Advising the Congress on Medicare issues

Mandated report: Outpatient therapy services in Medicare

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Mandated report on improved Medicare therapy benefits

- Include recommendations on how to reform the payment system under Part B
- Include examination of private sector initiatives as they relate to outpatient therapy benefits
- Due June 15, 2013

Overview of today's presentation

- Background
  - Therapy types
  - Institutional and private practice providers
- Medicare spending on outpatient therapy services
  - Spending growth over time
  - Geographic variation in spending
  - Therapy caps, and exceptions
- Payment policy concerns about outpatient therapy
  - Poor data on diagnosis, service, and patient assessment

What is outpatient therapy?

Physical therapy: Exercises and treatments to restore or prevent impairments that result from disease or injury (e.g. walk, stand)

Occupational therapy: Therapies to improve and restore the ability to independently conduct activities of daily living (e.g. bathing) and instrumental activities of daily living (e.g. food preparation)

Speech-language pathology: Assist patients with communication and swallowing

Conditions for outpatient therapy services to be furnished

- Need for therapy services
- A treatment plan
- Care of a physician or non-physician practitioner
- Services are furnished on an outpatient basis
- Outpatient therapy services are identified by the related 5-digit HCPCs codes

Providers of outpatient therapy services

- Physical therapists
- Occupational therapists
- Speech and language pathologists
- Physicians
- Qualified physical and occupational assistants are covered but must be supervised

Spending on outpatient therapy in 2009

	Number of therapy users (millions)	Total spending (billions)	Therapy spending by type	Average spending per user
Physical Therapy	3.9	$ 3.8	73%	$ 958
Occupational Therapy	1.0	1.1	20	1,055
Speech-Language Pathology	0.5	0.4	7	741
Total	4.5	$5.3		$1,165

