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December 30, 2004

The Honorable Richard B. Cheney
President of the Senate
U.S. Capitol
Washington, D.C. 20515

Dear Mr. Vice President:

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Congress mandated MedPAC to study the feasibility and advisability of allowing Medicare fee-for-service beneficiaries to have “direct access” to outpatient physical therapy (PT) services and comprehensive rehabilitation facility services.¹

Current Medicare coverage rules require a beneficiary to be referred by and under the care of a physician for outpatient PT services to be covered by Medicare. Physical therapists would like these requirements removed so that Medicare would cover outpatient PT services even when the care was not referred or reviewed by a physician.

Proponents of eliminating the physician requirements for outpatient PT services contend that it would improve beneficiary care by shortening delays before therapy began. They also argue that eliminating the physician referral requirement would result in more cost-effective care and enhanced patient choice. Opponents argue that a physician examination is required to correctly assess and diagnose a patient’s medical condition before the initiation of physical therapy. They also state that ongoing medical supervision ensures that a patient’s response to treatment is considered within the context of his or her total medical care.

The physician referral and review requirements are a necessary but not sufficient mechanism to help beneficiaries get outpatient PT services that are needed and appropriate for their clinical conditions. Beneficiaries often have multiple medical conditions and physicians can consider their broad medical care needs. Like Medicare, private insurers usually control service provision, by requiring physician referrals and/or imposing limits on service use. Medicare’s physician requirements do not appear to impede access—the majority of beneficiaries report no problems accessing these services. Eliminating the physician requirements for physical therapy services could establish a precedent for other services that currently have similar Medicare coverage requirements.

¹ The language of section 647 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is found in Attachment A.

While we find no compelling reason to change Medicare's current requirements for physician referrals and care review, we note that other steps, in addition to the physician requirements, need to be taken to help ensure that service provision is appropriate. First, providers need to be made more aware of coverage rules for beneficiaries—for example, through increased educational initiatives by the professional associations, the claims contractors, and facilities in which physical therapists practice. Second, better data are needed about the efficacy of physical therapy for older patients. Evidence-based research needs to be undertaken on when and how much outpatient PT benefits older patients. Finally, this information would assist in the development of evidence-based guidelines that are disseminated to physicians and physical therapists so that their practices deliver the best value to beneficiaries.

Background

Physical therapy is the range of service provided by a physical therapist to restore and maintain physical function and to treat or prevent impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries. Primarily through therapeutic exercise and functional training, physical therapy services include strengthening and improving a patient's mobility. Physical therapists have received a post-baccalaureate degree from an accredited education program and have passed a state-administered national examination. State licensure is required in each state in which a physical therapist practices and must be renewed on a regular basis.

Physical therapy services covered by Medicare. Medicare covers outpatient physical therapy services as long as the services are furnished by a skilled professional, are appropriate and effective for a patient's condition, and are reasonable in terms of frequency and duration. Further, a physician must refer the patient; review a written plan of care every 30 days; and, for longer-term treatment (extending beyond 60 days), reevaluate the patient. In addition, providers must have a physician on call to support emergency medical care. Beneficiaries are expected to improve significantly in a reasonable period of time. Medicare does not cover physical therapy designed to maintain a level of functioning or serve as a general exercise program. Finally, services are not covered when the expected patient gains from therapy are insignificant in relation to the therapy required to reach them or when it has been decided that a patient will not realize treatment goals.

Though Medicare's coverage policies are fairly broad, the local contractors that review and pay the claims submitted to Medicare often issue more specific medical review policies, thereby making the coverage requirements more specific.

Providers of outpatient physical therapy. Physical therapy services are furnished in many different settings. The largest (in terms of Medicare payments and patients treated) are hospital outpatient departments and skilled nursing facilities (SNFs).² Other settings include physicians'

² Outpatient PT services may be furnished by a SNF to a beneficiary who does not qualify for a Medicare-covered SNF-stay under part A (for example, because he or she was not hospitalized prior to entering the SNF or does not require skilled services). Though provided in an inpatient setting, the PT is billed as an outpatient service and covered under part B. SNFs also furnish PT to beneficiaries who live in the community but use the SNF as a provider of outpatient PT services.

offices, physical therapists in private practice, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies (Attachment B). CORFs differ from other outpatient PT providers in two ways: (1) they must offer psychological or social services and the services of a physician who specializes in rehabilitation medicine, and (2) they are authorized to provide (and be paid separately for) nontherapy ancillary services (such as respiratory therapy, drugs that cannot be self administered, and nursing services) when medically necessary. Across all these settings, about 9 percent of beneficiaries receive PT services.

