CHAPTER 9

Mandated report: Improving Medicare's payment system for outpatient therapy services

RECOMMENDATIONS

9-1 The Congress should direct the Secretary to:

- reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and
- develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

9-2 To avoid caps without exceptions, the Congress should:

- reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index.
- direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose.
- permanently include services delivered in hospital outpatient departments under therapy caps.
- apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

9-3 The Congress should direct the Secretary to:

- prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and
- collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 9

Mandated report: Improving Medicare's payment system for outpatient therapy services

Chapter summary

Medicare's outpatient therapy benefit covers services for physical therapy, occupational therapy, and speech–language pathology. These services can be beneficial when medically necessary but may be subject to inappropriate use. The Middle Class Tax Relief and Job Creation Act of 2012 required the Commission to study outpatient therapy services provided under Medicare Part B and make recommendations for reforming Medicare's payment system for these services by June 15, 2013. The legislation directed the Commission to examine two areas: (1) how to better document patients' functional limitations and severity of condition and thus better assess patients' therapy needs, and (2) private sector initiatives to manage outpatient therapy. The Commission issued recommendations to the Congress in November 2012, in advance of the statutory report deadline, because certain statutory provisions related to Medicare's outpatient therapy benefit were scheduled to expire at the end of 2012. The recommendations in this report are based on information available and analyses completed at that time.

Outpatient therapy services are designed to restore function that patients have lost due to illness or injury and to help patients maintain improved function. Physical therapy can improve a patient's balance, strength, mobility, and independence. Occupational therapy can improve a patient's ability to perform activities of daily living, such as bathing, dressing, and managing medications.

In this chapter

- Introduction
- Medicare payment policy for outpatient therapy services
- Medicare spending on outpatient therapy services
- Recommendations

Speech therapy can improve language skills for patients who suffer from difficulty speaking after a stroke.

To qualify for coverage under the Medicare outpatient therapy benefit, beneficiaries must meet several conditions, which include (but are not limited to) being under the care of a physician and having a certified plan of care for therapy. Medicare pays for outpatient therapy services under the fee schedule for physicians and other health professionals. In 2011, Medicare spending on outpatient therapy totaled $5.7 billion, with services provided to 4.9 million beneficiaries. That year, about 45,000 physical therapists, occupational therapists, and speech–language pathologists billed Medicare independently for outpatient therapy services. Outpatient therapy services were delivered in skilled nursing facilities (37 percent of total spending), hospital outpatient departments (16 percent), outpatient rehabilitation facilities and home health agencies (11 percent), and other settings (7 percent). In office-based settings, physical therapists in private practice accounted for 30 percent of spending.

Under Medicare, there are two per beneficiary annual spending limits (caps) on outpatient therapy services to restrain excessive spending and utilization. There is one cap for physical therapy and speech–language pathology services combined and another cap for occupational therapy services. Each cap equals $1,900 in allowed charges for 2013. A broad exceptions process allows providers to deliver services above either spending cap relatively easily, limiting the effectiveness of the caps. There also is a manual review process, implemented in October 2012, for beneficiaries whose annual spending on occupational therapy or physical therapy and speech–language pathology services combined exceeds $3,700, but it does not apply to the majority of beneficiaries who exceed the caps. While the caps are permanent by statute, the exceptions process expires periodically under current law unless explicitly reauthorized by the Congress. At the time the Commission prepared this report, the exceptions process was scheduled to expire on December 31, 2012. However, the American Taxpayer Relief Act of 2012 extended the exceptions process from January 1, 2013, through December 31, 2013. Had the exceptions process expired, the caps would have been enforced with no process for beneficiaries to obtain additional outpatient therapy services beyond the caps.

The Commission found that outpatient therapy services can help Medicare beneficiaries improve their level of function and live independently, but at the same time, Medicare's outpatient therapy benefit is vulnerable to abuse. Medicare lacks clear guidelines to determine the appropriate frequency, type, and duration of outpatient therapy services. Further, Medicare's physician oversight requirements for outpatient therapy are relatively weak—once a physician or nonphysician practitioner certifies that a beneficiary requires outpatient therapy, the beneficiary

can receive services for 90 days without further oversight. Due to the lack of comprehensive coverage guidelines and effective mechanisms to control volume, the use of outpatient therapy varies widely across the country. Medicare spending on outpatient therapy users in the highest spending areas of the country is five times more than that in the lowest spending areas of the country, even after controlling for differences in patients' health status.

To evaluate the recommendations for improving Medicare's outpatient therapy benefit, the Commission specifically focused on each recommendation's effect on program spending, quality of care, and beneficiaries' access to care. We also considered whether a recommendation would advance payment reform—that is, move Medicare payment policy away from fee-for-service payment toward a more integrated delivery system. The Commission's recommendations aim to strike a balance between ensuring access to needed care and discouraging unnecessary service use.

