OUTPATIENT THERAPY SERVICES PAYMENT SYSTEM

*payment***basics**

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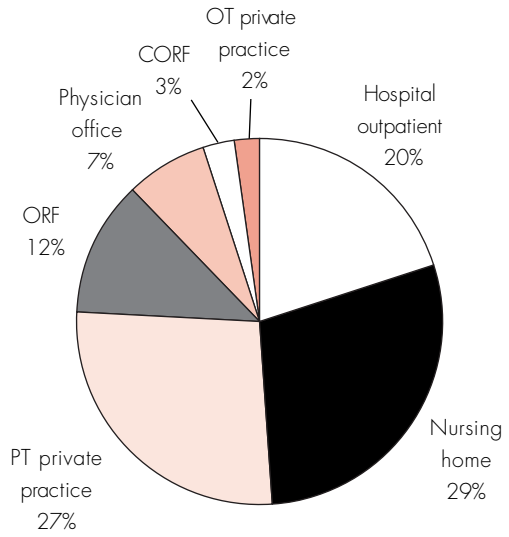
Outpatient therapy services include physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services. PT includes services that restore and maintain physical function and treat or prevent impairments that result from disease or injury. Examples include therapeutic exercise (e.g., aerobic training) and therapeutic activities (e.g., balance training). OT services improve and compensate for 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. Examples include functional training in self care and home management. SLP services help patients with difficulties communicating and swallowing as a result of disease, injury, or surgery. For example, a patient who has had a stroke may receive SLP services to recover the ability to speak. Common SLP services are the evaluation and treatment of swallowing disorders and treatment of a speech disorder.

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. The beneficiary must be under the care of a physician, have a treatable condition, and be improving. Medicare does not cover outpatient therapy services that maintain a level of functioning or serve as a general exercise program.

Medicare spending on outpatient therapy exceeded $4.3 billion in 2007, a 6.6 percent increase from 2006 (Drozd et al. 2009). PT services make up three-quarters of beneficiary therapy use.

Outpatient therapy is furnished in many different settings, including therapists in private practice (who may work in a physician's office but bill independently), nursing homes, hospital outpatient departments, physicians' offices, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, and home health agencies. Services furnished in therapists' private practices and in nursing homes account for over half of Medicare therapy payments, with outpatient departments accounting for 19 percent (Figure 1). Across settings, spending per user has varied threefold, with hospital outpatient departments having the lowest spending and comprehesive outpatient rehabilitation facilities having the highest. The information is not available to know if this variation reflects differences in the types or complexity of patients treated or if patients who received more services had better outcomes.

Figure 1 Distribution of outpatient therapy spending by setting



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive rehabilitation facility), OT (occupational therapist).

Source: Ciolek and Hwang 2008.

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Defining the services Medicare buys

Medicare pays for outpatient therapy according to fees established in the physician fee schedule regardless of where the services are provided. Under Medicare's physician fee schedule, the unit of payment is each individual service. All services are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS).

Medicare pays for therapy services furnished by physical therapists, occupational therapists, speech–language pathologists, and physicians. Medicare also covers therapy services furnished by physician assistants, nurse practitioners, and clinical nurse specialists if the state in which they practice permits them to furnish therapy. Certain services furnished by physical and occupational assistants are also covered as long as the practitioner is supervised by a qualified therapist who bills for the service. Services furnished by aides, even if supervised, are not covered by the program. In addition, 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.

Setting the payment rates

Under the fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide services: clinician's work, practice expenses, and professional liability insurance (PLI) expenses. The RVUs for the clinician's work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses providers incur when they rent office space, buy supplies and equipment, and hire nonclinical and administrative staff. The PLI RVUs are based on the premiums providers pay for professional liability insurance, also known as medical malpractice insurance. As with all service payments set by Medicare's physician fee schedule, the RVUs for work, practice expense, and PLI are established relative to the "average" service, which has an RVU value of 1.0.