Medicare payments. Medicare covers all outpatient PT services under part B, the Supplementary Medical Insurance Trust Fund.³ Payments are established for each outpatient PT service in the physician fee schedule, regardless of where the services are provided.⁴ 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 2000, Medicare payments for outpatient therapy totaled almost \$2.1 billion, two-thirds of which were for physical therapy (the other third paid for occupational and speech therapies.)

No limit currently exists on the amount of medically necessary outpatient PT a beneficiary may receive, but this has not always been the case. Limits on the amount of outpatient therapy furnished by therapists in independent practice were first implemented in 1972 and subsequently increased three times. The Balanced Budget Act of 1997 extended the cap to all nonhospital therapy providers and raised the cap to \$1,500. Hospital providers were excluded from the cap to allow beneficiaries with high care needs to continue to receive services.⁵ These 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 2002 and were again suspended beginning December 8, 2003, by the MMA. This latest suspension lasts through December 31, 2005. As a result, there are currently no monetary limits on the amount of outpatient PT that can be provided by physical therapists to patients.

³ Part B is an optional program that covers physician and other outpatient services that beneficiaries may buy into through monthly premiums. About 92 percent of beneficiaries participate in Part B.

⁴ 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 established payments for all providers of outpatient PT and, as an interim savings measure for 1998, reduced payments to institutional providers.

⁵ Maxwell, Stephanie et al. 2001. *Part B therapy services under Medicare 1998–2000: Impact of extending fee schedule payments and coverage limits.* Washington, DC: Urban Institute.

Physician requirements help ensure beneficiaries receive medically appropriate care

Since the beginning of the program, Medicare has relied on physicians to determine which services are reasonable and necessary.⁶ Before referring a patient for physical therapy, physicians generally examine the patient and, if necessary, order and evaluate the results of diagnostic services such as radiological exams and laboratory tests to establish an initial diagnosis. Patient diagnoses and comorbidities are considered in assessing whether physical therapy services will be beneficial to a patient and, if so, how much therapy a patient could tolerate. Once therapy has begun, the physician recertifies that the plan of care continues to match the beneficiary's care needs and, in the case of longer-term therapy, periodically reexamines the patient. Given the multiple, often chronic, medical care needs of many beneficiaries, the physician oversight requirements are a reasonable way to help beneficiaries receive medically appropriate care.⁷

Without these physician requirements, the medical appropriateness of starting or continuing physical therapy services would be more uncertain. Under Medicare, physical therapists are not allowed to order the diagnostic services that may be critical to identifying the patient's underlying medical conditions. In some cases, physical therapy would not be beneficial to the patient and would raise program and beneficiary costs. In other cases, underlying medical conditions that look similar to other musculoskeletal conditions would go undetected. For these beneficiaries, overlooked medical conditions could result in delayed medical attention that could result in harmful or negative outcomes. While physician referral requirements do not ensure the medical appropriateness of services furnished, they help to prevent the provision of services of marginal or no clinical value.

Physical therapists counter that their training and practice ensures that patients are adequately screened for medical referrals. During each patient's examination, the physical therapist assesses whether the patient's condition is consistent with the diagnosis provided by the physician and whether the patient needs to be referred back to a physician for further medical attention. Physical therapists note that the physician referral may provide little clinical guidance regarding the services to be furnished. One study found that physician referral forms do not consistently include specific clinical diagnoses.⁸ Physical therapists also contend that general instructions such as "evaluate and treat" require the same assessment skills and responsibilities that they would assume under their proposal to eliminate the physician referral requirement.⁹

⁶ Tunis, Sean. 2004. Why Medicare has not established criteria for coverage decisions. *New England Journal of Medicine* 350, no. 21 (May): 2196–2198.

⁷ About 78 percent of beneficiaries had at least one chronic condition and 63 percent had two or more. Medicare Payment Advisory Commission. 2004a. *Report to the Congress: New approaches in Medicare*. Washington, DC: MedPAC. Chapter 2.