The Commission's recommendations are intended to decrease inappropriate use of outpatient therapy services and to provide the Medicare program with essential data on patients' conditions, services received, and outcomes. The recommendations would improve payment accuracy by fully accounting for the efficiencies of a single provider delivering multiple therapy services to a patient on the same day, increase physician oversight of outpatient therapy regimens, and provide physicians and therapy practitioners with clear guidance regarding when such services are medically indicated and the outcomes that should be expected. The recommendations also lay out a rigorous review process designed to minimize the potential for abuse of the outpatient therapy benefit while giving beneficiaries who need higher levels of outpatient therapy the means to obtain it. Enactment of the Commission's recommendations would increase Medicare spending for outpatient therapy services relative to a policy of hard therapy caps (i.e., caps with no exceptions). However, hard therapy caps would decrease access to therapy services not only for those who might otherwise receive questionable levels of therapy but also for those whose medical conditions appropriately warrant high levels of therapy services. ■

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

SEC. 3005. PAYMENT FOR OUTPATIENT THERAPY SERVICES.

(f) MedPAC Report on Improved Medicare Therapy Benefits.—Not later than June 15, 2013, the Medicare Payment Advisory Commission shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and to the Committee on Finance of the Senate a report making recommendations on how to improve the outpatient therapy benefit under part B of title XVIII of the Social Security Act. The report shall include recommendations on how to reform the payment system for such outpatient therapy services under such part so that the benefit is better designed to reflect individual acuity, condition, and therapy needs of the patient. Such report shall include an examination of private sector initiatives relating to outpatient therapy benefits. ■

Introduction

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required the Commission to study the Medicare outpatient therapy benefit and make recommendations on how to improve the payment system (see text box). The law also directed the Commission to examine techniques used by private health plans to manage outpatient therapy benefits (see text box, p. 234). Underlying the Commission's mandate was the scheduled expiration at the end of 2012 of an exceptions process that allowed beneficiaries to receive outpatient therapy services above certain dollar limits, or "caps," which are set by law. To inform the Congress's work prior to this scheduled expiration of the caps' exceptions process, the Commission issued its recommendations to the Congress in November 2012. The recommendations in this report are based on information available and analysis completed by the Commission at that time.

To evaluate the recommendations for improving Medicare's outpatient therapy benefit, we considered each recommendation's effect on program spending, quality of care, and beneficiaries' access to care. We also considered whether they would advance payment reform—that is, move Medicare payment policy away from fee-for-service (FFS) payment and encourage a more integrated delivery system.

Definition of outpatient therapy

Outpatient therapy services include three separate categories of clinical services that aim to improve and restore function that patients have lost after an illness or injury and to help patients maintain improved function: physical therapy, occupational therapy, and speech–language pathology services. Descriptions of these services are as follows:

- ***Physical therapy*—**Restore and maintain physical function and treat or prevent further impairments that result from disease or injury. Treatment may include therapeutic exercise, manual therapy, patient education, and other interventions to improve strength and mobility, restore and maintain function, and increase independence. Examples of physical therapy outcomes include improved ability to stand, lift, carry, and walk independently.
- ***Occupational therapy*—**Restore and maintain the ability to conduct activities of daily living, such as bathing and dressing, and instrumental activities of daily living, such as food preparation and household management. Therapies may focus on motor skills, lifting, bending, feeding and swallowing, and time management. Outcomes may include bathing, dressing, and preparing a meal independently, with or without environmental modification or assistive technology.
- ***Speech–language pathology*—**Restore and maintain the ability to communicate, swallow, and speak. Speech–language pathology therapies include guided drills and training to improve speech and swallowing functions. Outcomes may include recovery of speech after a stroke (Centers for Medicare & Medicaid Services 2009).

Therapy services may be furnished by physicians or by physical therapists, occupational therapists, and speech–language pathologists in their respective disciplines. These services also may be furnished by physician assistants, nurse practitioners, and clinical nurse specialists, if permitted by the state in which the provider practices. Qualified physical and occupational therapy assistants may also provide therapy services when supervised by

Management techniques used by private plans and other payers

The Middle Class Tax Relief and Job Creation Act of 2012 required the Commission to evaluate private sector initiatives for outpatient therapy. The Commission engaged NORC (formerly National Opinion Research Center) at the University of Chicago and Georgetown University to evaluate techniques that private health plans (including Medicare Advantage plans), integrated delivery systems, and private benefit managers use to manage their enrollees' outpatient therapy use. Our contractors interviewed representatives from 10 health plans and integrated delivery systems and three large private benefit managers regarding their approaches to payment methods, utilization management methods, and outcomes measurement.

The most common utilization management technique is to limit the number of visits a patient can receive, after which further therapy may be authorized after a review for medical necessity. Plans vary widely in the visit limits they set. A few plans require prior authorization before any therapy; others require review and authorization to receive more services after 6 to 8 visits; most require authorization to continue after 20 or 30 visits. The intensity of the authorization process also varies; some involve routine checks against benchmarks (such as the average number of visits for other therapists), while others involve a careful review of the medical record and plan of care by a physician, nurse, or therapist.

Cost sharing is another common management technique among plans and benefit managers. Copays are almost always paid per visit and range from $10 to $35 per visit. One plan that had experimented unsuccessfully with a prior authorization program indicated that it has a high per visit copay of $50 to manage this benefit.

