# OUTPATIENT THERAPY SERVICES

*Medicare***basics**

## QUICK**FACTS**

### Medicare spending on outpatient therapy (in billions)

| Year | Medicare spending |
|---|---|
| 1998 | $2.4 |
| 1999 | 1.3 |
| 2000 | 1.8 |
| 2001 | 2.6 |
| 2002 | 3.3 |
| 2003 | 3.7 |

Source: Ciolek and Hwang 2004a.

### Users and spending per user

| | |
|---|---|
| Percent of beneficiaries using outpatient therapy services | 9% |
| Number of users | 3.7 million |
| Average spending per user in 2002 | $896 |
| Median spending per user in 2002 | $466 |
| Spending per Medicare Part B enrollee in 2002 | $85 |
| Mix of therapy spending: | |
| Physical therapy | 75% |
| Occupational therapy | 18% |
| Speech and language pathology services | 7% |

Source: Ciolek and Hwang 2004c.

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Spending on outpatient therapy services has grown considerably recently. Between 2000 and 2003, spending doubled. In its letter to the Medicare Payment Advisory Commission this past March on the physician update, the Centers for Medicare & Medicaid Services (CMS) noted that growth in outpatient therapy services during 2004 was a key contributor to increased spending on services considered in updating physician payments. These spending increases raise questions for Medicare about what it is buying for its additional outlays—for example, has access improved or are patient outcomes better?

Given the increased attention on outpatient therapy services, the Commission has put together a primer on outpatient therapy services to answer the following questions:

- What are outpatient therapy services?
- What services and settings does Medicare cover?
- Which beneficiaries use outpatient therapy?
- What are "therapy caps" and, when they were in place, what was their effect on spending?
- What are the recent trends in therapy spending? Does spending vary?

### What are outpatient therapy services?

***Physical therapy*** (PT) includes services that restore and maintain physical function and treat or prevent impairments that result from disease or injury (American Physical Therapy Association 2003). Common PT services include therapeutic exercise (such as treadmill use and stretching), therapeutic activities (such as bending and lifting), and manual therapy (such as massage) (Ciolek and Hwang 2004a).

***Occupational therapy*** (OT) services improve a patient's ability to conduct activities of daily living independently, such as food preparation after the loss of a limb or regaining balance after a hip fracture so the patient can get dressed (American Occupational Therapy Association 2005). The most common OT services are therapeutic exercise and activities, and functional training in self care and home management (Ciolek and Hwang 2004a).

**Table 1 Frequently used therapy services and 2005 Medicare payment rates**

| HCPCS | Description | Payment |
|---|---|---|
| **PT services** | | |
| 97001 | PT evaluation | $76 |
| 97112 | Neuromuscular reeducation (15 min.) | 30 |
| 97140 | Manual therapy (15 min.) | 27 |
| **OT services** | | |
| 97535 | Self care management training (15 min.) | 30 |
| **PT and OT** | | |
| 97110 | Therapeutic exercise (15 min.) | 28 |
| 97530 | Therapeutic activities (15 min.) | 30 |
| **Speech and language pathology services** | | |
| 92506 | Speech/hearing evaluation | 132 |
| 92507 | Speech therapy | 63 |
| 92526 | Oral therapy | 84 |

Note: HCPCS (Healthcare Common Procedure and Coding System), PT (physical therapy), OT (occupational therapy).

Source: CMS 2004.

***Speech and language pathology*** (SLP) services help patients with difficulties communicating and swallowing as a result of disease, injury, or surgery (American Speech Language and Hearing Association 2005). For example, a patient who had a stroke may receive SLP services to recover his/her ability to speak. The most frequently billed SLP services are the evaluation and treatment of swallowing disorders and treatment of a speech disorder (Ciolek and Hwang 2004a).

***Qualifications of therapists.*** Therapy services may be furnished by physicians, physical therapists, occupational therapists, and speech-language pathologists. Medicare will also cover therapy services furnished by physician assistants, nurse practitioners, and clinical nurse specialists if the state in which they practice permits them to furnish therapy. Qualified physical and occupational assistants are also covered as long as they are supervised.[1]

All therapists must be licensed, certified, or registered to practice in the state in which they furnish services and have passed a national examination. The entry level requirement for physical therapists is to have completed a master's degree; master's degrees will be required in 2007 for occupational therapists. Speech-language pathologists are licensed in 46 states, and most require master's degrees or equivalent. Therapy assistants typically earn associate's degrees from certified programs. All therapy programs have coursework and supervised clinical field work requirements (Bureau of Labor Statistics 2004).

Last year, in response to studies and medical review of claims indicating that services performed in physicians' offices did not consistently meet Medicare's conditions of coverage, Medicare clarified the qualifications for personnel furnishing therapy services in physicians' offices and in therapists' private practices (CMS 2004). Specifically, athletic trainers, chiropractors, and nurses do not meet the qualification and training requirements for therapists and therefore can not bill or receive payments from the program.