Source: MedPAC analysis of 2009 Medicare claims data

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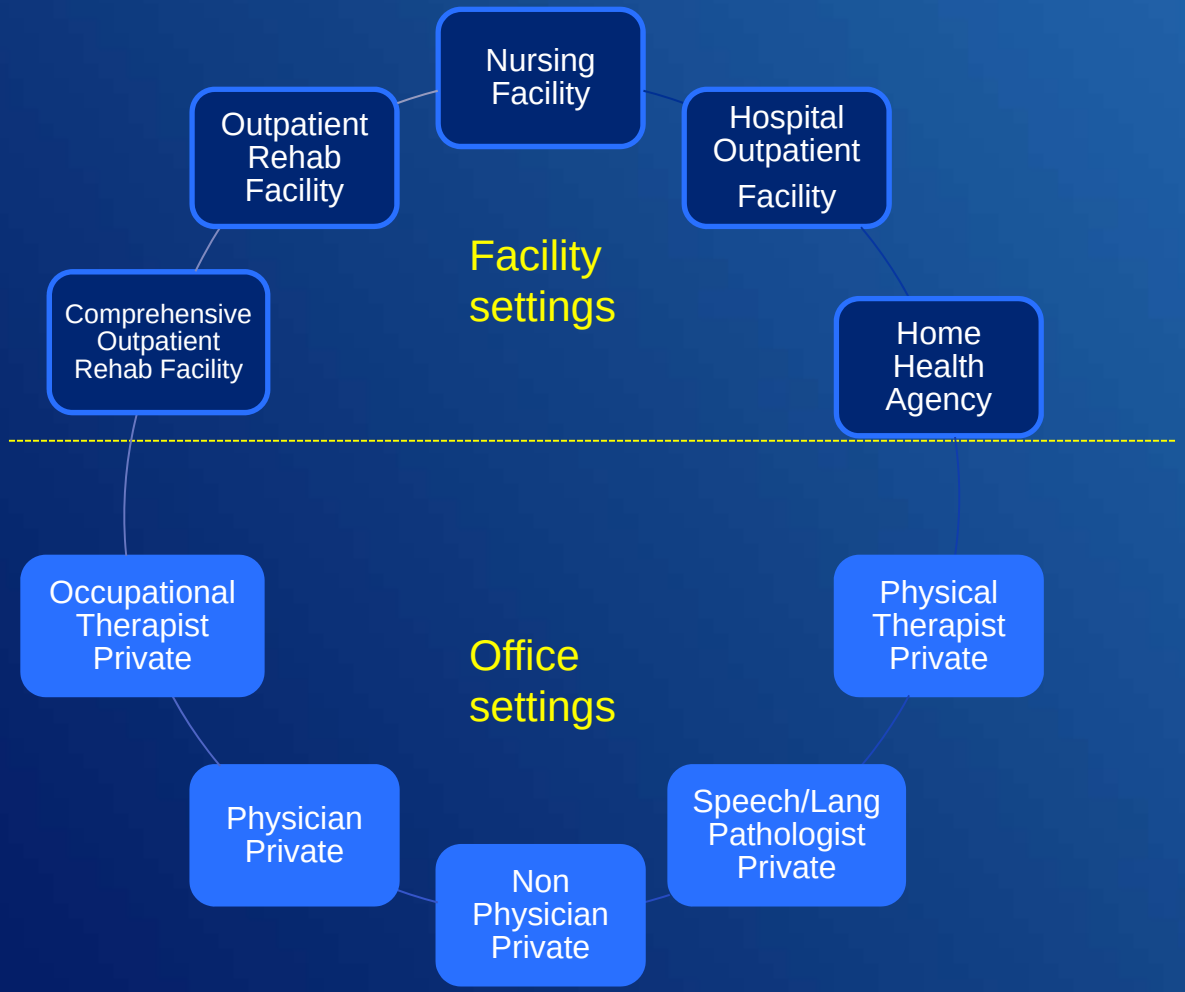
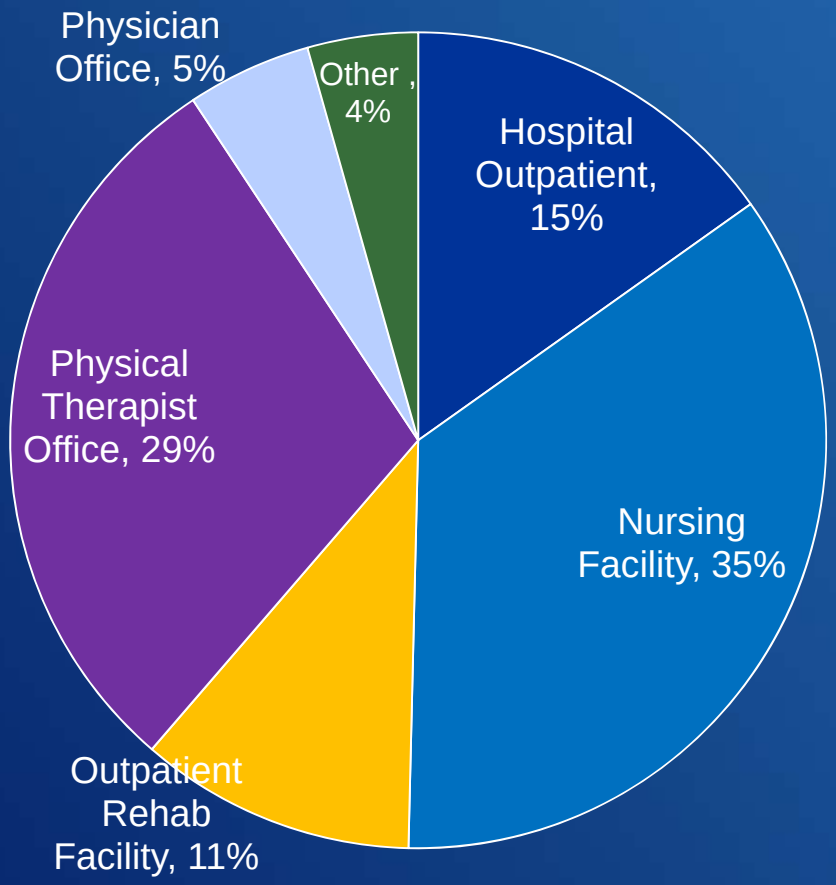
Outpatient therapy services delivered in 10 different settings in 2009



Spending on outpatient therapy, by setting, 2009

Total= $5.3 billion



Other includes comprehensive outpatient rehab facilities home health agencies; occupational therapists, speech and language pathologists, and non-physician practitioners' office settings.

MEDPAC Source: MedPAC analysis of 2009 Medicare claims data

Average growth in spending on outpatient therapy services

Setting	2004 (billions)	2009 (billions)	Average % change 2004-2009	% change in 2008-2009
Facilities				
Nursing facilities	$ 1.2	$ 1.9	8.4%	21%
Subtotal, all facilities	2.8	3.3	3.4	10
Professional offices				
Physical therapists' private practice	1.0	1.5	9.6	13
Subtotal, all professional	1.4	1.9	5.7	12
Total, all settings	$4.3	$5.3	4.2%	11%

MEDPAC Source: MedPAC analysis of 2009 Medicare claims data.
Note: Numbers may not sum to totals due to rounding.