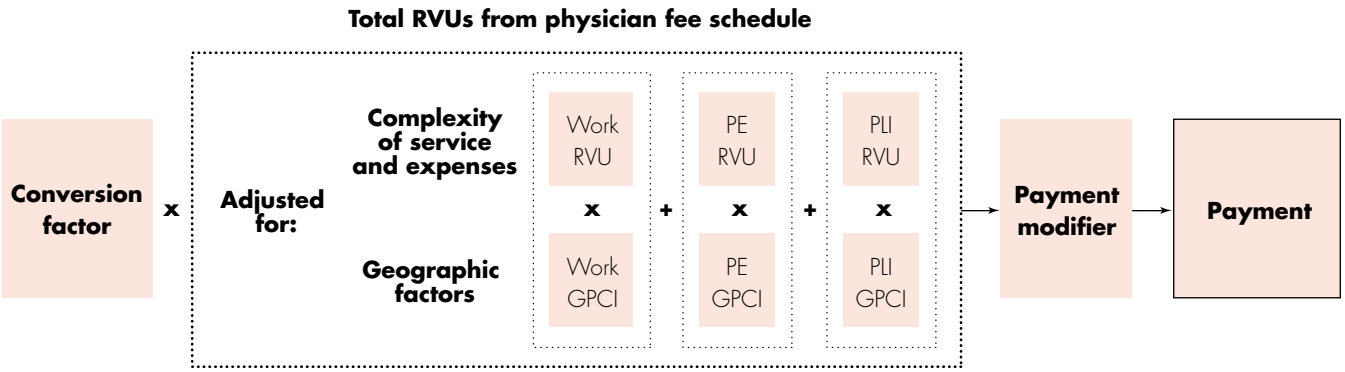
In calculating payment rates, each of the three RVUs is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (Figure 2). Through payment modifiers, Medicare may adjust its payments upward or downward to reflect other factors. For example, services billed separately and provided by nurse practitioners are paid at 85 percent of physicians' fees. Payments are increased when services are provided in health professional shortage areas. For most services, Medicare pays the provider 80 percent of the fee schedule amount and the beneficiary is liable for the remaining 20 percent coinsurance.

Updating payments

The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from the Relative Value Scale Update Committee, a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the sustainable growth rate (SGR) system, a formula intended to keep spending on physician fee schedule services consistent with a target based on growth in the national economy. The SGR ties payment updates to a number of factors, including growth in input costs, growth in fee-for-

Figure 2 Outpatient therapy services payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance). This figure depicts Medicare payments only. The physician fee schedule lists separate PE RVUs for facility and nonfacility settings.

service enrollment, and growth in the volume of services relative to growth in the national economy. The *Physician services payment system* document in our "Payment Basics" series provides more information on the SGR.

The therapy caps

There are annual spending limits on Medicare payments for outpatient therapy services except those provided in hospital outpatient departments. Two separate limits—one on PT and SLP services and another on OT services—limit Medicare spending to $1,840 per beneficiary. These limits are referred to as the "therapy caps." The Balanced Budget Act of 1997 imposed these limits and while they have been repeatedly suspended, they went back into effect on January 1, 2006.

CMS exceptions process The Deficit Reduction Act of 2005 required the Secretary of Health and Human Services to establish an exceptions process allowing beneficiaries to request an exemption from the therapy caps if the services they require are reasonable and medically necessary. CMS established an automatic process to exempt service use above the limits for patients with qualifying medical conditions or complexities. The list of qualifying conditions is extensive and includes comorbidities common among beneficiaries. Although CMS established a manual process to consider requests from beneficiaries who were not automatically eligible for exemption, it stopped the manual process in 2007. Its contractors told CMS that the majority of these requests were for services that were necessary and appropriately provided. As required by law, the exceptions process expired on December 31, 2007. The Medicare Improvements for Patients and Providers Act of 2008 reinstated the exceptions process as of July 1, 2008, and extends the process through December 31, 2009. ■

References:

Ciolek, D., and W. Hwang. 2008. *Outpatient therapy alternative payment study task order: CY 2006 outpatient therapy services utilization report.* Baltimore, MD: Computer Sciences Corporation.

Drozd, E., B. Lyda-McDonald, and A. Kandilov. 2009. *Developing outpatient therapy payment alternatives: 2009 annual report.* Research Triangle Park, NC: RTI International.