***Service billing.*** The majority of PT and OT services are time-based codes that are billed in 15-minute increments (Table 1). For example a 45-minute session would be billed as 3 units of a therapy service. The majority of SLP services provided to Medicare beneficiaries are not timed and typically

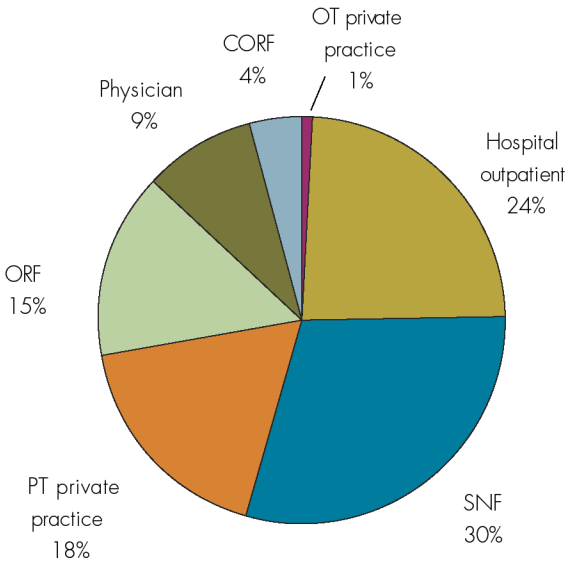
providers can bill only one unit per visit. One claim may include billings for multiple types of services (e.g., PT and SLP) and multiple units for any given time-based service.

## What services and settings does Medicare cover?

***Coverage.*** Medicare covers outpatient therapy services as long as they are furnished by a skilled professional, are appropriate and effective for a patient's condition, and are reasonable in terms of frequency and duration. A physician must refer the patient to a therapist; review a written plan of care every 30 days; and, for longer-term treatment (extending beyond 60 days), re-evaluate the patient. Medicare does not cover outpatient therapy services that maintain a level of functioning or serve as a general exercise program.

***Provider settings.*** Outpatient therapy services are furnished in many different settings. The largest (in terms of Medicare payments and patients treated) are skilled nursing facilities (SNFs) and hospital outpatient departments (Figure 1). Other settings include physicians' offices, physical and occupational therapists in private practice, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies.

**Figure 1 Distribution of outpatient therapy spending by setting**




Note: OT (occupational therapist), SNF (skilled nursing facility), PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive rehabilitation facility). Percentages of Medicare spending on outpatient therapy services in 2002.

Source: Ciolek and Hwang 2004a.

***Medicare payments.*** Medicare pays for all outpatient therapy services under Part B, the Supplementary Medical Insurance Trust Fund.[2] Payments are established in the physician fee schedule for each unit of service, regardless of where the services are provided.[3] As with most services covered under Part B, Medicare pays 80 percent of the payment amount and the beneficiary is responsible for a 20 percent coinsurance.

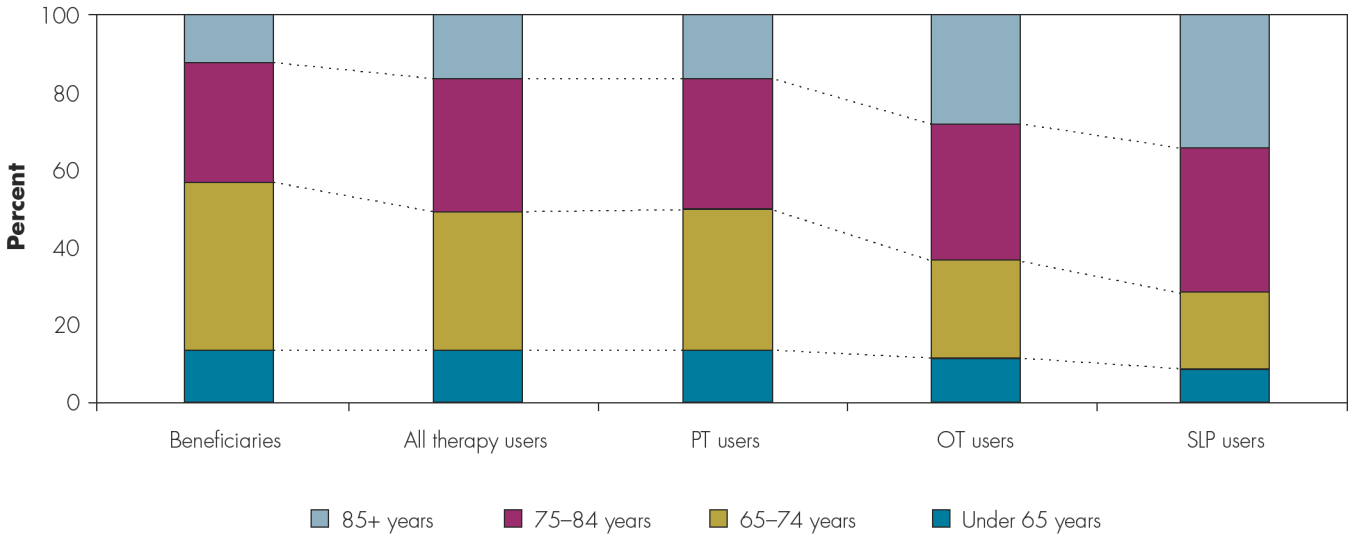
In 2003, Medicare payments for outpatient therapy totaled $3.7 billion (Ciolek and Hwang 2004a). Physical therapy services make up about three-quarters of this spending, with occupational and speech therapies making up the remaining quarter. Two services (therapeutic exercise and therapeutic activities, such as gait training on stairs and strengthening and mobility exercises) accounted for almost half of all therapy spending.

