Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR THERAPY SERVICES IN EXCESS OF STATE LIMITS

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Inspector General

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EXECUTIVE SUMMARY: MEDICAID PAYMENTS FOR THERAPY SERVICES IN EXCESS OF STATE LIMITS
OEI-07-10-00370

WHY WE DID THIS STUDY

Past Office of Inspector General work has shown that Medicare- and Medicaid-paid physical, occupational, and speech therapy services were vulnerable to improper payments because (1) plans of care were incomplete or missing; (2) documentation was missing, or providers failed to respond to our request for documentation; or (3) providers lacked proper qualifications, or we could not determine whether they had proper qualifications.

HOW WE DID THIS STUDY

We asked Medicaid staff from all States and the District of Columbia (States) to respond to a questionnaire requesting information about whether their States placed limits on therapy services, and if so, the nature of those limits. We examined paid Medicaid fee-for-service claims for therapy services in eight States (Arkansas, Florida, Hawaii, Illinois, Maine, Maryland, Michigan, and North Carolina) for the period July 1, 2008, through June 30, 2009, to determine whether the therapy services complied with State limits. We asked State Medicaid officials to describe the safeguards established to prevent payments in excess of State limits. We also asked State Medicaid staff to identify the reason(s) States' safeguards failed to prevent payments in excess of State limits.

WHAT WE FOUND

Thirty-five of the forty-eight States that paid for any type of Medicaid therapy services placed limits on the amount of services a beneficiary could receive. All eight States we reviewed described safeguards established to prevent payments in excess of State limits; however, six of those States improperly paid claims totaling approximately $744,000. Three States paid claims for therapy services that were potentially improper. Although we identified a relatively low number of claims for therapy services paid improperly, the errors were easily preventable in most instances. Several States reported improving their program integrity safeguards to address our findings.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (CMS) work with States to prevent Medicaid payments for therapy services in excess of State limits and to follow up on the inappropriate claims identified in our review. CMS concurred with our recommendations.

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OBJECTIVES

1. To describe the limits that States established on physical; occupational; and speech, hearing, and language therapy services.
2. To identify payment safeguards that States established to prevent payments for therapy services in excess of State limits.
3. To identify Medicaid payments for therapy services that exceeded State limits.

BACKGROUND

Previous Office of Inspector General (OIG) work has shown that Medicare- and Medicaid-paid therapy services were vulnerable to improper payments because (1) plans of care were incomplete or missing; (2) documentation was missing, or providers failed to respond to requests for documentation; or (3) providers lacked proper qualifications, or we could not determine whether they had proper qualifications. However, prior to this report, we had not assessed whether Medicaid payments for therapy services were paid in excess of State limits. Identifying the extent of improper payments for therapy services and the reasons safeguards fail to prevent them will assist in ensuring the integrity of the Medicaid program.

Title XIX of the Social Security Act (the Act) requires State Medicaid programs to provide certain basic medical services (e.g., physician services, hospital care, nursing facility care) to all categorically needy recipients.[1] Additionally, the Act allows States to provide optional services—such as physical; occupational; and speech, hearing, and language (speech) therapy—through their Medicaid State plans.[2] In fiscal year (FY) 2008, approximately $700 million for 16 million claims was paid for physical, occupational, and speech therapy services (therapy services).[3] This $700 million represents both the State and Federal shares of the expenditures.

[1] Medicaid is funded by both the Federal and State governments. Under § 1903 (a)(1) of the Act, the Federal Medical Assistance Percentage (FMAP) is used to determine the amount of Federal matching funds for State medical assistance expenditures. Sections 1905(b) and 1101(a)(8)(B) of the Act specify the basic formula for calculating the FMAP.

[2] Therapy services can be provided through the home health benefit (§ 1905(a)(7) of the Act; 42 CFR § 440.70); the Early Periodic Screening, Diagnosis, and Treatment benefit (§ 1905(a)(4)(B) of the Act; 42 CFR § 441.50); the rehabilitative services benefit (§ 1905(a)(13) of the Act; 42 CFR § 440.130); and various types of waivers.

[3] Medicaid Statistical Information System State Summary Datamart. Accessed at http://msis.cms.hhs.gov/ on August 19, 2011. The most recent data available for all 51 State Medicaid programs are from FY 2008.

State Limitations on Therapy Services

States may establish limits on the amount, duration, and scope of the Medicaid services they will cover, as long as each service is sufficient to reasonably achieve its purpose.[4] Such limits are included in the State Medicaid plan that the Centers for Medicare & Medicaid Services (CMS) approves. State-established limits include the number of therapy services, hours of therapy services, or total dollar amount the Medicaid program will pay for each beneficiary during a certain period. In some States, a single limit may include more than one type of therapy service—for example, a State could limit beneficiaries to 60 hours per year of physical and occupational therapy combined.

