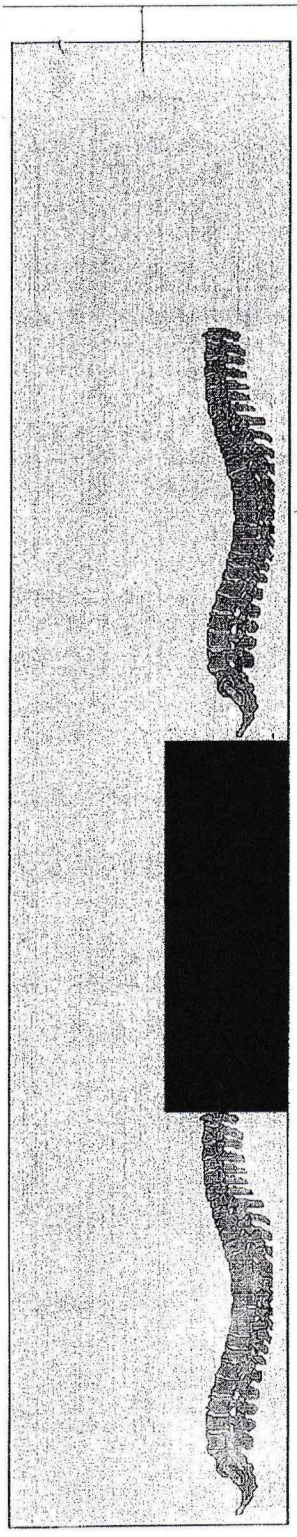
Beneficiary Claim Days in Frame	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Beneficiary Claim Days	Value of Unallowable Beneficiary Claim Days
8,771	$764,086	100	$8,597	19	$1,585

ESTIMATES

Estimated Value of Unallowable Beneficiary Claim Days
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$139,025
Lower limit	90,166
Upper limit	187,883

APPENDIX D: PHYSICAL THERAPIST COMMENTS



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Date: 12-08-15
Report Number: A-06-14-00064
RE: Medical Review of 20 Cases by Selected DOS

In reviewing all of the 20 identified cases, it is obvious that the medical review entity chose to apply Official Disability Guidelines (ODG) treatment guidelines to determine when each patient's treatment should have been terminated or the patient should have been discharged to self-care and a final home exercise program (HEP). However, in doing so it appears no consideration was given to either the complicating factors that took them outside the ODG norm for recovery for their medical conditions we provided physical therapy (PT) or the physical therapist's judgment in the determination of the appropriate frequency and duration of treatment provided. Litigation before administrative agencies and courts established that the ODG provides valuable norm treatment guidelines, but are not an absolute prescription for determining for every individual what medical care is appropriate and for how long. To make this clear Appendix D was added to the ODG and as an introduction provides:

> "These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions and also help payers make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances. http://www.odg-twc.com/preface.htm#COPYRIGHTPAGE"

The predominance of these 20 cases clearly had multiple comorbidities requiring care beyond the ODG norm. These included diabetes, heart disease, osteoarthritis to multiple joints, and the greatest being the age range of 65-90 years old; and they were not injured workers. I thank you for your reconsideration of these cases and any redeterminations would be greatly appreciated in your final determinations.

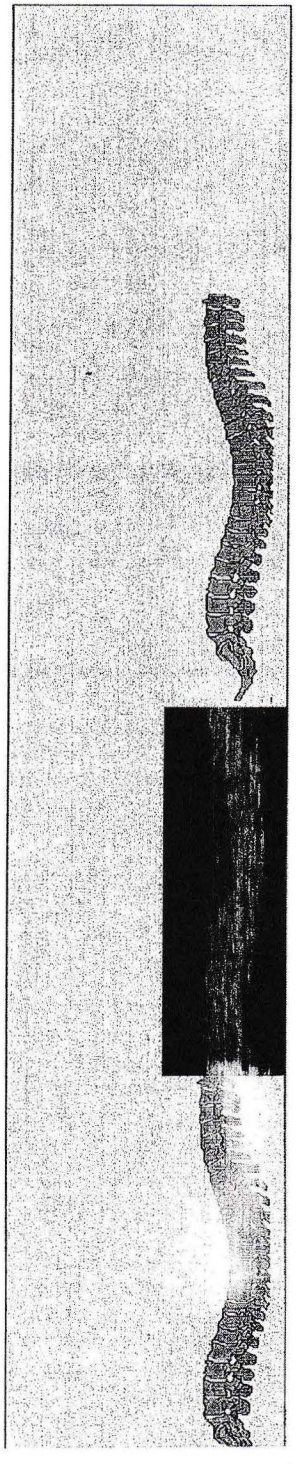
During your visit I had indicated to you that we had gone through a transition making it somewhat challenging to be sure you got all of our supporting documentation. Based on my review of these 20 cases it appears Medical Review may not have received or does not have all of the material supporting documents. So I have attached additional redacted supporting documentation to support my comments on most of those 20 cases.