## Which beneficiaries use outpatient therapy?

About 9 percent of beneficiaries use outpatient therapy. Of therapy users, the vast majority (88 percent) use physical therapy services. Therapy users, particularly those of OT and SLP services, tend to be older than other beneficiaries (Figure 2, p. 4). For example, those aged 65–74 years old made up 43 percent of beneficiaries but only 36 percent of all therapy users and only a quarter of OT users (Ciolek and Hwang 2004b). Conversely, the oldest group (85 years and older) made up 12 percent of beneficiaries but were over a third of the SLP users. Users are disproportionately female; while just over half of beneficiaries were female, they accounted for two thirds of outpatient therapy users.

***Patient diagnoses.*** The diagnosis information on outpatient therapy claims is poor. Although all providers must use a standard coding scheme (the Healthcare Common Procedure Coding System, or HCPCS), institutions are not required to submit specific diagnoses on their therapy claims. Thus, for example, the most common therapy code used for PT services is "other physical therapy (HCPCS code V57.1)." Other top "diagnoses" are often vague or describe the location of pain, such as "pain in shoulder" (HCPCS code 719.41) and "pain in limb" (HCPCS code 729.5), as opposed to the patient's

**Figure 2 Medicare users of outpatient therapy tend to be older than other beneficiaries**




Note: PT (physical therapy), OT (occupational therapy), SLP (speech-language pathology). Distribution of Medicare users in 2002.

Source: Ciolek and Hwang 2004b.

diagnosis. The poor state of diagnoses coding limits the development of a classification system and a risk adjustment methodology needed to establish a prospective payment system for these services.

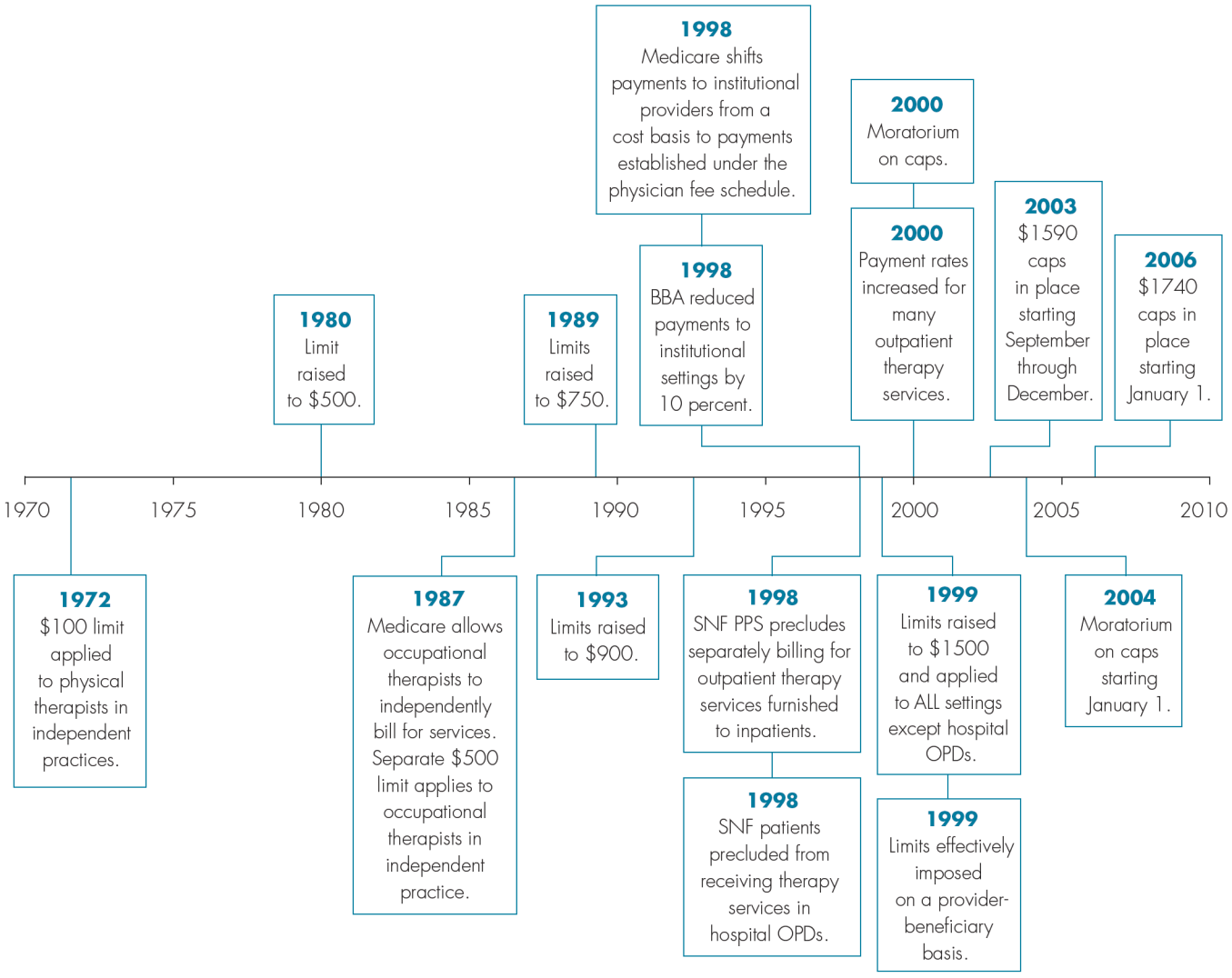
Another problem with the diagnosis coding is that although a single claim may include more than one type of therapy furnished during the visit, providers are not required to list separate diagnoses for each service rendered. As a result, the diagnoses associated with OT and SLP are likely to more properly describe the condition motivating PT service use, the more frequently provided service. For example, "abnormality of gait" is a common diagnosis for beneficiaries receiving SLP services.