⁸ One study found that fewer than 30 percent of claims included differential diagnoses information. Clawson, Al, et al. 1994. Content of physician referrals to physical therapists at clinical education sites in Indiana. *Physical Therapy* 74, no. 4 (April): 356–360.

⁹ General instructions may reflect a lack of oversight on the part of the physician or a high degree of confidence the physician has in the physical therapist.

Medicare's requirement that physical therapy services be under the care of a physician is similar to those for other services and practitioners. Physician referrals or orders are required for home health care, skilled nursing facility stays, durable medical equipment, medical supplies, outpatient drugs, oxygen, and occupational therapy. Medicare has similar coverage rules for physician assistants and nurse practitioners—these providers can bill Medicare independently but must practice under physician supervision or in collaboration with physicians. For home health services, physicians are also subject to civil monetary penalties when they falsely certify eligibility for beneficiaries they know to be ineligible for services. Other practitioners—podiatrists, optometrists, and chiropractors—are included in Medicare law's definition of physicians and do not require physician referral or oversight.

Changing the physician requirements for outpatient PT services is likely to have repercussions for other services. In a letter to MedPAC, the American Occupational Therapy Association (AOTA) notes that rehabilitation services—including physical and occupational therapies (OT) and speech-language pathology—are treated the same under Medicare.¹⁰ It asserts that if changes were made to the requirements for physician certification and recertification requirements for PT, then changes should be made to OT and speech-language pathology. The position of the AOTA regarding the physician requirements is under consideration. Last year, AOTA noted that there were important public policy reasons to ensure that physicians review the therapy plan of care and attest to a continuing medical need for therapy services.¹¹

Private payers use multiple strategies to control service use

Private payers generally use a combination of “front end” and “back end” mechanisms to control PT service use, particularly given their younger populations who may have less proven need for PT services. At the front end, managed care organizations, self-insured plans, and the national Federal Employees Health Benefit Programs (FEHBP) often require physician referrals. Blue Cross Blue Shield Association (BCBSA) plans vary in their requirements for physician referrals, depending on the plan and the employer. Their managed care plans are most likely to require physician referrals, whereas their preferred provider plans are less likely to require some form of prior authorization. Five BCBSA plans (Arizona, Delaware, Maryland, Montana, and North Dakota) do not require physician referrals, though representatives from the Blue Cross Association told us that many physical therapists prefer to have a physician referral before they begin treating patients.

Most private payers have adopted some kind of “back end” controls to limit PT service use. Many payers restrict coverage to a predefined number of days or visits per year, such as 60 calendar days from the beginning of an “event” or 30 visits. Some private plans also attempt to control the provision of individual services by paying for a “bundle” of therapy care on a “per visit” basis. For these visits, payments are uniform, regardless of the number of services furnished during the visit.

¹⁰ American Occupational Therapy Association. 2004. Letter to MedPAC, September 28.

¹¹ American Occupational Therapy Association. 2003. Comment letter to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, January 23. http://www.cms.gov/faca/ppac.writ_aota.pdf.

Some private payers also use practice guidelines that have been developed by clinical experts in combination with a review of the current medical literature.¹² These guidelines are sometimes used to establish eligibility for coverage but more often to perform utilization review. For a specific diagnosis, the guidelines typically include a brief description, indicators of the condition (such as the presence of pain), recommended treatment (for example, therapy or exercise), and the average or suggested number of visits. Guidelines sometimes describe the amount of improvement that can be expected from a given course of treatment and suggested end points based on range of motion, the amount of pain, and a patient's ability to work.

Consistent with the private payers, Medicare should have a control in place to consider the medical appropriateness and necessity of the services furnished. If Medicare removed the physician requirements, its only control mechanism, as a prudent purchaser it would need to establish an alternative method to control service use.

Many state laws restrict physical therapy practices

Although state laws relating to physical therapy vary considerably, only two states (Iowa and Montana) explicitly allow the provision of physical therapy services without a physician referral (Table 1). Another fifteen states implicitly allow physical therapists to see patients without a physician referral because their laws are silent on the issue. In these 15 states, the coverage policies of the insurers may still require physician referrals. More common are laws that in some way limit the services a physical therapist can deliver to patients. These restrictions include: allowing physical therapists to evaluate, but not treat, patients; placing time limits on how long a physical therapist may treat a patient before a physician must be seen; and limiting the types of services physical therapists can provide without a physician referral. For example, in Washington, interventions related to musculoskeletal conditions do not require referrals but providing orthotics for feet do. Four states explicitly require physician referrals.