State Payment Safeguards

For many types of Medicaid services, States establish safeguards to prevent improper payments, including payment system edits, utilization reviews, and postpayment audits. One example of a payment system edit is to track the number of units or hours paid per recipient in a certain period and automatically deny payments for additional services once the limit is reached. In utilization reviews, staff typically examine paid claims for therapy services to determine whether payments were made for services in excess of established limits. Finally, postpayment audits consider whether the payments made to a particular provider were appropriate according to Federal and State rules, including service limits.

Related Reports

A 2006 OIG study of Medicare payments for physical therapy services billed by physicians found that 91 percent of the payments allowed by Medicare during the first 6 months of 2002 did not meet program requirements, resulting in $136 million in improper payments.[5] That study found patterns in physician billing that suggest that physical therapy is vulnerable to abuse. Four percent of physicians who submitted physical therapy claims made more than half of all allowed claims in 2004. Additionally, 134 physicians billed Medicare for more than 500 patients during the same period. The median number of patients per physician in the study was eight.

Another 2006 OIG study, which reviewed Medicaid claims for school-based therapy services, found that 43 out of 150 sampled claims did not meet Federal requirements regarding providers of therapy services.[6] The study found that either the providers did not meet Federal

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[4] 42 CFR § 440.230.

[5] OIG, *Physical Therapy Billed by Physicians,* OEI-09-02-00200, May 2006.

[6] OIG, *Review of Medicaid Claims for School-Based Health Services in New Jersey,* A-02-03-01003, May 2006.

provider qualification requirements or their qualifications could not be documented.

METHODOLOGY

Scope and Limitations

This evaluation identified Medicaid fee-for-service claims for therapy services in eight States that exceeded State limits on amount, duration, and/or scope from July 1, 2008, through June 30, 2009. We examined Medicaid paid claims for therapy services provided only through fee-for-service arrangements. We did not determine whether therapy services were medically necessary or whether the providers were qualified. We did not test the effectiveness of payment safeguards that States established to prevent payments for therapy services in excess of State limits.

State Selection

In the summer of 2010, we asked Medicaid staff from all States and the District of Columbia (States) to respond to a questionnaire requesting information about (1) whether their States provided therapy services paid on a fee-for-service basis from July 1, 2008, through June 30, 2009; (2) whether their States placed limits on those services; and (3) if so, the nature of those limits. It was necessary to collect this information from State Medicaid programs to select States for our review. We received responses from all 51 States. From the responses, we identified six primary types of therapy limits (e.g., maximum number of units per specific procedure code in a specified timeframe, maximum number of units of service in a specified timeframe based on diagnosis). We grouped six States' responses into an "Other" category because their limits were not similar to those of other States.

We selected States for further review based on two criteria: (1) higher dollar expenditures for therapy services among all State Medicaid programs; and (2) representation of each type of limit we identified, including the "Other" category. We selected the following eight States for review: Arkansas, Florida, Hawaii, Illinois, Maine, Maryland, Michigan, and North Carolina. Therapy service expenditures in these States accounted for 61 percent of national Medicaid spending on therapy services in FY 2008. All eight States provided each type of therapy services (i.e., physical, occupational, and speech) and imposed a limit on each type of service during the study period.

Structured Interviews With State Medicaid Staff

We conducted structured interviews by conference call with Medicaid agency staff in each selected State. During these interviews, we collected

information regarding the authorities through which therapy services were provided (e.g., benefit category), how the limits applied to these authorities, how therapy services were billed, and what safeguards existed to prevent payment of therapy services in excess of State limits. We also collected copies of the relevant sections of State Medicaid plans and State Medicaid manuals.

Claims Data and Analysis

We requested data from each selected State's Medicaid Management Information System for all final paid claims for therapy services provided from July 1, 2008, through June 30, 2009.[7] Table 1 shows the number and dollar amount of those claims.

Table 1: Medicaid-Paid Claims for Therapy Services, July 1, 2008, Through June 30, 2009

State	Number of Claims	Dollar Amount
Arkansas	439,522	$29,518,966
Florida	1,467,340	$82,219,947
Hawaii	23,553	$560,809
Illinois	737,518	$41,071,817
Maine	191,479	$6,322,529
Maryland	13,150	$235,259
Michigan	288,722	$12,097,106
North Carolina	746,822	$47,802,908
Total	**3,918,348**	**$219,829,341**

Source: Claims for therapy services submitted by States, 2011.

In addition to requesting the claims information in Table 1, we requested claims data for hospital outpatient services from two States to determine whether the limits on therapy services were exceeded. The Arkansas and Florida Medicaid programs established a hospital outpatient service limit that included therapy services for recipients over the age of 21. For those States, we determined whether hospital outpatient service limits were exceeded. In addition to submitting the claims in Table 1, the Arkansas Medicaid program submitted 31,346 claims totaling $1,974,623 and the Florida Medicaid program submitted 10,242 claims totaling $715,519 for the period of our review.

[7] We did not verify the number or dollar amount of claims that States reported to us with any other data source.