Most health plans did not manage the benefit by conducting wide-scale claims or postpayment reviews. Some plans used these tools to investigate fraud and abuse, identify outlier providers, and conduct audit and payment adjustment activities.

Most private plans do not require the use of a standard tool to collect functional status or improvement data. Therapists are required to document improvement in their patients in the medical record using the tool of their choice, but those data are not submitted with claims to plans or benefit managers.

In addition to our contract with NORC and Georgetown to examine how private plans manage outpatient therapy, we also spoke with staff at the Veterans Health Administration (VHA) to learn about their management techniques. The VHA uses methods similar to those used in the private sector to manage outpatient therapy services. It does not require the use of standard tools to measure functional status and improvement but requires a certified plan of care that lasts no more than 60 days. While there are no visit limits, the VHA charges copayments for outpatient therapy services—$15 per visit for physical therapy and occupational therapy services and $50 per visit for specialized services. ■

physical and occupational therapists, respectively. Athletic trainers, chiropractors, nurses, and nurse aides do not meet Medicare's qualification and training requirements for therapists and therefore can neither provide nor bill Medicare for therapy services.

Many types of patients can benefit from outpatient therapy. For example, for people recovering from a stroke, physical therapy can facilitate the recovery of balance and strengthen a lower paretic limb (Van Peppen et al. 2004). Stretching and strengthening physical therapy exercises can improve symptoms associated with chronic lower back pain (Hayden et al. 2005). Further, physical therapy can reduce a beneficiary's risk of falling (Michael et al. 2010). Occupational therapy can improve a patient's ability to perform activities of daily living (Donnelly and Carswell 2002). For people with rheumatoid arthritis, for example, occupational therapy is effective in reducing pain (Steultjens et al. 2002). Several studies show that patients who receive occupational therapy after a stroke have a lower risk of death, deterioration, and dependency in personal activities of daily living (Legg et al. 2007). In addition, occupational therapy interventions for community-dwelling older adults, particularly those who

live alone, can improve their functional ability, social participation, and quality of life (Steultjens et al. 2004).

Intense speech therapy over a shorter time has been found to improve the speaking ability of patients who suffer from apahsia (difficulty speaking) following a stroke (Bhogal et al. 2003). For people with Parkinson's disease, speech therapy has been shown to improve vocal intensity and to decrease complaints of weak, monotonous, and unintelligible speech (de Angelis et al. 1997). Speech–language pathology services may also help patients restore communicative, cognitive, and swallowing function after a stroke or head injury or because of declining motor control (Robbins et al. 2008).

While outpatient therapy can improve outcomes for patients with certain conditions, the challenge for Medicare is ensuring that therapy services are delivered to the patients who will benefit from them. The Commission believes that Medicare needs to gather more clinical data on outcomes to better determine who needs therapy services and the relative effectiveness of their treatment.

Medicare's coverage of outpatient therapy

To be covered by Medicare, a beneficiary's need for physical therapy, occupational therapy, or speech–language pathology services must be documented in a written treatment plan developed by the beneficiary's therapist, a physician, or a nonphysician practitioner after consultation with a qualified therapist. The plan of care must be established prior to initiating treatment. The prescribed course of therapy must be reasonable and necessary to treat the individual's illness or injury.

Among other requirements, covered therapy services must:

- qualify as skilled therapy services appropriate for specific and effective treatment of the patient's condition, and
- be sufficiently complex and sophisticated such that the services required can be safely and effectively performed only by a qualified therapist or under the supervision of a qualified therapist (Centers for Medicare & Medicaid Services 2009).[1]

In the absence of detailed national coverage policy, each Medicare administrative contractor (MAC) has developed local coverage policies, called local coverage determinations, for outpatient therapy services provided to beneficiaries in their regions (text box, p. 237).

Characteristics of outpatient therapy users

In 2011, about 4.9 million beneficiaries (15 percent of FFS beneficiaries) received outpatient therapy services. Compared with the Medicare Part B FFS population, outpatient therapy users generally were older (73 years vs. 70 years), more likely to be women (64 percent vs. 55 percent), more likely to be White (87 percent vs. 83 percent), and more likely to be dually eligible for Medicare and Medicaid (28 percent vs. 20 percent).

The diagnosis codes used to bill therapy services tend to be nonspecific International Classification of Diseases, Ninth Revision (ICD–9) codes (e.g., pain in joint), and many are V codes, which are nondescriptive codes that reflect the services patients receive and not their clinical condition.[2] We classified ICD–9 codes into larger disease categories to determine the main clinical conditions of therapy beneficiaries (Elixhauser and McCarthy 1996). For physical and occupational therapy, the most frequent diagnosis categories are back problems, nontraumatic joint disorders, and connective tissue disorders (Table 9-1, p. 236). Speech–language pathology patients tend to have conditions largely classified as gastrointestinal disorders (related to difficulties with swallowing), and many suffer from delirium, dementia, and other cognitive disorders. Current data do not permit a more detailed description of the clinical conditions of Part B beneficiaries who use therapy services.