¹² Maxwell, Stephanie, and Cristina Baseggio. 2000. *Outpatient therapy services under Medicare: Background and policy issues*. Washington, DC: Urban Institute.

Table 1
State laws differ on physician referral requirements for physical therapy services

Provision	States
Referrals not required	Iowa and Montana (explicitly granted)
(2 states explicitly granted and 15 states implied through omission)	Alaska, Arizona, California, Colorado, Idaho, Maryland, Massachusetts, Nebraska, Nevada, North Carolina, North Dakota, South Dakota, Utah, Vermont, West Virginia (implied through omission)
Referrals not required for specific services (3 states)	Arkansas, Washington, Wyoming
Referrals not required for a limited period of time (11 states)	Delaware, Florida, Maine, Minnesota, New Hampshire, New Jersey, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina
Referrals not required to evaluate patients (16 states)	Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New Mexico, New York, Oklahoma, Tennessee, Texas
Physician referral required to evaluate and treat (4 states)	Alabama, Indiana, Virginia, Wisconsin

Note: Implied through omission: State laws do not explicitly mention physician referral requirements for either evaluation or treatment.

Referrals not required for a limited period of time: Physical therapists can evaluate and treat patients without a physician referral for a specific number days (for example, 21, or 30 days) before a physician must be consulted.

Referrals not required to evaluate patients: Physical therapists can evaluate patients without a physician referral but referrals are required to treat patients.

Source: Analysis of state laws as compiled by the American Association of Orthopedic Surgeons (in correspondence to MedPAC, 2004) and the American Physical Therapy Association, 2004. Establishing the Feasibility and Advisability of Direct Access to Physical Therapists: A Report to the Medicare Payment Advisory Commission. Alexandria, VA: APTA.

Two studies examining the experience of physical therapists practicing in states that do not require physician referrals found that between 34 and 45 percent of the therapists surveyed had practiced without physician referrals. Of those, between 10 and 35 percent of their cases were seen through direct access. Direct access was not more common among patients because either their employers or insurers required physician referrals or the therapists preferred to treat patients by referral.¹³

¹³ Crout, K.L. et al. 1998. Physical therapists' opinions and practices regarding direct access. *Physical Therapy* 78, no.1 (January): 52–61 and Domholdt, E., and A.G. Durchholz. 1992. Direct access use by experienced therapists in states with direct access. *Physical Therapy* 72, no. 8 (August): 569–574.

Medically unnecessary physical therapy services could increase if physician requirements were eliminated

Another concern with eliminating the referral and oversight requirements is that unnecessary use of outpatient PT services would increase. Long-standing concern about appropriate use has prompted the examination of these services furnished to Medicare beneficiaries. The studies have consistently found that despite the physician requirements, medically unnecessary therapy services were frequently furnished.

Amount of medically unnecessary PT services. The Office of Inspector General (OIG) of the Department of Health and Human Services examined the provision of outpatient physical and occupational therapy services provided in skilled nursing facilities (SNFs) and found considerable and widely varying shares of medically unnecessary services. One study found that from 5 to 26 percent of services was unnecessary, depending on the patient diagnosis.¹⁴ Another OIG study found that three quarters of the contractors hired to review and process claims for payment commonly found medically unnecessary and excessive therapy claims.¹⁵ The services were medically unnecessary because:

- the services were not skilled,
- the treatment goals were too ambitious for the patient's condition, and
- the frequency of the service provision was excessive given the patient's condition.

The appropriateness of care provided at CORFs and ORFs has also prompted examination. In its study of ORFs, the 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.¹⁶ The Government Accountability Office (GAO) examined CORFs in Florida and found that on a per patient basis, Florida CORFs' payments were two to three times higher than payments to other facility-based therapy providers and that the differences were not explained by patient characteristics such as diagnosis.¹⁷

These studies indicate that unnecessary therapy is frequently provided and that the current requirements alone do not eliminate unnecessary service provision, even in settings supervised by physicians, such as SNFs and CORFs. The studies may also reflect low levels of physician oversight provided in some institutional settings. It is possible that unnecessary services are provided more frequently in settings where there even less physician supervision. Finally, the findings may illustrate a poor understanding of Medicare coverage by physicians and physical therapists.