We also requested additional claims and eligibility information from all eight sampled States, such as recipient age, diagnosis, benefit category, or prior authorization information, to determine whether the therapy services received complied with State limits. Using statistical analysis software (i.e., SAS), we calculated the number of paid Medicaid claims and the total number of units, visits, and/or dollars paid per recipient per period, as expressed in the appropriate State's limit. For example, if a State expressed its limit in terms of visits per month, we calculated the number of visits per month for each recipient; if a State expressed its limit in terms of dollars per year, we calculated dollars per year. We compared these totals to the limits for each State to identify claims that exceeded those limits.

We held followup discussions with State Medicaid staff regarding any identified paid claims for therapy services that exceeded the limits to determine whether any extenuating circumstances existed (e.g., the recipient received prior authorization for additional therapy services that was not apparent in the data we received from the State). We also asked State Medicaid staff to identify the reason(s) safeguards failed to prevent payments in excess of State limits. We calculated the total number and dollar amount of improperly paid claims.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Thirty-five State Medicaid programs established limits on therapy services

Using the responses to our questionnaire, we determined that 47 States provided physical and occupational therapy services and 48 States provided speech therapy services on a fee-for-service basis during our period of review.[8] Thirty-five of the forty-eight States that paid for any type of Medicaid therapy services placed limits on the amount of therapy services a beneficiary could receive.[9] Thirty-five States placed limits on physical and occupational therapy services and 33 States placed limits on speech therapy services.

State Medicaid programs varied in the types of limits they established on therapy services. Even within a State, some programs varied the type of limit established among therapy disciplines. For example, the Colorado Medicaid program established a unit limit per calendar year for physical and occupational therapy with the potential for additional services approved through prior authorization. For speech therapy, the limit was a unit limit per date of service with no provision for additional services.

We grouped the types of limits States established into seven categories. Table 2 provides a description and example of each category. Appendix A lists the types of limits each State established for each type of therapy service.

[8] The States that did not provide physical or occupational therapy through their fee-for-service Medicaid programs were the District of Columbia, Rhode Island, Tennessee, and Vermont. The States that did not provide speech therapy through their fee-for-service Medicaid programs were Rhode Island, Tennessee, and Vermont.

[9] The 13 States that did not place limits on the amount of therapy services a recipient could receive were Alaska, Arizona, Connecticut, the District of Columbia, Delaware, Louisiana, Minnesota, Mississippi, New Jersey, New Mexico, Oklahoma, South Carolina, and South Dakota.

Table 2: Types and Examples of Therapy Service Limits Established by State Medicaid Programs, July 1, 2008, through June 30, 2009

State	Type of Limit	Example of Limit
Alabama	Maximum number of units per specific procedure code in a specified timeframe.	Maximum of one physical therapy evaluation per day.
Idaho	Maximum number of units in a specified timeframe; prior authorization required to exceed maximum.	Maximum of 25 occupational therapy visits per recipient per calendar year; additional services must have prior authorization.
New York	Maximum number of units in a specified timeframe; additional services cannot be approved through a prior authorization.	Maximum of 10 physician or clinic visits per 12-month period, inclusive of physical, occupational, and speech therapy visits.
California	Prior authorization required for most or all services and maximum number of units in a specified timeframe.	Initial and 6-month occupational therapy evaluations do not require prior authorization. All other occupational therapy services require prior authorization and are limited to two services per month per recipient.
Georgia	For recipients up to age 21, maximum number of units in a specified timeframe or maximum number of units per specific procedure code. For recipients over age 21, therapy must be provided by a particular provider type or in a particular setting; prior authorization is required for all services.	Up to age 21, one occupational therapy evaluation per year; over age 21, physical therapy must follow the onset of an acute illness, injury, or impairment and requires prior authorization.
Nebraska	For recipients up to age 21, no limits. For recipients over age 21, maximum number of units in a specified timeframe or maximum number of units based on diagnosis, place of service, or provider type.	Up to age 21, no limits on any therapy service; over age 21, combined physical, occupational, and speech therapy services cannot exceed 60 visits per year per recipient.
Iowa	Other (e.g., dollar limit per specified timeframe).	Expenditures for combined physical and speech therapy services cannot exceed $1,840 per year per recipient; expenditures for occupational therapy cannot exceed $1,840 per year per recipient.

Source: OIG analysis of State responses, 2010.

All eight States reported safeguards to prevent payments in excess of State limits

During our structured interviews with the eight selected States, we confirmed our understanding of the limits that each State reported on its initial questionnaire. Details of these limits are in Appendix B.

We also asked State officials what safeguards (e.g., payment system edits, postpayment reviews) were established to prevent payments of claims that exceeded the limits. All eight States reported having system edits to prevent payments in excess of State limits, and four States reported performing postpayment reviews of therapy claims. Table 3 describes each State's payment safeguards.