To measure patient severity, we used risk scores from the hierarchical condition categories (HCC) risk-adjustment model. HCC risk scores predict beneficiaries' relative costliness based on their diagnoses from the prior year and demographic information (e.g., age and sex) (Table 9-2, p. 236). In 2009, Medicare outpatient therapy users had a higher mean risk score (1.51) than all Medicare beneficiaries (roughly 1.0), indicating greater patient severity among therapy users. Physical therapy users had lower risk scores (1.47) than occupational therapy users (2.02) and speech–language pathology users (2.23). Of those who received therapy in a nursing facility, beneficiaries who were residents had higher risk scores (2.46) than nonresidents (1.78).[3]

Medicare payment policy for outpatient therapy services

In accordance with the Balanced Budget Act of 1997, Medicare pays for outpatient therapy services under the

TABLE 9–1 **Top five clinical categories by therapy type, 2009**

Clinical category	Share of total claims within therapy type
Physical therapy	
Back problem	27%
Other nontraumatic joint disorders	19
Other connective tissue disease	15
Osteoarthritis	9
Other nervous system disorders	7
Occupational therapy	
Other connective tissue disorder	16
Other nontraumatic joint disorders	12
Rehabilitation care, fitting for prostheses, adjustment of devices	9
Other nervous system disorders	9
Osteoarthritis	8
Speech–language pathology	
Other gastrointestinal disorders	24
Rehabilitation care, fitting for prostheses, adjustment of devices	14
Delirium, dementia, and amnestic and other cognitive disorders	7
Other nervous system disorders	7
Late effects of cerebrovascular disease	6

Note: Ranking is based on the number of claims from 2009 that fall under each clinical classification determined by the Agency for Healthcare Research and Quality software (Elixhauser and McCarthy 1996).

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2009.

fee schedule for physicians and other health professional services regardless of whether the services are provided in facilities or in professional offices. Under the fee schedule, most physical therapy and occupational therapy codes are defined in 15-minute increments, but most speech–language pathology services are not. Each service's procedure code has a separate payment rate that is determined by multiplying each code's relative weight—expressed as relative value units (RVUs)—by a standard dollar amount (the conversion factor). The resulting payment rate is then adjusted for geographic differences in input prices. Each service's RVUs include three components: (1) work, which accounts for the therapist's time and skill; (2) practice expense, which covers the cost of ancillary clinical staff (such as a physical therapy assistant or physical therapy aide), medical supplies, medical equipment, and overhead; and (3) professional liability insurance.[4]

Therapy services may be covered under Part B when they are provided in various settings—such as an outpatient rehabilitation facility, a therapist's office, a hospital, a critical access hospital, or a beneficiary's residence. Medicare beneficiaries who are hospital inpatients and who have exhausted their Part A–covered benefits may have medically necessary therapy services covered under the Part B outpatient therapy benefit. Part B also covers therapy for Medicare patients residing in a skilled nursing facility (SNF) whose stay is not covered by Part A and for nonresidents who receive outpatient rehabilitation services from the nursing facility. Similarly, outpatient therapy services that are delivered by home health agencies to beneficiaries who are not homebound, and therefore not receiving services under a home health plan of care, are paid for under the Part B fee schedule. Therapy services provided by home health agencies under a home health plan of care are covered under the home health prospective payment system.

As with other Part B benefits, Medicare beneficiaries are responsible for paying coinsurance for outpatient therapy services. This coinsurance is equal to 20 percent of the Medicare allowed amount for each service. Over 90 percent of beneficiaries in traditional FFS Medicare

TABLE 9–2 **HCC risk scores by outpatient therapy user group, 2009**

Therapy user group	Mean risk score
All Medicare outpatient therapy users	1.51
Physical therapy user	1.47
Occupational therapy user	2.02
Speech–language pathology user	2.23
Prior hospitalization (≤ 30 days before therapy)	1.72
No prior hospitalization	1.49
Nursing facility user (resident)	2.46
Nursing facility user (nonresident)	1.78

Note: HCC (hierarchical condition categories).

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2009.

National and local coverage determinations for outpatient therapy

Medicare's coverage policies for outpatient therapy are broad. We examined national coverage determinations (NCDs) for outpatient therapy, which are issued by CMS, and local coverage determinations (LCDs), which are written by Medicare administrative contractors (MACs).[5] We identified few NCDs related to outpatient therapy. With the exception of speech–language pathology services, NCDs generally do not address the most common outpatient therapy services. An NCD for speech–language pathology covers these services for the treatment of dysphagia (a swallowing disorder that may be due to neurological, structural, or cognitive deficits). The NCDs for physical and occupational therapy are limited to specific services such as infrared therapy devices and neuromuscular electrical stimulation. For example, the NCD on infrared therapy devices does not cover their use for the treatment of symptoms related to peripheral sensory neuropathy and certain other conditions (Centers for Medicare & Medicaid Services 2012d).