¹⁴ Office of the Inspector General, Department of Health and Human Services. 2001a. Physical, occupational, and speech therapy for Medicare nursing home patients: Medical necessity and quality of care based on treatment diagnosis. Washington, DC: OIG. Report no. OEI-09-99-00563.

¹⁵ Office of the Inspector General, Department of Health and Human Services. 2000a. Monitoring Part B therapy in SNF patients. Washington, DC: OIG. Report no. OEI-09-99-00550.

¹⁶ Office of the Inspector General, Department of Health and Human Services. 2000b. Six-state review of outpatient rehabilitation facilities. Washington, DC. Report no. A-04-99-01193.

¹⁷ General Accounting Office. 2004. Comprehensive outpatient rehabilitation facilities: High Medicare payments in Florida raise program integrity concerns. Washington, DC: GAO. Report no. GAO-04-709.

The OIG and GAO have recommended that CMS ensure that its contractors expand and conduct adequate medical reviews of PT claims. The OIG also recommended educating facilities and their staffs about Medicare's medical necessity guidelines and local medical review policies. It also encouraged national therapy and nursing home associations to disseminate information about coverage rules and proper documentation.

Service provision during and after the outpatient therapy caps. Service provision also appears to increase as Medicare payment policies become less restrictive. 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.¹⁸ Then, when the constraints imposed by therapy caps were lifted, spending increased 36 percent between 1999 and 2000, again due primarily to increases in per patient spending.¹⁹ The OIG found that even under the restrictive therapy caps, about 12 percent of physical therapy services provided to SNF patients were not medically necessary, primarily because the services furnished did not match the patients' conditions or the services provided did not match treatment goals.²⁰ In some cases, the patients were not candidates for PT services; in others, skilled services were provided when routine maintenance would have been more appropriate to the patients' conditions. Regarding the fit between services provided and treatment plans, in some cases, services continued to be provided even though patients had met their goals; in others, the patients were not meeting their goals but their treatment plans were not reevaluated.

Variation in service spending. Variation in spending may be another indicator of unnecessary service provision. In 2000, there was a five-fold variation in Medicare payments per patient for outpatient PT services across states.²¹ Although a large share of this variation is probably due to differences in health status, local prices, and provider mix, some of this difference in practice patterns may suggest overutilization.²² But even for similar diagnoses, payments varied three-fold suggesting that either different types of providers treat patients of varying severity or that considerable variation in treating similar cases exists.²³ One study found that after controlling for differences in diagnosis and illness severity, orthopedic surgeons were more likely than primary care physicians to refer patients to physical therapy and that PT supply also explained differences in PT referral rates.²⁴ A better understanding of the reasons for the wide variation in outpatient

¹⁸ Olshin, Judith M. et al. 2002. *Study and report on outpatient therapy utilization: Physical therapy, occupational therapy and speech-language pathology services billed to Medicare Part B in all settings in 1998, 1999, and 2000*. Columbia, MD: Advance Med. <http://www.cms.hhs.gov/medlearn/therapy> and Maxwell, Stephanie et al, op. cit., 2001.

¹⁹ Over the two year period (from 1998 to 2000), spending decreased 10 percent, in part reflecting the implementation of the fee schedule for institutional providers and budget-savings reductions taken in 1998.

²⁰ Office of the Inspector General, Department of Health and Human Services. 2001b. Physical, occupational, and speech therapy for Medicare nursing home patients: Medical necessity, cost, and documentation under the \$1,500 caps. Washington, DC: OIG. Report no. OEI-09-99-00560 and Office of the Inspector General, op. cit., 2001a.

²¹ Olshin, Judith M. et al, op. cit. Note that state measures do not accurately account for services that beneficiaries receive in nearby states.

²² MedPAC estimates that across all health care spending, about 40 percent of the variation is attributable to differences in local prices and health status. Medicare Payment Advisory Commission. 2003. *Report to the Congress: Variation and innovation in Medicare*. Washington, DC: MedPAC. Chapter 3.

²³ Maxwell, Stephanie, op. cit., 2001.