Table 3: Payment Safeguards Reported by State Medicaid Programs, July 1, 2008, Through June 30, 2009

State	Edits	Postpayment Reviews
Arkansas	Check the total units or visits against the limit for evaluations and treatment services	Determine whether the services were correctly billed as prescribed, whether services were delivered, and whether the services were medically necessary
Florida	Disallow payments over the unit or dollar limit	None reported
Hawaii	Check for the number of services within previous 90- or 120-day timeframe and check for number of minutes, units, and visits per day	None reported
Illinois	Deny payments for dates of service beyond the initial treatment period	Determine whether services were provided as stated in the patient's plan of care
Maine	Deny claims in excess of limits	Review services billed by physical and occupational therapy providers on a case-by-case basis
Maryland	Check for number of units per day	None reported
Michigan	Deny claims in excess of 36 within a 90-day timeframe	None reported
North Carolina	Match prior authorization information with type of service and number of units billed on the claim; edits prevent payments for more than one evaluation per day	Each month, review a random sample of paid claims to monitor utilization, quality, and appropriateness of services

Source: OIG analysis of State responses, 2010.

Despite reported program safeguards, six States improperly paid claims for therapy services totaling $744,000

We identified 16,268 claims for therapy services that exceeded State limits. Six States in our review paid approximately $744,000 out of approximately $220 million for these claims.[10] As an example of improperly paid claims, the Hawaii Medicaid program has a limit of 36 units of therapy service in a 120-day period. However, 1 recipient received 47 units of physical therapy from September 29, 2008, through January 21, 2009 (115 days). Therefore, 11 units were paid in error, totaling $378. We did not find any therapy services paid in excess of State limits in North Carolina. Because we did not test the functionality of safeguards, we are unable to determine whether safeguards in North Carolina (and other States) prevented improper payments or whether providers simply did not submit claims in excess of State limits. Table 4 shows the number of improperly paid claims and amounts paid to providers for these claims.

Table 4: Therapy Services Paid in Excess of State Limits, July 1, 2008, Through June 30, 2009

State	Number of Claims	Total Improper Payments
Arkansas	930	$77,574
Florida	13,707	$621,364
Hawaii	60	$3,236
Illinois	1,517	$39,287
Maryland	26	$2,235
Michigan	28	$1,486
Total	**16,268**	**$743,679**

Note: We did not find any therapy services paid in excess of State limits in North Carolina. The analysis of therapy services paid in excess of State limits in Maine is discussed later in this report.

Source: OIG analysis of Medicaid therapy claims, 2011.

States lacked system edits to prevent some payments for therapy services in excess of limits, but described actions being taken to prevent future improper payments

Although officials from all eight States initially reported having system edits to prevent claims in excess of limits from being paid, officials from

[10] The period of our review of therapy claims overlaps two Federal FYs; therefore, different FMAPs were in effect for this period. We did not calculate the Federal and State shares for these claims.

six States responded that edits were not set up to prevent the claims in excess of limits that we identified. Officials from several States told us that our analysis alerted them to areas in which system edits need to be implemented or reimbursement policy revised to prevent payments for therapy services in excess of State limits. Following are descriptions of claims paid in excess of limits and the State officials' explanations of the reasons that the claims were paid improperly. This information may assist other State Medicaid programs in their program integrity efforts.

In Arkansas, officials stated that system errors allowed claims to be paid for units of evaluation per year and units of treatment per day in excess of State limits. In some cases, this happened because the claims system did not indicate that the same type of service was billed by different providers on the same date. Arkansas officials reported that the system errors were corrected to properly control for therapy service limits.

In Florida, the largest portion of claims paid improperly (10,936 claims totaling $491,604) was paid for more than 4 units per day or 14 units per week for services within each therapy discipline. Following our review, Florida Medicaid officials stated that they had implemented a system edit to deny claims for more than 4 units per day and were implementing an edit to deny claims in excess of 14 units per calendar week. The next-largest portion of improperly paid claims was paid for therapy evaluations for recipients under age 21 (2,162 claims totaling $103,990). Florida officials stated that these payments were caused by conflicting policy.[11] Following our review, officials stated that they distributed policy clarification to providers via a provider forum, email, and the therapy services section of the Florida Medicaid Web site. Additionally, Florida officials stated that they implemented an edit in the claims system to prevent payments for evaluations that exceed the limits.

Illinois Medicaid officials explained that the claims system edits in place during the period of review did not consider time or session limits. Instead, Illinois relied upon providers to bill the appropriate amount and duration of services for the recipients' conditions. Officials reported that a change to the Medicaid Management Information System to correct this vulnerability was initiated as a result of our review; however, it was not yet complete at the writing of this report.

Hawaii, Maryland, and Michigan each paid relatively few claims in excess of State limits. Officials from these States focused on recouping payments from providers and stated that they would implement minor changes to the

[11] Because of the conflicting policy, Florida officials believe these claims should not be considered overpayments. However, these claims meet the definition of improperly paid claims as defined in this report.

edits in their claims systems to prevent future improper payments. In one instance, the necessary system edit existed, but was put in place after the period of our claims review.