Attached are my comments of concurrence and nonoccurrence for each of the 20 cases identified and the corrective actions that have been taken and will be taken.

Please take into consideration that we provide PT care to patients in good faith and to meet their medical needs.

[redacted]

Office of Inspector General Note—Text has been redacted because it is personally identifiable information.



Additional Improvements:

Also note that we have greatly improved upon our procedures for obtaining all Plan of Care's in a more timely fashion and the method in tracking them through our current EHR program/software.

All PT's are being refreshed on the ODG treatment guidelines and being required to complete the certification training.

All PT's are receiving annual MC compliance training in addition to periodic CME education relevant to MC treatment and documentation guidelines.

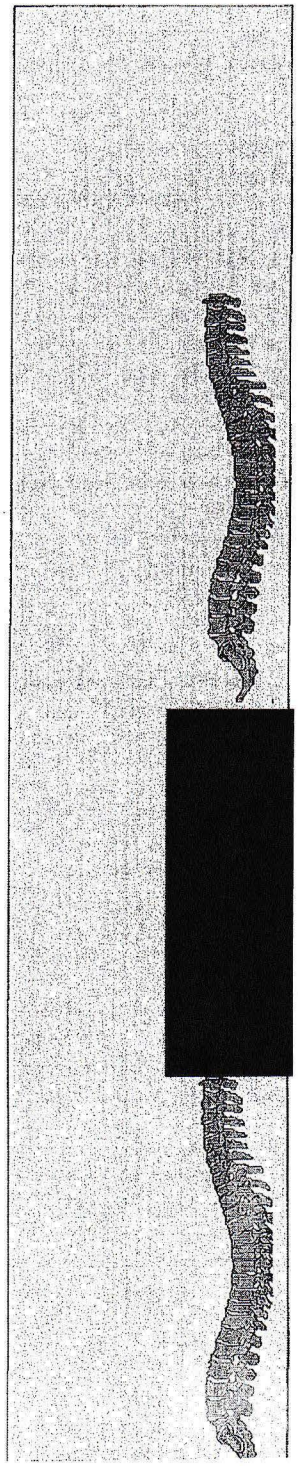
Also noted is that peer review is also being done on a regular basis.

Acronym List:

AROM	Active Range of Motion
DDD	Degenerative Disc Disease
DJD	Degenerative Joint Disease
HEP	Home Exercise Program
ODG	Official Disability Guidelines
PII	Personal Identifying Information
POC	Plan of Care
PROM	Passive Rom of Motion
VAS	Visual Analog Scale
WNL's	Within Normal Limits

Physical Therapy Guidelines (From the ODG)

Physical Therapy Guidelines, showing recommended frequency and duration of PT visits are next. Only appropriate conditions have physical therapy guidelines. These guidelines provide evidence-based benchmarks for the number of visits with a physical or occupational therapist and the period of time during which these visits take place. (Note: These guidelines do not include work hardening programs.) The physical therapy guidelines do not describe the type of therapy required, and the number of visits does not include physical therapy that the patient should perform in their own home or work site, after proper training from a clinician. Unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in the determination of the appropriate frequency and duration of treatment. Support for the physical therapy guidelines is relevant medical literature and actual experience data, combined with consensus review by experts. The most important data sources are the high quality medical studies that are referenced in the treatment guidelines, ODG Treatment in Workers' Comp, within the Procedure Summaries of each relevant chapter, summarized under the entry for "Physical Therapy." For clinical trials that show effectiveness for these therapies, the number of visits required to achieve this are isolated from each study and combined with the same