²⁴ Freburger, Janet K. 2003. Physician referrals to physical therapy for the treatment of musculoskeletal conditions, *Archives of Physical Medicine and Rehabilitation* 84 (December): 1839--1849.

PT services is essential to activities aimed at increasing the appropriateness of service use, such as practice guidelines and practitioner profiling.

Amount of medical review. Stepped-up medical review of physical therapy services could help reduce medically unnecessary services. The Congress required the Secretary to focus attention on the medical appropriateness of outpatient PT, especially that provided in SNFs.²⁵ Currently, most of the contractors that review and process claims for payment do some kind of review, but in aggregate fewer than two percent of all therapy claims are examined. This scale of activity is unlikely to ensure that the PT services provided, and the beneficiaries receiving them, meet coverage rules. This lack of aggressive medical review is an additional factor to consider in relaxing restrictions on PT requirements.

Need for evidence-based research. Stepped up medical review is not, by itself, a solution to problem of unnecessary service provision. Lacking evidence on when older patients benefit from PT, it will be difficult for contractors responsible for medical review to determine which services were appropriate without conducting chart review. Evidence-based research to establish the clinical effectiveness of PT services for older patients could be used to educate physicians and physical therapists about best practices, which should begin to narrow the variation in practice patterns. Practice guidelines could also form the basis of Medicare's medical reviews of the appropriateness of PT services. Until evidence-based research has established when and how much PT services benefit the typical beneficiary, retaining the physician requirements is one, albeit imperfect, way to curtail unnecessary services.

The American Physical Therapy Association (APTA) has two initiatives underway that will help disseminate information about the effectiveness of physical therapy services. First, it developed an electronic patient record that includes an outcomes instrument, which it will market in the spring 2005. These data are intended to lead to the development of a national outcomes data base. Second, it has established and made available to its membership an information repository of 1,600 articles summarizing the peer reviewed literature on treatment effectiveness. Expanding the availability of this information to those physicians who refer many patients to PT would help them assess when and how much therapy is likely to benefit patients.

Physician requirements may not increase the cost of care

Proponents of eliminating the physician requirements claim that eliminating the requirement for physician referrals would increase the cost effectiveness of care. They say that the program would save money on physician office visits and beneficiaries would save on the associated copayments.

²⁵ In the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999, the Congress required that CMS recommend a mechanism to assure the appropriate utilization of outpatient therapy services and conduct focused medical review of part B therapy claims, in particular SNF claims for 2000 and 2001. A year later, in the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, it extended the requirement for focused review of SNF therapy claims until 2003.

Sometimes, however, the patient comes to the physician's office with a medical complaint and the physician does not recommend physical therapy as part of the treatment plan. For this patient, the requirement for a physician referral results in better medical care that may be more cost effective. The physician referral requirement may lower the amount of unnecessary care that is provided and result in net savings to the program. Other beneficiaries have multiple health conditions that require medical attention. Even if the referral requirement were lifted, these beneficiaries would still see their physicians for their other medical conditions. For these patients, their physician office visits would not be eliminated and there may be no savings, depending on what remaining physician services are furnished.

Supporters point to a study done of Maryland Blue Cross Blue Shield claims comparing the cost of care for patients with and without a physician referral for physical therapy. This study, funded by APTA, found that the care provided to patients without a physician referral was shorter in duration and about half the cost of care initiated with a physician referral.²⁶ However, the authors acknowledge that differences in severity between patients seen by physical therapists and physicians could explain the differences in the cost of care. Direct measures of severity were not included in the analysis. Further, because the study did not include Medicare beneficiaries, it is not clear if similar cost differences would be observed in an older and sicker population.

Beneficiary access to physical therapy services appears good

Proponents of removing the physician referral requirement assert that the elimination of delays associated with getting a physician referral would promote quicker recoveries for beneficiaries who would benefit from physical therapy.²⁷ Yet, most beneficiaries report that they do not encounter problems in getting special therapy services (which include physical and occupational therapies and speech-language pathology services.)²⁸ In 2003, 85 percent of beneficiaries reported having no problems, an increase over the share in 2000 (Table 2). Across all beneficiaries, the share of beneficiaries reporting "big" and "little" problems decreased, with 6 percent reporting "big" problems and 8 percent reporting "little" problems in 2003, though these problems may not be related to the physician referral requirement. Almost all of the subgroups of beneficiaries reported fewer problems in 2003 than in 2000. Access to special therapy services is not uniform across all subgroups of beneficiaries, similar to differences noted for other health care services.²⁹ But even among subgroups reporting the most problems getting special therapy services, over 70 percent of beneficiaries report no problems.