Three States reviewed paid claims for therapy services that were potentially improper

For two States, Florida and Illinois, we were able to evaluate most but not all aspects of therapy service limits. In addition, Maine Medicaid officials did not respond to our request to review our initial analysis of claims. Because we were unable to determine whether therapy service limits were exceeded, these three States paid claims for therapy services that were potentially improper.

Not all Florida Medicaid program claims data indicated the type of service provided

We were unable to evaluate one aspect of therapy service limits for Florida. The program limits outpatient hospital services (including therapy services) to $1,500 per year for recipients over age 21. Florida provided a dataset of all outpatient hospital services for our period of review; however, the dataset did not include descriptions of the types of services provided. We found 623 claims for 175 recipients totaling $65,792 that exceeded the limit of $1,500 of outpatient hospital services per year. We cannot definitively determine which claims in excess of State limits were for therapy services; therefore, they are not included in Table 4.

The Illinois Medicaid program did not provide sufficient information in all cases to determine whether therapy limits were exceeded

The Illinois Medicaid program limits the number of therapy service sessions provided to a beneficiary during an initial evaluation and treatment period without prior approval from the program. The limit varies by diagnosis, ranging from 1 month and 8 sessions for the diagnosis "fracture of vertebral column," to 3 months and 39 sessions for numerous diagnoses (e.g., closed head injury).[12] Payments for claims exceeding 3 months and 39 sessions are clearly improper, as no limit for any diagnosis exceeds this threshold. Table 4 identifies the 1,517 claims totaling $39,287 that exceeded the 3-month and 39-session limit. Determining whether the remaining 5,691 claims, totaling $133,333, were paid improperly would require individual assessment of whether the number and duration of services exceeded the maximum threshold set by Illinois Medicaid for the condition being treated. Such an assessment would be complicated by the fact that

[12] Illinois Department of Healthcare and Family Services, *Handbook for Providers of Therapy Services*, App. J-4, January 2009.

claims data indicate beneficiary conditions using diagnosis codes, but the Illinois Medicaid program establishes treatment limits based on general descriptive groupings of diagnoses. According to Illinois Medicaid program officials, there is no list of the diagnosis codes that correspond to the diagnosis groupings. Therefore, we could not determine whether the 5,691 claims totaling $133,333 were paid properly.

Maine did not respond to requests to validate our initial analysis

The Maine Medicaid program limits the number of hours of service per day for most services and the number of services per year for one particular procedure code. Our initial analysis of therapy claims produced 695 claims totaling $56,628 that appeared to exceed the maximum number of hours of service per day. We provided these claims to Maine Medicaid officials on June 3, 2011. One of Maine's therapy service limits involved recipients' condition(s), but we were not provided this information. Therefore, we needed a response from Maine to determine whether we correctly applied limits according to recipients' condition(s). We made repeated attempts via telephone and email to obtain a response. We notified Maine officials on August 2, 2011, that we would report these claims as potentially improper. We did not receive a response to this notification.

RECOMMENDATIONS

Thirty-five State Medicaid programs established limits on therapy services during the period July 1, 2008, through June 30, 2009. All eight States we reviewed said they had safeguards to prevent payments in excess of State limits; however, six States improperly paid claims for Medicaid therapy services totaling approximately $744,000. Three States paid claims for therapy services that were potentially improper. Although we identified a relatively low number of claims for therapy services paid improperly, the errors were easily preventable in most instances. States that paid claims in excess of State limits described actions they are taking to improve program integrity safeguards based on our findings and to prevent future improper payments.

We recommend that CMS:

Work With States To Prevent Medicaid Payments for Therapy Services in Excess of State Limits

In implementing this recommendation, CMS could work with all States to:

- alert State Medicaid directors and staff to the findings of this report so they can better target their program integrity efforts and
- encourage State Medicaid programs to ensure that edits are in place to prevent payment of claims for therapy services in excess of State limits.

In addition, CMS could ensure that Medicaid Integrity Contractors are aware of the findings of this report so they may, as appropriate, include therapy services in their Medicaid claims data analyses.

Follow Up on the Inappropriate Claims Identified in Our Review

We will forward information regarding the inappropriate claims we identified to CMS in a separate memorandum. Where our findings have identified an overpayment by the State to a provider for therapy services, the State should refund the Federal share to CMS.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. In response to the first recommendation, CMS stated that the National Correct Coding Initiative (NCCI) methodologies provided State Medicaid agencies with claim-specific edits to improve the correct coding of claims and avoid paying for services that have been incorrectly submitted by the provider. States were required to implement the NCCI methodologies as of

October 1, 2010. In addition, CMS plans to ensure that all State Medicaid agencies and Medicaid Integrity Contractors are aware of the findings of this report. In response to the second recommendation, upon receipt of OIG's separate memorandum identifying the inappropriate claims, CMS will take action to ensure that the Federal share of any overpayment by the State Medicaid agency is refunded or recovered. We addressed the technical comment that CMS provided. For the full text of CMS's comments, see Appendix C.