We examined LCDs issued by eight MACs for outpatient therapy services. The LCDs allow broad coverage for the most common types of therapy services, and their coverage rules usually are consistent with one another. The most commonly billed outpatient therapy service is "therapeutic exercises to develop strength and endurance, range of motion, and flexibility" (Current Procedural Terminology (CPT) code 97110), and this service is considered medically necessary for many types of conditions. For example, one MAC, Trailblazer, covers therapeutic exercises for a loss or restriction of joint motion, strength, functional capacity, and mobility resulting from a disease or injury (Centers for Medicare & Medicaid Services 2012c). Similarly, the second most common therapy service—therapeutic activities (CPT 97530)—is considered medically necessary for patients needing a broad range of rehabilitative techniques.

Two MACs, Novitas and Trailblazer, limit the number of therapy services that can be provided per patient without a review of medical records. They allow 5 physical therapy or occupational therapy services per patient per day (each unit of service is 15 minutes) and 60 physical therapy or occupational therapy services per patient per month (Centers for Medicare & Medicaid Services 2012c). For services beyond these limits, these MACs require a review of medical records to determine medical necessity. Similarly, the Wisconsin Physicians Insurance Corporation states that therapy sessions longer than 60 minutes (i.e., 4 units of service), except for an evaluation, must be accompanied by documentation that supports the medical necessity of the duration of the session and the number of interventions performed (Centers for Medicare & Medicaid Services 2012a).

Some LCDs limit certain modalities, which are treatments that are sometimes used in association with therapeutic exercises and activities. For example, First Coast Service Options and Palmetto GBA limit coverage of therapeutic ultrasound (CPT 97035), which is a deep heating modality that uses sound waves to increase muscle, tendon, and ligament flexibility (Centers for Medicare & Medicaid Services 2012b). These MACs limit this modality to three or four treatments per week for one month.[6] ■

have all or some of their Part B coinsurance liabilities covered by private supplemental insurance or Medicaid (Medicare Payment Advisory Commission 2012). Because of the extent of supplemental insurance coverage, many outpatient therapy users are insulated from cost sharing for their therapy services.

Outpatient therapy caps

To constrain excessive spending and utilization, the Congress enacted two caps on annual per beneficiary spending for outpatient therapy services: one for physical therapy and speech–language pathology services combined and another for occupational therapy services. The dollar amount of each cap was $1,880 in 2012 and $1,900 in 2013.[7] The caps are adjusted annually according to the change in the Medicare Economic Index. The annual cap amount is unrelated to the condition for which a particular beneficiary is receiving therapy. Consequently, the cap policy initially caused concerns that it could restrict access to medically necessary services.

TABLE 9–3

Distribution of Medicare spending on outpatient therapy services by percentile of users, 2011

Percentile of users	Allowed charges: Physical therapy and speech–language pathology	Allowed charges: Occupational therapy
5	$70	$74
10	106	77
15	149	101
20	211	131
25	286	179
30	365	246
35	449	331
40	535	427
45	629	535
50	731	656
55	845	793
60	974	950
65	1,124	1,135
70	1,301	1,354
75	1,513	1,603
80	1,750	1,913
85	2,098	2,387
90	2,734	3,118
95	4,025	4,435
99	7,799	7,925

Note: Users in the 100th percentile were outliers, totaling $54,641 for physical therapy and speech–language pathology and $36,187 for outpatient therapy. Each therapy cap amount was $1,870 in 2011.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

In addition, therapy providers raised concerns that they would not know if a beneficiary was approaching the cap if the beneficiary also received services from other providers. Hospital outpatient departments (HOPDs) were initially excluded from the caps with the rationale that beneficiaries with high care needs would receive therapy services in that setting, but eventually they were included in the caps as well (Maxwell et al. 2001). These concerns led the Congress to suspend the caps from 2000 to 2005 (except for September 1, 2003, through December 7, 2003, when the provision suspending the caps expired). In 2006, the Congress reinstated the caps along with an exceptions process intended to address the beneficiary access and provider concerns. In 2011, between 80 percent and 85 percent of physical therapy and speech–language pathology therapy users had spending below the cap, and between 75 percent and 80 percent of occupational therapy users had spending below the cap (Table 9-3).

Exceptions process for therapy caps

As noted earlier, the Congress established an exceptions process in 2006 to allow beneficiaries to exceed the statutory per beneficiary annual spending cap if the responsible clinician certifies that continued therapy services are medically necessary. Patients who had qualifying conditions or complexities could use an automatic process to exceed the therapy caps. Patients who were not eligible for the automatic exceptions process could apply for a manual exception if they believed that they required services beyond the cap. In 2007, the exceptions process became fully automatic, allowing a clinician to certify the medical necessity of therapy services in excess of the cap by adding a modifier to the therapy procedure code on a claim. These claims are subject to manual review for medical necessity, but in practice, the frequency of these reviews and subsequent denials appears to be relatively low.[8]

Unlike the caps, the exceptions process expires periodically under current law unless explicitly reauthorized by the Congress. The Medicare and Medicaid Extenders Act of 2010 extended the therapy cap exceptions process from its original expiration date of December 31, 2010, until December 31, 2011; MCTRJCA extended it through December 31, 2012; and the American Taxpayer Relief Act of 2012 (ATRA) extended it through December 31, 2013.