²⁶ Mitchell, Jean M., and Gregory de Lissovoy. 1997. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy. *Physical Therapy* 77, no. 1 (May): 10–17.

²⁷ For example, in 2000, one third of beneficiaries waited a week or more for an appointment for a specific problem. Trude, Sally, and Paul B. Ginsburg. 2002. *Growing physician access problems complicate Medicare payment debate*. Washington, DC: Center for Studying Health System Change. These delays are not, however, specific to waiting times associated with obtaining a referral for PT services.

²⁸ Beneficiaries may report access problems to services that are not medically appropriate or necessary. Ideally, our access measures would reflect beneficiaries' ability to get appropriate care.

²⁹ Medicare Payment Advisory Commission. 2004b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. Chapter 1.

Table 2
Most beneficiaries report no problems getting special therapy services

Beneficiary group	2000	2003
Beneficiaries reporting no problems	83%	85%
Urban	82	85 ^a
Rural	84	87 ^a
Under age 65	72 ^b	71 ^b
65–74	85 ^b	87 ^b
75 and older	85 ^b	89 ^b
Dual eligible	75 ^a	77 ^a
Nondual eligible	85 ^a	87 ^a
White	84 ^c	87 ^c
African American	76 ^c	79 ^c
Other race	72 ^c	73 ^c
Beneficiaries reporting “big” problems	8	6
Urban	9 ^a	7 ^a
Rural	8 ^a	5 ^a
Under age 65	16 ^b	16 ^b
65–74	7 ^b	5 ^b
75 and older	7 ^b	4 ^b
Dual eligible	13 ^a	1 ^a
Nondual eligible	7 ^a	5 ^a
White	8 ^c	6 ^c
African Americans	13 ^c	10 ^c
Other race	13 ^c	12 ^c
Beneficiaries reporting “little” problems	9	8
Urban	9	9 ^a
Rural	8	7 ^a
Dual eligible	12 ^a	13 ^a
Nondual eligible	8 ^a	8 ^a
Under age 65	9 ^b	7 ^b
65–74	12 ^b	12 ^b
75 and older	8 ^b	7 ^b
White	8 ^c	7 ^c
African Americans	11 ^c	11 ^c
Other race	15 ^c	15 ^c

Note: Special services include physical and occupational therapy and speech and language pathology services. There is some overlap between these subgroups. Dual eligible beneficiaries are disproportionately under age 65, African American, or Hispanic (included in the “other race” category).

^a Differences between the subgroups are statistically significant.

^b Differences between the subgroups of older beneficiaries (age 65–74 and 75 and older) and the under age 65 subgroup are statistically significant.

^c Differences between the African American and the other race subgroups are statistically significant from the white subgroup but not from each other.

Source: MedPAC analysis of the 2000 and 2003 Consumer Assessment of Health Plans Survey.

Another measure of access is the number of beneficiaries receiving outpatient therapy services. Access appears to be stable, although this measure does not consider if the services were appropriate. Between 1998 and 2000, the number of Medicare beneficiaries receiving outpatient therapy services increased 2 percent, identical to the increase in the number of beneficiaries.

Conclusions

Several compelling reasons argue for retaining Medicare's current requirements that physicians refer beneficiaries to PT services and oversee their care. These requirements are in place so that beneficiary health care needs are correctly diagnosed, referred for treatment, and followed up. Given many beneficiaries' multiple and chronic health problems, the requirements encourage coordination of the medical care beneficiaries receive. The current requirements do not appear to impair access for most beneficiaries. Most private payers also restrict their coverage of outpatient physical therapy services, either by requiring physician referrals or setting service limits, or both. Were Medicare to eliminate its only method of controlling service use, it would need to consider alternative ways to screen services so that unnecessary care—already a problem with the current requirements—does not increase. Finally, lifting the referral requirements for physical therapy services would set a precedent for other services with similar coverage requirements.