APPENDIX A

The following table illustrates the type of limit placed on therapy services in each of the 35 States that had such limits.

Limit Type Key

1—Maximum number of units per specific procedure code in a specified timeframe.

2—Maximum number of units in a specified timeframe; prior authorization required to exceed maximum.

3—Maximum number of units in a specified timeframe; additional services cannot be approved through a prior authorization.

4—Prior authorization required for most or all services and maximum number of units in a specified timeframe.

5—For recipients up to age 21, maximum number of units in a specified timeframe or maximum number of units per specific procedure code. For recipients over age 21, therapy must be provided by a particular provider type or in a particular setting; prior authorization is required for all services, or no therapy services are covered.

6—For recipients up to age 21, no limits. For recipients over age 21, maximum number of units in a specified timeframe based on diagnosis, place of service, or provider type.

7—Other.

Table A-1: State Limits on Medicaid Therapy Services

State	Therapy Service	Limit Type						
		1	2	3	4	5	6	7
Alabama	Physical	●						
	Occupational	●						
	Speech	No limit on speech therapy services						
Arkansas	Physical					●		
	Occupational					●		
	Speech					●		
California	Physical				●			
	Occupational				●			
	Speech				●			

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Table A-1: State Limits on Therapy Services (Continued)

State	Therapy Service	Limit Type						
		1	2	3	4	5	6	7
Colorado	Physical		●					
	Occupational		●					
	Speech			●				
Florida	Physical							●
	Occupational							●
	Speech							●
Georgia	Physical					●		
	Occupational					●		
	Speech					●		
Hawaii	Physical				●			
	Occupational				●			
	Speech				●			
Iowa	Physical							●
	Occupational							●
	Speech							●
Idaho	Physical		●					
	Occupational		●					
	Speech		●					
Illinois	Physical						●	
	Occupational						●	
	Speech						●	
Indiana	Physical		●					
	Occupational		●					
	Speech		●					
Kansas	Physical							●
	Occupational							●
	Speech							●
Kentucky	Physical						●	
	Occupational						●	
	Speech						●	

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Table A-1: State Limits on Therapy Services (Continued)

State	Therapy Service	Limit Type						
		1	2	3	4	5	6	7
Maine	Physical			●				
	Occupational		●					
	Speech		●					
Maryland	Physical			●				
	Occupational					●		
	Speech					●		
Massachusetts	Physical							●
	Occupational							●
	Speech							●
Michigan	Physical	●						
	Occupational	●						
	Speech	●						
Missouri	Physical					●		
	Occupational					●		
	Speech					●		
Montana	Physical					●		
	Occupational					●		
	Speech					●		
Nebraska	Physical						●	
	Occupational						●	
	Speech						●	
Nevada	Physical						●	
	Occupational						●	
	Speech						●	
New Hampshire	Physical		●					
	Occupational		●					
	Speech		●					
New York	Physical			●				
	Occupational			●				
	Speech			●				
North Carolina	Physical		●					
	Occupational		●					
	Speech		●					

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Table A-1: State Limits on Therapy Services (Continued)

State	Therapy Service	Limit Type						
		1	2	3	4	5	6	7
North Dakota	Physical		●					
	Occupational		●					
	Speech		●					
Ohio	Physical		●					
	Occupational		●					
	Speech		●					
Oregon	Physical							●
	Occupational							●
	Speech							●
Pennsylvania	Physical					●		
	Occupational					●		
	Speech					●		
Texas	Physical					●		
	Occupational					●		
	Speech					●		
Utah	Physical							●
	Occupational							●
	Speech							●
Virginia	Physical		●					
	Occupational		●					
	Speech		●					
Washington	Physical						●	
	Occupational						●	
	Speech						●	
West Virginia	Physical		●					
	Occupational		●					
	Speech	No limit on speech therapy services						

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Table A-1: State Limits on Therapy Services (Continued)

State	Therapy Service	Limit Type						
		1	2	3	4	5	6	7
Wisconsin	Physical		●					
	Occupational		●					
	Speech		●					
Wyoming	Physical						●	
	Occupational						●	
	Speech						●	
Total States:*		**2**	**11**	**4**	**2**	**7**	**6**	**6**

*The sum of the limit type totals does not equal 35 because 3 States use different types of limits for different therapy services.

Source: Office of Inspector General analysis of responses to questionnaire regarding therapy services limits, 2010.