With these limitations in mind, 6 of the top 10 diagnoses for patients receiving PT services were musculoskeletal-related. Among OT users, stroke was the most frequent diagnosis, though it accounted for only 4 percent of OT claims. In contrast, SLP diagnoses were more concentrated—28 percent of claims were for patients with swallowing disorders (Ciolek and Hwang 2004c).

## What are the therapy caps?

***History.*** Limits on Medicare payments to outpatient therapists in independent practice began in 1972 and were subsequently increased three times (Figure 3). The Balanced Budget Act of 1997 (BBA) extended the limit to all providers except hospital outpatient departments and raised the limit from $900 to $1,500 (to be adjusted annually for inflation). These limits are referred to as the "therapy caps." Hospital outpatient departments were excluded from the caps to allow beneficiaries with high care needs to continue to receive services (Maxwell and Bassegio 2001). However, due to computer resource limitations, the caps were applied at the provider, not beneficiary, level. Beneficiaries reaching a limit at one provider could switch providers to avoid the therapy caps. The caps were in effect for calendar year 1999 and then suspended by the Congress for three years. Due to delays in implementation, the inflation-adjusted limits ($1,590) were not reimposed until September 2003.[4] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 suspended the caps beginning December 8, 2003, through 2005. As a result of the moratorium on the therapy caps, there was no limit on the services Medicare paid for, assuming the services meet other coverage requirements. Beginning January 1, 2006, therapy caps will be in effect. Two separate limits—one on PT and SLP services and another on OT services—will each limit Medicare spending to $1,740 per beneficiary (CMS 2005).

**Figure 3 History of changes to outpatient therapy payment policy**




Note: BBA (Balanced Budget Act of 1997), SNF (skilled nursing facility), PPS (prospective payment system), OPD (outpatient department).

Source: Adapted from Olshin 2002.

## Other payment policy changes

Between 1998 and 2000, other policies also shaped spending on outpatient therapy services. First, to end cost-based reimbursement and establish uniform payment policies for all providers of outpatient therapy services, in 1999 Medicare shifted from paying institutional providers on a cost-basis to paying them according to the fees established in the physician fee schedule. As a one-time interim savings measure for 1998, the BBA reduced therapy payments to institutional settings by 10 percent. In addition, with the implementation of the SNF PPS (prospective payment system) in 1998, SNFs were responsible for all services provided to beneficiaries. Under the consolidated billing requirements of the SNF PPS, SNFs (and therapists under contract to them) were precluded from separately billing for outpatient services furnished to their inpatients. SNF patients were also not allowed to receive additional outpatient therapy services in hospital outpatient settings, where services were not capped. In 2000, revisions to the physician fee schedule raised payment rates for many frequently provided therapy services, some more than 10 percent. (Olshin et al. 2002, Maxwell and Baseggio 2001)