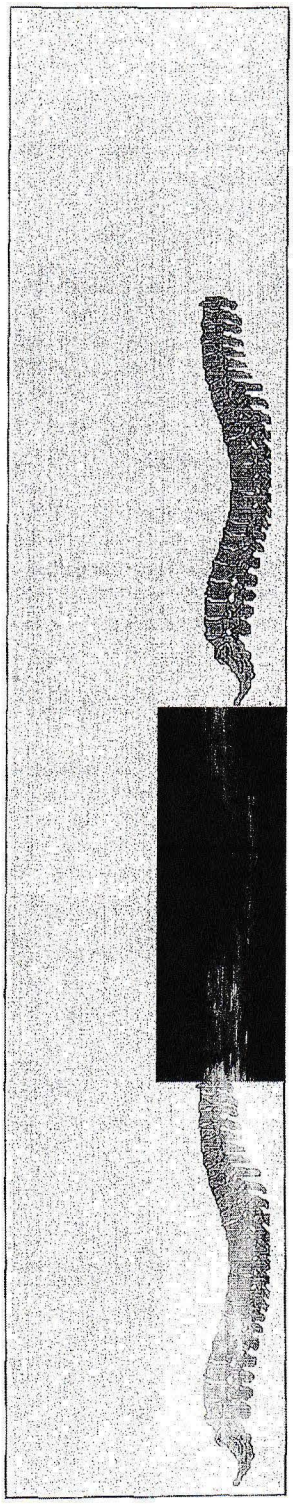


information from other successful studies to arrive at the benchmark number of visits in ODG.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

Generally there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where co-morbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker.

As described above, for more detail users should refer to ODG Treatment in Workers' Comp, within the Procedure Summaries of each relevant chapter, for recommendations about specific treatments and modalities, along with supporting links to the highest quality relevant medical studies, which have been summarized, rated, and highlighted. In these Procedure Summaries ODG covers many different types of treatments that can be supported by the medical evidence, and it also identifies the maximum number of visits that can be justified by the evidence; however, this does not mean that a provider should do every possible treatment that may be recommended (actually, this would be highly unlikely since different specialties would be required), or always deliver the maximum number of visits, without taking into account what was needed to cure the patient in a particular case. Furthermore, duplication of services is not considered medically necessary. While the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an "entitlement"). Any provider doing this is not using the guidelines correctly, and provider profiling would flag these providers as outliers. This applies to all types of treatment, and not just physical therapy. Furthermore, flexibility is especially important in the time frame recommendations. Generally, the number of weeks recommended should fall within a relatively cohesive time period, between date of first and last visit, but this time period should not restrict additional recommended treatments that come later, for example due to scheduling issues or necessary follow-up compliance



with a home-based program. When there are co-morbidities, the same principles should apply as in the ODG guidelines for return-to-work. See Additional note on co-morbidities at the end of the description of the Return-To-Work "Best Practice" Guidelines. In estimating the maximum number of treatment visits for workers with multiple diagnoses, users should use the number from the diagnosis with the longest number of visits. This assumes that whatever separate therapy, if any, that the lesser diagnosis requires, it can be done during the same visits addressing the more serious problem. If there are reasons why these therapies cannot be concurrent, documentation should support medical necessity. For example, in unusual cases where co-morbidities involve completely separate body domains, requiring separate treatments that would be difficult to combine, either additional visits or additional time for a visit may be justified. [For the purpose of this discussion, we would assume there could be only three separate body domains: (1) spine and pelvis; (2) upper extremity and hands; & (3) lower extremity and feet.] Of course, each billed treatment should require one-on-one patient contact with the licensed therapist and not include modalities/exercises that the patient has learned to do on their own without supervision, and there should also be some economies of scale such that the involvement of two body domains should not require either a doubling of the number of visits or a doubling of the modalities (or time) per visit. Also see multiple incidences of disability duration in the same section for recommendations regarding number of treatment visits, for example, physical therapy, in these situations. And physical therapy visits post-surgery should be considered separately from visits used up in an attempt at conservative treatment that might have avoided surgery.

Physical medicine treatment (including PT, OT and chiropractic care) should be an option when there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations; the functional limitations are likely to respond to skilled physical medicine treatment (e.g., fusion of an ankle would result in loss of ROM but this loss would not respond to PT, though there may be PT needs for gait training, etc.); care is active and includes a home exercise program; & the patient is compliant with care and makes significant functional gains with treatment.

The recommended number of physical therapy visits for a diagnosis applies to physical therapy or occupational therapy providers. While the services they provide may be different, the number of visits is assumed to be the same, and recommendations specific to those treatments may be covered in the treatment guideline procedure summaries along with a summary of the current medical evidence. With respect to requests for concurrent or additional physical therapy and occupational therapy, it is assumed that the patient visits one specialist or the other, depending on their needs and the availability of appropriate providers.

[redacted]