APPENDIX B

Table B-1: Sampled States' Limits on Therapy Services

State	Recipient Category	Description of Limit	Prior Authorization May Override Limit*
Arkansas	Under age 21	For each therapy discipline, there is a limit of four units of evaluation each year and four units of treatment per day. Recipients may receive four units per day of treatment with and without "UB" modifier (i.e., "UB" modifier indicates service provided by physical therapy assistant). Recipients may receive one evaluation for an augmentative communication device every 3 years.	Yes
	Over age 21	In addition to the limits for recipients under age 21, recipients must receive therapy services in outpatient hospital settings. Outpatient hospital visits are limited to 12 per year.	Yes
Florida	Under age 21	For all therapy disciplines combined, recipients may receive four units of therapy service per day. In addition, there is a limit of 14 units of service per week for each therapy discipline. Each recipient may receive one evaluation and one reevaluation per discipline every 6 months; the first reevaluation may be done at 4 months. For an initial evaluation for an alternative communication device, up to three providers (one physical, one occupational, and one speech) who are members of the interdisciplinary team may be reimbursed. Each recipient may receive one followup evaluation per alternative communication device, as well as one reevaluation every 6 months.	No
	Over age 21	Outpatient hospital services (including all disciplines of therapy) are limited to $1,500 per year. For alternative communication devices, one initial evaluation is allowed per year.	No
	All ages	Recipients may receive eight treatments related to an augmentative and alternative communication device per year. One evaluation and two followup evaluations related to wheelchair use per year are allowed; the third wheelchair evaluation must be at least 6 months after the second.	No
	Aged and Disabled Waiver	Recipients may receive a maximum of 4 hours of physical therapy, 2 hours of occupational therapy, and 4 hours of speech therapy per day.	No
	Mentally Retarded/ Developmental Disabilities Waiver	Recipients may receive a maximum of eight units of each therapy discipline per day and one evaluation per therapy discipline per year.	No
Hawaii	All ages	For physical and occupational therapy services, there is a limit of 45 minutes of service per therapy discipline per day. In addition, there is a limit of 36 units of service for procedure codes billed in units and a limit of 12 visits for procedure codes billed in visits in a 120-day period per discipline. All speech therapy requires prior authorization.	Yes
Illinois	Home and Community Based Services Waiver	Recipients may receive up to 26 hours of therapy per discipline per year.	Yes

continued on next page

Table B-1: Sampled States' Limits on Therapy Services (Continued)

State	Recipient Category	Description of Limit	Prior Authorization May Override Limit*
Illinois	Over 21	Every service must have prior authorization unless: 1. the date of service is within 60 calendar days following discharge from an acute care or rehab hospital, or 2. the service is covered by Medicare (i.e., Medicaid is simply paying the copayment for a dual-eligible), or 3. the service is for an individual who was hospitalized in the past 30 days and was receiving therapy services while hospitalized, or 4. the service occurs during the initial evaluation and treatment period as defined in State policy. These periods vary by diagnosis.	No
Maine	Over age 21	Recipients may receive one evaluation or reevaluation per condition per year.** For physical and occupational therapy, treatment is limited to 2 hours per therapy discipline per day, plus up to 1 hour of collateral contacts per condition (collateral contacts are made by the therapy provider to the recipient's other providers regarding the recipient's treatment). Recipients may receive up to two sensory integration visits per year.*** Audiology evaluations must be at least 4 months apart; otherwise, no specific limit is placed on speech therapy services.	Yes
Maryland	Under age 21	Recipients may receive one physical therapy evaluation per condition.** For occupational therapy, recipients may receive one unit of evaluation and up to four units of treatment per day. For speech therapy, recipients may receive one unit of evaluation and up to one unit of individual or group treatment per day.	No
	Over age 21	Only physical therapy is provided through fee-for-service arrangements; occupational and speech therapy are provided through managed care. Recipients may receive one physical therapy evaluation per condition.** Recipients may receive up to four units of physical therapy treatment per day, with the exception of certain procedures, which are limited to one unit per day.	No
Michigan	All ages	Limits vary by procedure code.	No
	Seriously Emotionally Disturbed Waiver	Limits vary by procedure code.	No
	Children's Waiver	Limits vary by procedure code.	No
North Carolina	All ages	Recipients may receive up to six visits per therapy discipline per year, excluding evaluations and reevaluations.	Yes

*Prior authorization means that the provider must seek permission from the State to provide the service to a particular recipient. Typically, requests for prior authorization must be accompanied by documents justifying the medical necessity of the service and outlining the patient's treatment plan. If the State does not grant the request, Medicaid will not pay the provider for the service.

**Maine and Maryland limit some therapy services based on recipients' condition. We were unable to determine whether the limits for these services were exceeded because we did not receive information on recipients' conditions.

***Sensory integration is a type of occupational therapy that takes place in a room specifically designed to stimulate all of the patient's senses. The goal of sensory integration therapy is to improve the brain's ability to process sensory information. It is often used to treat autism spectrum disorders.

Source: Office of Inspector General analysis of State responses, 2010.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 1 9 2012

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Therapy Services in Excess of State Limits" (OEI-07-10-00370)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this subject OIG draft report. The objectives of the report were: 1) to identify the limits that States established on physical; occupational; and speech, hearing, and language therapy services; 2) to determine payment safeguards that States established to prevent payments for therapy services in excess of State limits; and 3) to identify Medicaid payments for therapy services that exceeded State limits.