Medical reviews for therapy services beyond a $3,700 threshold

In 2012, the Congress introduced additional reviews of therapy services for the highest spending beneficiaries. MCTRJCA required CMS to conduct manual medical reviews between October 1, 2012, and December 31, 2012, for therapy claims that exceeded a specified spending threshold. ATRA extended this requirement until December 31, 2013. Under this provision, CMS must review claims submitted on behalf of beneficiaries whose use of outpatient therapy services exceeded $3,700 in spending for physical therapy and speech–language pathology services combined or for occupational therapy services separately. The top 5 percent of outpatient therapy users in 2008 and 2009 reached this spending level.

Under the manual review process, CMS requires providers to obtain prior approval before delivering therapy services

The use of advance beneficiary notice of noncoverage

The advance beneficiary notice (ABN) informs a beneficiary that Medicare may not consider a given service to be medically reasonable and necessary for the patient in a particular instance and therefore may not cover the service and pay the usual 80 percent of the allowed charge. The information contained in an ABN is intended to allow a beneficiary to make an informed decision about whether to receive additional therapy services and to accept responsibility for payment in full for those services if Medicare does not cover and pay for them.

According to a provision of the American Taxpayer Relief Act of 2012, if a beneficiary has met his or her treatment goals but prefers to continue with therapy services for reasons that are unrelated to medical necessity, the provider must issue an ABN before the beneficiary can be held liable for the cost of the additional services. In order to be paid, the provider cannot bill the beneficiary directly; the claim must first be submitted to Medicare. If Medicare denies the claim based on an assessment that the services were not medically reasonable and necessary, the provider can then bill the beneficiary. If the provider fails to issue a valid ABN to the beneficiary, the provider may not bill the beneficiary for the services and assumes financial responsibility for those services if Medicare denies coverage. ■

beyond the $3,700 threshold. Providers' requests—submitted by mail or by fax to their MAC—must include certain administrative information regarding the beneficiary, the provider certifying the care, the provider performing treatment, and dates of service. Requests also have to include justification for the additional services, objectives and measurable goals, other documentation required by local coverage determinations, progress reports, treatment notes, and other information requested by the MAC.

The provider can request approval for additional therapy in increments of 20 treatment days. Once approval is granted, the provider can continue to deliver therapy services for the number of days approved by the MAC. If the approval is not granted, Medicare will not pay for additional services. If the provider chooses to deliver additional services before a request is approved, the beneficiary could be liable for the cost of those services if the request is denied and if the beneficiary has been issued an advance beneficiary notice (see text box).

Because of the limited methods available for providers to submit requests (via fax or mail only) and the amount of documentation required by the MACs, some providers reported spending many hours submitting requests, which may have caused delays in care. Providers may submit their requests for approval up to two weeks before the patient would exceed the $3,700 threshold in order to minimize such delays. CMS reported that some providers submitted requests with incomplete information—for example, without the name of the beneficiary or provider—which led to denials that could delay the provision of therapy.

Medicare spending on outpatient therapy services

In 2011, Medicare spending on outpatient therapy totaled $5.7 billion for services provided to 4.9 million beneficiaries (Table 9-4, p. 240). Spending on physical therapy ($4.1 billion) accounted for about two-thirds of all therapy services; this proportion has been relatively stable over time. Spending on occupational therapy and speech–language pathology services totaled about $1.1 billion and $540 million, respectively. In 2011, about 15 percent of Part B beneficiaries used therapy services, and the average Part B payment per therapy user was just under $1,200. The number of days (from the first date of service to the last) of an episode of care averaged 33 days across all therapy types.

The sites where outpatient therapy services are furnished shifted somewhat from 2004 to 2011 (Figure 9-1, p. 240). In 2004, Medicare spent about $4.3 billion on outpatient therapy services. Payments to physical therapists in private practice accounted for almost one-quarter of Medicare spending in that year. Among facilities, nursing facilities made up the largest share of therapy spending, followed

TABLE 9–4

Spending for and utilization of Medicare outpatient therapy services, 2011

		Spending			Utilization		
	Number of beneficiaries (in millions)	Total (in billions)	Share by type	Per user	Per user service counts	Mean number of visits per user	Mean length of episode (in days)
Physical therapy	4.3	$4.1	71%	$942	47	13	34
Occupational therapy	1.1	1.1	19	1,026	48	14	28
Speech–language pathology	0.6	0.5	10	981	18	12	34
Total	4.9	5.7	100	1,173	54	16	33