**Table 2 Service provision appears responsive to Medicare payment policy**

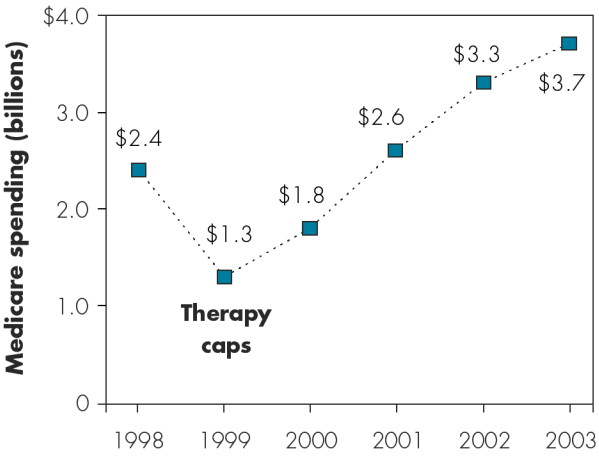
| | 1998 | 1999 (caps) | 2000 | 2002 | Percent change 98–99 | 99–00 | 00–02 (2 years) |
|---|---|---|---|---|---|---|---|
| Number of users (thousands) | 3,512 | 3,424 | 3,590 | 3,747 | –2.5% | 4.8% | 4.4% |
| Spending (millions) | $2,326 | $1,538 | $2,087 | $3,392 | –34 | 36 | 63 |
| Average spending per user | $662 | $449 | $581 | $896 | –32 | 30 | 54 |

Source: Ciolek and Hwang 2004b.

***Impact on total spending.*** Service providers appear to have responded to Medicare payment policies. After the implementation of the outpatient therapy caps in 1999, total Part B therapy expenditures decreased 34 percent between 1998 and 1999, mostly as a result of lower per beneficiary payments (Table 2). The number of therapy users declined slightly during this year. Then, when the constraints imposed by therapy caps were lifted, spending increased 36 percent between 1999 and 2000, again due primarily to higher patient spending. Contributing to this growth was the number of therapy users, which rose faster than the number of beneficiaries.

***Impact varied by setting.*** The caps had varying effects on spending per patient across different settings. Institutional settings other than hospitals—SNFs, ORFs, and CORFs—experienced the largest declines in 1999 and had the largest subsequent increases. The Urban Institute estimated that at least half of the decline in expenditures to SNFs, ORFs, and CORFs was attributable to policy changes other than the therapy cap, such as the shift from cost-based payments to the physician fee schedule (Maxwell and Baseggio 2001). Spending in hospital outpatient departments, a setting excluded from the caps, steadily increased during this period. Spending also grew for therapists in independent practice during the year of the therapy caps. For them, the BBA raised the limits they had operated under for many years, from $900 to $1500.

**Figure 4 After therapy caps were lifted in 2000, Medicare spending increased steadily**




Note: Therapy caps were in place between September and December 2003.

Source: Ciolek and Hwang 2004a.

***Beneficiaries affected by the caps.*** In the year the caps were operational (1999), fewer than 8 percent of beneficiaries exceeded the therapy caps; however, this varied by setting and diagnosis. The estimated share drops below 4 percent if patients who received services in hospital outpatient departments (which were not subject to the caps) are excluded (Olshin et al. 2002). A larger share of patients treated in CORFs hit the caps, compared with no patients hitting the caps in independent practices. One quarter of the patients who exceeded the caps had spending at least $600 above the caps. Beneficiaries who were over 80 years old and those with stroke, hip fractures, Parkinson's disease, or swallowing disorders were among those most likely to incur spending above the therapy caps (Maxwell and Baseggio 2001).

## Recent spending trends

Between 2000 and 2003, spending on outpatient therapy services doubled (Figure 4). Spending has increased mostly because spending per user increased but also because there were more users. In its estimates of the 2006 physician fee schedule, CMS noted that spending on minor procedures

(which include physical therapy services) accounted for one quarter of the 15 percent increase in spending for all services considered in the updates to physician payments between 2003 and 2004.[5]

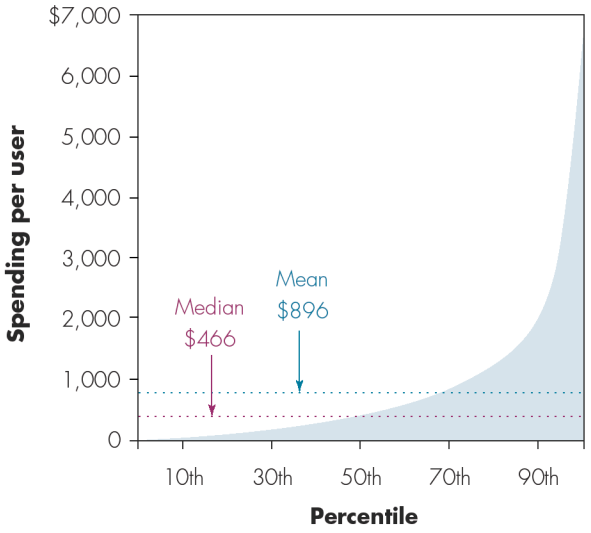
Had spending remained the same, more beneficiaries would have exceeded the caps had they been in place. In 2002, almost 15 percent of beneficiaries receiving PT/SLP services and 17 percent of beneficiaries receiving OT services had spending that met or exceeded the cap amounts (Ciolek and Hwang 2004c). The average amounts paid above the thresholds were $1,263 and $1,195 for PT/SLP and OT respectively. In that year, Medicare paid $802 million (almost one quarter of the spending on outpatient therapy) on services provided to beneficiaries whose spending reached or exceeded the cap amounts.