Spending per therapy user in high and low spending counties (national mean 2009 = $1,165)

High spending counties

Rank	State	County	$
1	FL	MIAMI-DADE	4,474
2	NY	KINGS	2,632
3	LA	ST. MARY	2,548
4	TX	RUSK	2,485
5	AK	KENAI-COOK INLET	2,470
6	FL	OKEECHOBEE	2,452
7	LA	AVOYELLES	2,221
8	TX	ANGELINA	2,198
9	MS	LEFLORE	2,197
10	LA	OUACHITA	2,124

Low spending counties

Rank	State	County	$
1	NY	OTSEGO	346
2	ND	GRAND FORKS	399
3	ND	MORTON	425
4	IA	CLAY	432
5	MN	KANDIYOHI	435
6	MN	OTTER TAIL	443
7	ND	WARD	452
8	MN	OLMSTED	456
9	MT	YELLOWSTONE	462
10	MT	LEWIS AND CLARK	463

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Source: MedPAC analysis of 2009 Medicare claims data

Spending has increased but the number of therapy users has remained relatively constant

Source: MedPAC analysis of 2009 Medicare claims data; CSC contractor reports to CMS on outpatient therapy

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Therapy caps

- Annual per-beneficiary limit on allowed outpatient therapy services (caps)
- There are two cap limits: cap for PT and SLP services combined; cap for occupational therapy services
- Cap for 2012 is $1,880 each
- Services obtained from hospital outpatient departments have not been subject to the caps until this year (starting in October 2012)

Exceptions to therapy caps

- The exceptions process allows beneficiaries to receive services above the cap limits in non-hospital settings
- CMS requires that a KX modifier be placed on the claim for services delivered beyond cap limits
- The therapy cap exceptions process has been extended until December 31, 2012

A large number of therapy users benefit from the exceptions process

Beneficiaries who exceeded 2009 caps (limit was $1,840)

	Physical Therapy/Speech Language Pathology Cap	Occupational Therapy Cap
Share who exceeded caps	23%	29%
Mean spending among exceeders	$ 2,972	$ 2,994

Source: MedPAC analysis of 2009 Medicare claims data

Lack of detailed diagnosis codes

- Few meaningful codes to determine patient acuity
- Most are non-specific diagnosis codes
- Some are V-codes which are descriptive of the service provided but not the condition

	ICD-9	Description	Share of total therapy payments
1	V57.1	Non-Specific, Other physical therapy	6%
2	724.2	Lumbago	5%
3	781.2	Abnormality of gait	4%
4	719.7	Difficulty in walking	3%
5	719.41	Pain in joint, shoulder	3%

Service codes for outpatient therapy are not specific

Top 6 HCPCs codes in 2009

	HCPC	Description	Share of therapy payments
1	97110	Therapeutic exercises	40%
2	97530	Therapeutic activity	13%
3	97140	Manual therapy	10%
4	97112	Neuromuscular reeducation	8%
5	97116	Gait training therapy	4%
6	97001	Physical therapy evaluation	4%

Reasons for requiring improved coding

- Clearer diagnoses should ideally pair with patient assessment to determine the specific therapy needs of the patient
- Improved ability to determine severity and complexity among patients
- Improved the ability to properly risk adjust based on clinical data
- Improved ability to define the Medicare outpatient therapy benefit

Lack of functional status measures to determine outcomes

- No widely-used instruments to measure functional status in outpatient therapy
- Difficult to consistently assess improvement as a result of therapy
- CARE-C and CARE-F tools for therapy are currently under study but a few years from results

Possible Commission work on the outpatient therapy mandated report

Major systems reform

- Patient assessment information, and improved service and diagnosis codes
- Change the payment system (e.g. episodes)

Tighter coding (shorter term)

- Require clear diagnosis codes on claims, eliminate use of V-codes
- Require more information about the reason for exceeding therapy caps

Improving management of the benefit

- Permanently include services from HOPDs under therapy caps
- Secretarial authority to intervene in high-use geographic areas or aberrant providers
- Physician attestation of medical necessity when ordering therapy
- Tighten the list of conditions that lead to exceptions to the cap
- Link annual increases to therapy caps to improved coding
- Evaluation of private sector initiatives to manage outpatient therapy services