The OIG found that 35 State Medicaid programs have established limits on therapy services. The review of claims was focused on therapy services for the 1- year period beginning July 1, 2008, for 8 States, all of which have established payment safeguards to prevent payments in excess of State limits. Six of the 8 States were found to have improperly paid therapy claims totaling $744,000, out of the sample of $220 million paid for therapy claims. OIG noted that the relatively low number of claims payment errors would be easily preventable with system edits in most cases and that several States reported having already taken corrective action to address OIG's findings. Moreover, CMS has taken a comprehensive approach by establishing the National Correct Coding Initiative (NCCI) in October 2010 to require States to implement an up-to-date library of system edits to prevent improper payments across a wide variety of Medicaid services such as those identified in this report.

We appreciate the OIG's efforts in assessing the effectiveness of States' safeguards to prevent payments for Medicaid therapy services that exceed State limits, and reporting on system vulnerabilities. Our response to each of the OIG recommendations follows our technical comment.

Technical Comment

Please note that the first recommendation in the report's summary statement is not the same as the first recommendation in the concluding section on page 13. The distinction between

Agency Comments (Continued)

recommendations and suggestions for implementing those recommendations is clear in the concluding section by the use of bold type for recommendations and the phrase "CMS could" for suggestions for implementation. However, in OIG's new format for the executive summary in this report, the same actions that are presented in the conclusion as suggestions for implementation appear as recommended actions in the executive summary (e.g., "alerting State Medicaid directors and staff of the findings of this report"). Because CMS carefully attends to the exact language of OIG's recommendations in preparing published responses, designing and tracking corrective action plans, and responding to OIG's Compendium of Unimplemented Recommendations, we request that the identical distinction between recommendations and suggestions in the concluding section be preserved in the executive summary to avoid miscommunication between readers focusing on different sections.

OIG Recommendation

The CMS should work with States to prevent Medicaid payments for therapy services in excess of State limits.

CMS Response

The CMS concurs with this recommendation and will continue to provide guidance and technical assistance to States to ensure that Medicaid payments for therapy services do not exceed State limits. We are encouraged by OIG's finding that safeguards in place in all 8 States limited payment errors for services in excess of State limits to less than 1 percent of claims submitted for this study and that 1 State had no claims paid in excess of State limits. We also appreciate OIG consulting with States to determine the causes of payment errors and reporting the explanations, so that other State Medicaid programs may benefit from examining their prepayment controls for similar vulnerabilities.

The CMS established the NCCI methodologies to provide State Medicaid agencies with claim specific edits to improve the correct coding of claims and avoid paying for services that have been incorrectly submitted by the provider, which contributes to the payment errors identified by OIG. Based on section 6507 of the Patient Protection and Affordable Care Act, States were required to implement the NCCI methodologies as of October 1, 2010. CMS issued a letter to State Medicaid Directors in September 2010 that provided initial guidance to States in implementing the NCCI methodologies.

To address this recommendation, OIG suggested that CMS could encourage State Medicaid programs to ensure that edits are included to prevent payment of claims for therapy services in excess of State limits. OIG examined claims for therapy services for the 1- year period ending June 30, 2009, over 1 year before the implementation of NCCI edits on October 1, 2010. NCCI methodologies provide a comprehensive approach to preventing improper Medicaid payments, covering thousands of potential error types over the spectrum of Medicaid services. A subset of NCCI edits addresses potential billing errors for 70 therapy codes, including many edits designed to detect when a medically-unlikely quantity of services is billed for an individual beneficiary over a defined period of time. The more comprehensive NCCI methodologies are designed to address the same over-utilization issues as State-specific limits on therapy services have

Agency Comments (Continued)

addressed. As a result, the NCCI methodologies are already working to strengthen State-specific safeguards against improper payments for therapy services that exceed State limits as well as potential errors across a wide variety of Medicaid services. The CMS will continue to work with States to ensure that prepayment edits are implemented to effectively prevent improper payments, including those identified by OIG in this report.

The OIG also suggested that CMS alert State Medicaid agencies and Federal Medicaid Integrity Contractors to the findings of this report. The CMS plans to ensure that all State Medicaid agencies are made aware of OIG's findings and the vulnerabilities in prepayment controls that were discovered in the selected States as a result of the study. CMS also plans to use these findings to inform the selection of audit targets for Medicaid Integrity Contractors.

OIG Recommendation

The CMS should follow up on the inappropriate claims identified in OIG's review.

CMS Response

The CMS concurs with this recommendation. When CMS receives OIG's separate memorandum identifying the inappropriate claims, we will take action to ensure that the Federal share of any overpayment by the State is refunded or recovered.

The CMS would like to thank OIG for their efforts in assessing the effectiveness of States' safeguards to prevent payments for Medicaid therapy services that exceed State limits, and reporting in detail on the nature of system errors responsible for detection failures. We look forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Brian T. Whitley, Deputy Regional Inspector General.

Tricia Fields served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael J. Brown and Michala Walker; central office staff who contributed include Kevin Farber and Scott Manley.

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