***Variation in spending.*** In 2002, spending averaged $896 per user, but this was substantially influenced by very high spending for a small number of beneficiaries—the median spending was $466 (Figure 5). Medicare spending on the most costly beneficiaries (the top 10 percent) was $2,092 or more. Spending on therapy services for the average user broke down as follows: $669 for PT, $163 for OT, and $63 for SLP services (Ciolek and Hwang 2004b).

***By diagnosis.*** By diagnosis and type of therapy furnished, there was considerable variation. Across all therapy users, spending on patients with back pain, the second most common diagnosis (the most common "diagnosis" was "other physical therapy"), averaged $744 compared with spending on stroke patients, which averaged over $1,700 (Ciolek and Hwang 2004b). However, spending on heavy users of OT and SLP services was considerably higher. For example, the most costly users of OT were patients with inflammation of the nerves in the arms—spending for them averaged $3,192.

Looking across episodes of care—where an episode represented a group of visits associated with one type of therapy—payments averaged $1,012 for spinal cord injury episodes, compared with $416 for ankle sprain episodes (Ciolek and Hwang 2004d). Therefore, patients are likely to be differentially affected by the therapy caps, depending on their diagnosis. For example, in 2002, an estimated 13 percent of patients with lumbago and 29 percent of patients with difficulty in walking reached or exceeded the PT/SLP cap amount (Ciolek and Hwang 2004b).

**Figure 5 Wide variation in Medicare spending per therapy user**




Note: Spending per Medicare user in 2002.

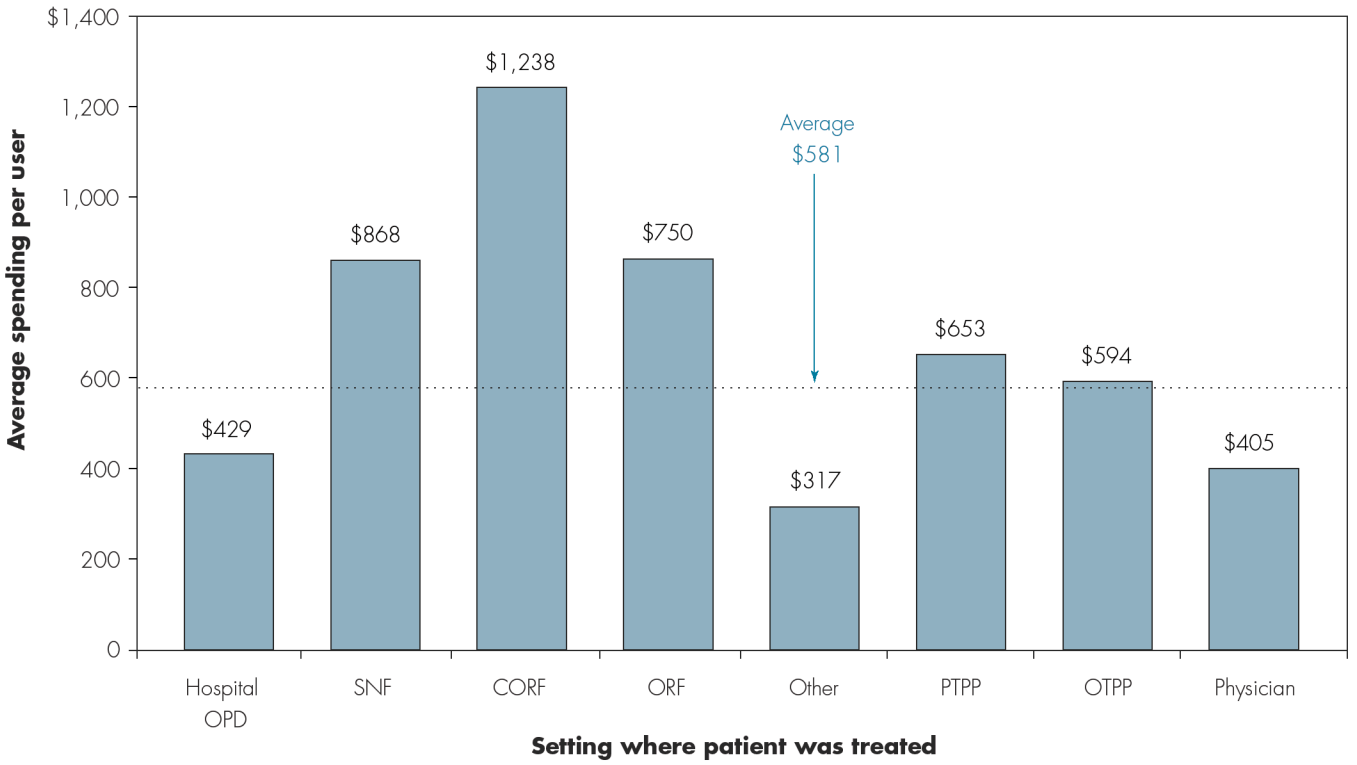
Source: Ciolek and Hwang 2004b.