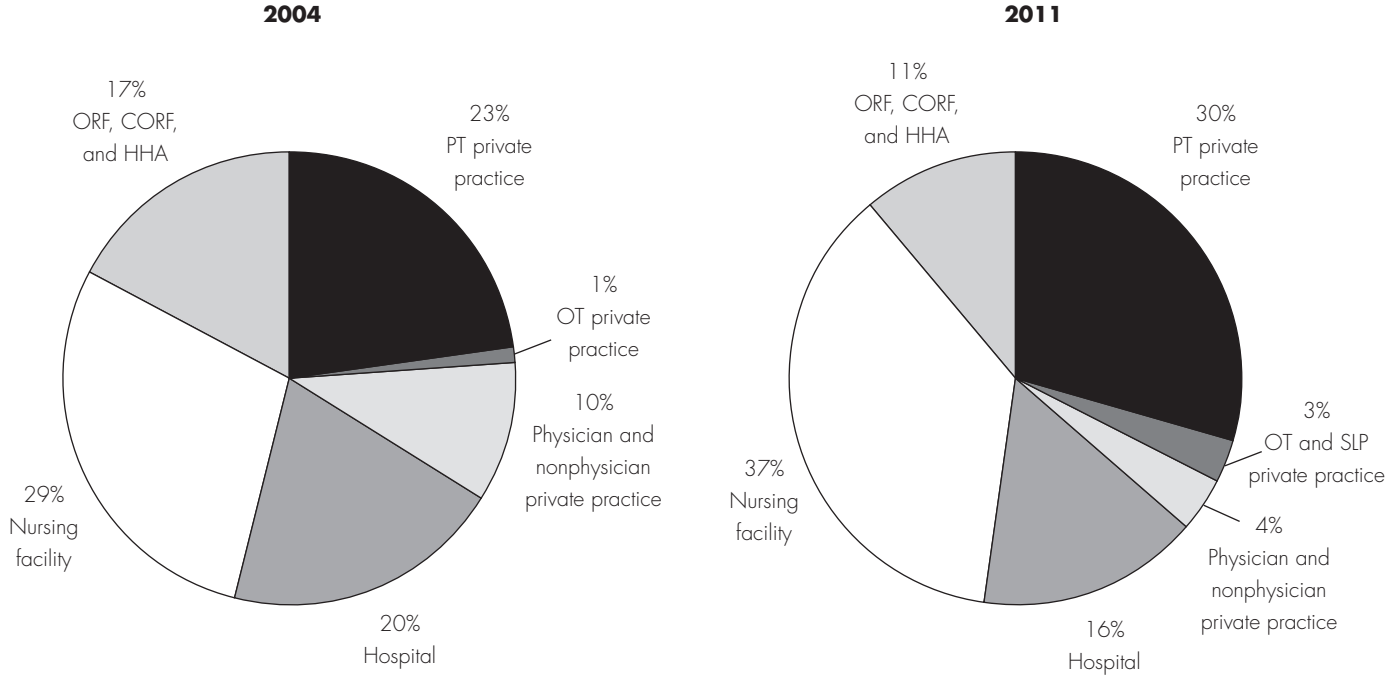
Note: Totals include beneficiaries who use multiple therapy types. Total number of beneficiaries is an unduplicated count. Service counts are miles/time/units/services (Medicare physician fee schedule) and revenue center unit (facility) counts. Per user service counts show the number of 15-minute service codes billed per user for occupational and physical therapy. Most speech–language pathology service codes are not defined in 15-minute timed increments. An episode begins with the first therapy service provided during the year and ends after a 30-day period during which there are no additional therapy services.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

by HOPDs, outpatient rehabilitation facilities, and home health agencies. From 2004 to 2011, the shares of spending grew for physical therapists in private practice and nursing facilities, while shares shrank in physicians' offices, outpatient rehabilitation facilities, home health agencies, and hospitals. In 2011, spending on outpatient therapy services in facility settings was most often provided in nursing facilities (37 percent of total spending). Spending in nonfacility settings was driven by physical therapists in private practice (30 percent of total spending).

FIGURE 9–1

Distribution of outpatient therapy spending by setting, 2004 and 2011



Note: ORF (outpatient rehabilitation facility), CORF (comprehensive outpatient rehabilitation facility), HHA (home health agency), PT (physical therapy), OT (occupational therapy), SLP (speech–language pathology). Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2004 and 2011.

TABLE 9–5 **Medicare spending for outpatient therapy services, 2004–2011**

Year	Medicare spending (in billions)	Share of all FFS Part B beneficiaries who used therapy	Average spending per user	Annual change in per user spending
2004	$4.3	13%	$994	
2005	N/A	N/A	N/A	N/A
2006	4.1	13	926	N/A
2007	4.4	14	999	8%
2008	4.8	14	1,057	6
2009	5.3	14	1,165	10
2010	5.6	15	1,182	1
2011	5.7	15	1,173	0

Note: FFS (fee-for-service), N/A (not available).

Source: MedPAC analysis of Medicare claims data and CMS contractor reports.

Growth in spending for outpatient therapy services

Overall, annual growth in spending on therapy services has been highly variable since 2004 (Table 9-5). Medicare spending per therapy user grew by 10 percent between 2008 and 2009 but remained constant between 2010 and 2011. The share of FFS beneficiaries who used therapy grew slightly from 13 percent in 2004 to 15 percent in 2011. The number of FFS beneficiaries using outpatient therapy increased by 10 percent between 2004 and 2011 even though FFS enrollment overall was virtually unchanged during this period.

From 2009 to 2011, spending grew more slowly than in prior years and may reflect recent trends in the overall growth rate of Part B spending and health care spending in general. For example, total Medicare Part B spending grew by an annual average rate of 8 percent from 2005 to 2009 but slowed to 5 percent from 2009 to 2011 (Boards of Trustees 2012).