While the current requirements are necessary, MedPAC acknowledges that they are not as effective as they might be at controlling unnecessary service provision. Provider education—for the physicians making the PT referrals and the therapists furnishing the services—is a key component to eliminating services of marginal value to beneficiaries. Evidence-based practice guidelines would help establish when and for how long beneficiaries would typically benefit from physical therapy services, thereby reducing the amount of inappropriate and medically unnecessary care. MedPAC encourages the physical therapy profession to help develop this body of evidence and use it to establish credible guidelines for outpatient physical therapy services furnished to older patients. These guidelines could then be used to educate physical therapists and physicians about PT service provision that is likely to be effective for beneficiaries.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Identical letter sent to the Honorable J. Dennis Hastert

Enclosures

Study mandate

Sec. 647. MedPAC study on direct access to physical therapy services of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(a) Study—The Medicare Payment Advisory Commission (in this section referred to as the “Commission”) shall conduct a study on the feasibility and advisability of allowing medicare [sic] fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.)

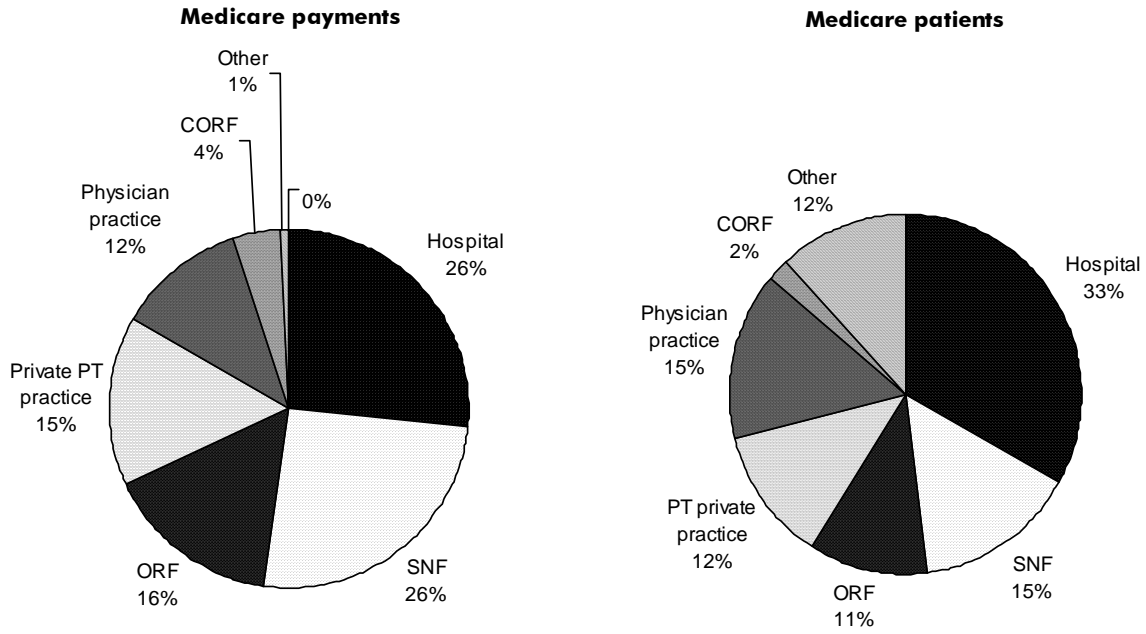
(b) Report—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

c) Direct Access Define—The term “direct access” means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage and payment for services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

1. without regard to any requirement that—
 - A. an individual be under the care of (or referred by) a physician; or
 - B. services be provided under the supervision of a physician; and
2. by allowing a physician or qualified physical therapist to satisfy any requirement for—
 - A. certification and recertification; and
 - B. establishment and periodic review of a plan of care.

Attachment B

Medicare payments and Medicare patients in 2000, by setting



Note: CORF (comprehensive outpatient rehabilitation facility), PT (physical therapy), ORF (outpatient rehabilitation facility), SNF (skilled nursing facility). Other includes other institutions such as home health agencies and ambulatory surgical centers.

Source: Olshin et al. 2002. Study and Report on Outpatient Therapy Utilization: Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Billed to Medicare Part B in All Settings in 1998, 1999, and 2000. Columbia, MD: Advance Med, 2002. Table 14 and Figure 20.