***By setting.*** Payments also varied considerably by setting (Figure 6, p. 8). This variation may in part reflect differences in the care needs of patients seen in different settings.

To compare patients with similar diagnoses, researchers have examined payments by episode—where an episode represented a group of visits associated with one type of therapy and lasting as long as care was provided without a 60-day break. Yet even for patients with the same diagnosis, episodes varied considerably in duration and the amount of services furnished per day. For example, payments for PT episodes for musculoskeletal conditions of the knee and lower leg varied two-fold, averaging $581 in hospital outpatient departments and $1,214 in CORFs (Figure 7, p. 9). The CORF episodes were both longer (13.2 days versus 9.8 days) and had higher daily payments ($92 per day versus $59) (Ciolek and Hwang 2004d).

Without adequate risk adjustment and outcomes data, it is difficult to assess whether more complex cases are seen in specific settings and if higher spending results in improved functional status for patients. The Government Accountability Office (GAO) examined CORFs in Florida and found that on a per patient basis, payments were two to three times higher than payments to other facility-

**Figure 6 Medicare spending varies considerably by setting**



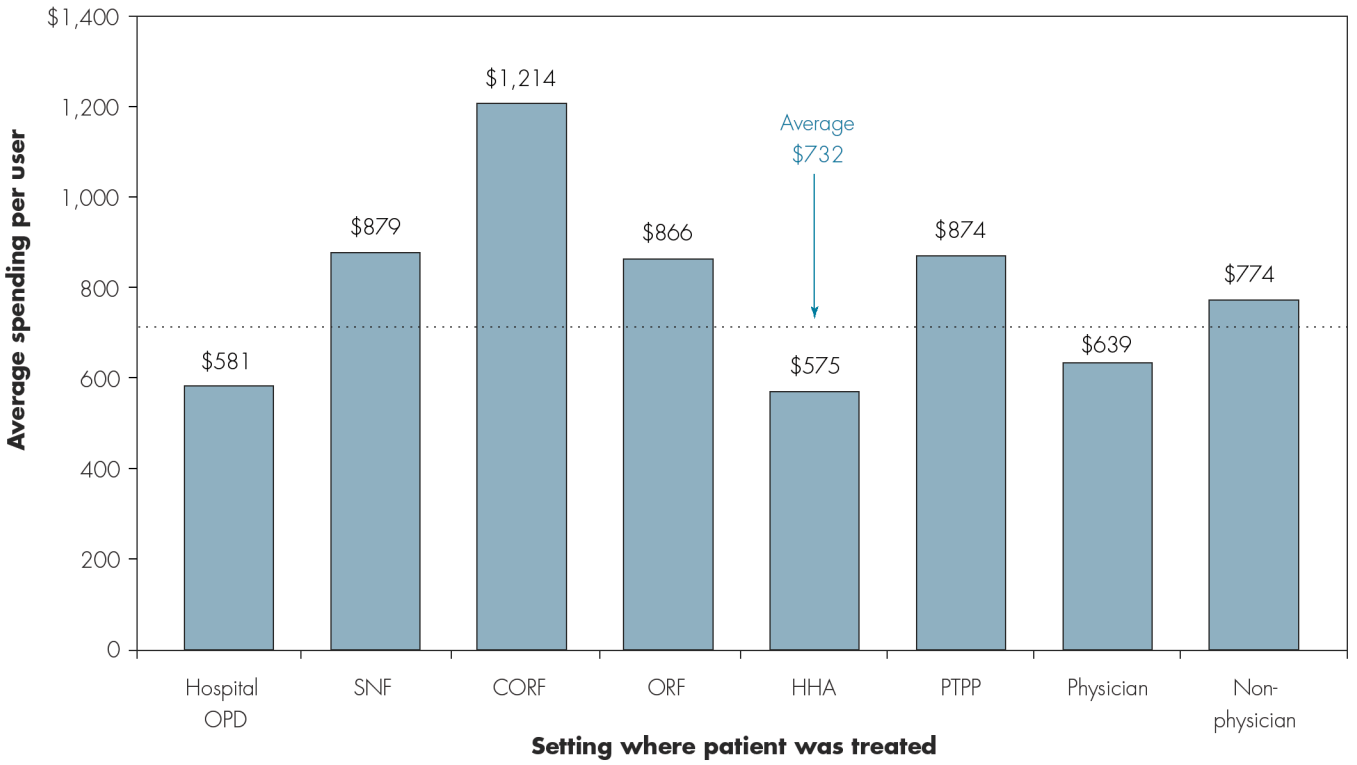

Note: OPD (outpatient department), SNF (skilled nursing facility), CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PTPP (physical therapist in private practice), OTPP (occupational therapist in private practice). Other includes home health agencies and ambulatory surgical centers. Spending per Medicare user in 2000.

Source: Olshin et al. 2002.

based therapy providers and that the differences were not explained by patient characteristics such as diagnosis, age, sex, disability, and prior hospitalization. For example, patients with neurologic disorders who were treated in CORFs received 33 percent more services than patients treated in ORFs, and four times the services furnished to patients treated in hospital outpatient departments. Therapy industry representatives they spoke with noted that patients seen in CORFs were not more clinically complex or in need of more extensive services than patients seen in other settings (GAO 2004). While differences in payment rates do not explain this variation (since all providers are paid according to the rates established in the physician fee schedule), differences in outcomes might. Another source of variation might be the amount of medically unnecessary services provided. In its study of ORFs, the Office of Inspector General (OIG) found that about 40 percent of the claims reviewed were for services that were not reasonable and medically necessary for the conditions of the patient (OIG 2000a).

***By region and state.*** Finally, there was a two-fold difference in average spending per user across CMS regions. In 2000, average spending ranged from $360 in the Denver CMS region to $744 in the Dallas CMS region (Olshin et al. 2002). There was considerably more variation by state. Texas and Maine led in average outpatient therapy spending per patient ($886 and $736, respectively), while spending in North Dakota and Nebraska is about one fifth these amounts. The distribution of providers may play a role in determining the costliness of services by state. Texas and Florida (both high therapy cost states) have over 40 percent of the nation's CORFs (the most expensive setting),

**Figure 7 Average Medicare spending on physical therapy services varied two-fold for patients with knee and lower leg musculoskeletal conditions**




Note: OPD (outpatient department); SNF (skilled nursing facility); CORF (comprehensive outpatient rehabilitation facility); ORF (outpatient rehabilitation facility); HHA (home health agency); PTPP (physical therapist in private practice). Non-physician includes nurse practitioners, physician assistants, and clinical nurse specialists. Medicare spending in 2002.

Source: Ciolek and Hwang 2004d.

yet only 13 percent of beneficiaries. Another factor is the difference in practice costs across markets that get reflected in Medicare's payments to providers.[6] When the caps are reinstated in January 2005, beneficiaries living in high-spending areas will be more likely to reach the therapy limits than beneficiaries living in low-spending areas.

***Medical necessity of services.*** Studies conducted by the OIG and GAO reflected concerns that medically unnecessary outpatient therapy services were furnished to beneficiaries. These concerns were substantiated; both agencies found that a high share of care provided in SNFs, ORFs, and CORFs appeared to be medically unneeded (OIG 2000a, OIG 2000b, OIG 2001, GAO 2004). Both agencies recommended that CMS have its contractors expand and conduct adequate medical reviews of outpatient therapy claims. The OIG also recommended that the contractors increase provider education about coverage rules, local medical review policies, and documentation requirements.

Although Medicare claims contractors provide some oversight of the services furnished, their reviews are limited and inconsistent across carriers and fiscal intermediaries. A CMS contractor identified three types of edits that could be applied to the claims review process to flag potentially improper payments (Ciolek and Hwang 2004a). Edits could examine whether multiple units on a single day should be allowed, whether patients were able to tolerate more than a certain amount of timed therapy during a single day (for example, an hour of physical therapy), or whether certain combinations of services make clinical sense. CMS plans to have the first type of edits in place in early 2006, and GAO recommended that CMS proceed with the implementation of the other edits (GAO 2005). ■

# ENDNOTES

1 For therapy assistants working for therapists in private practice, the supervision must be "direct" (the supervising therapist must be on site); for therapy assistants working in institutions, the supervision may be general (not necessarily on-site). The rationale provided for these different standards was that institutional settings have more stringent Medicare participation requirements through the survey and certification programs. More detail is available in the *Federal Register*, November 15, 2004, page 66355.

2 Part B covers physician and other outpatient services that beneficiaries may buy into through monthly premiums. About 92 percent of beneficiaries participate in Part B.

3 Until 1999, payments to institutional providers (hospital outpatient departments, SNFs, CORFs, and ORFs) were cost based. The Balanced Budget Act of 1997 replaced the cost-based method with a uniform fee schedule that establishes payments for all providers of outpatient therapy and, as a one-year interim savings measure for 1998, reduced payments to institutional providers.

4 The implementation was delayed because CMS was sued for not providing beneficiaries with adequate notification of the caps. In its settlement, CMS agreed to broadly notify its beneficiaries of the enforcement of the caps beginning September 2003.

5 During 2003 the therapy caps were in place only for four months, so part of the increase between the years may be due to the caps coming off.

6 Medicare adjusts its payments to providers using geographic practice cost indexes.

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