For much of the time that per beneficiary therapy spending caps have been in effect, the caps have been legislatively suspended or exceptions have allowed for substantial spending above the caps. The caps first took effect in 1999 and produced a noteworthy drop in per user spending relative to the preceding year (Figure 9-2, p. 242). From 2000 through 2005, the caps were suspended except for three months in 2003, and spending increased dramatically. In 2006, the therapy caps were reinstated and CMS implemented a two-part exceptions process to the caps that involved automatic and manual exceptions (Medicare Payment Advisory Commission 2006). Per user spending dropped in 2006 relative to 2004. Since the exceptions process became completely automatic in 2007, per user spending increased each year until 2011. These changes in spending from 1998 to 2011 demonstrate that, in the absence of clear directives from the program regarding the appropriate indications for outpatient therapy, providers appear to respond rapidly to changes in payment policy (similar to the responsiveness of SNFs and home health agencies to changes in Medicare payment policy for therapy services provided in the SNF and home health payment systems). This provider responsiveness raises questions about potential overuse of outpatient therapy services.

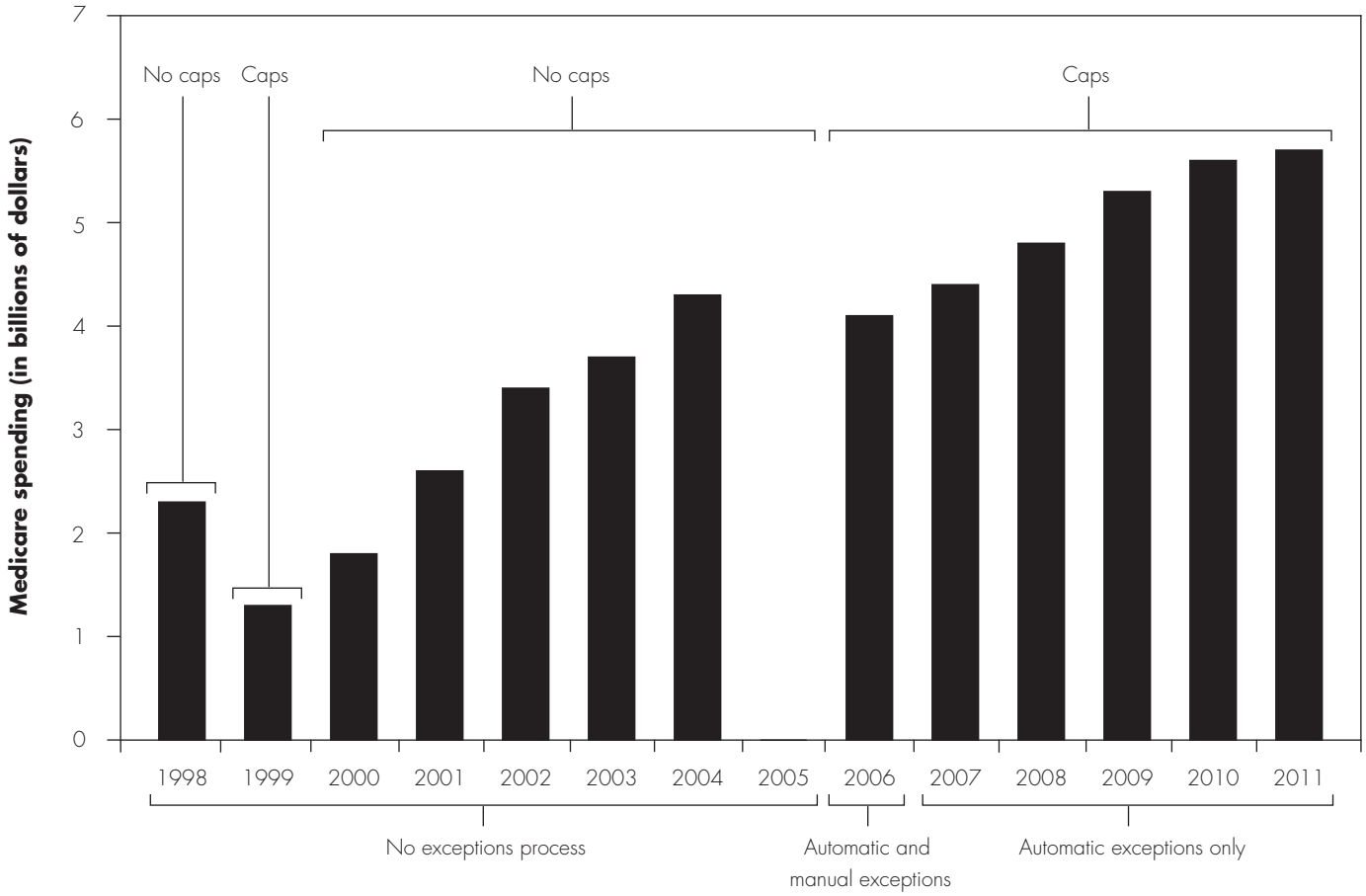
Geographic variation in spending on outpatient therapy

In 2011, Medicare spending on therapy services averaged $1,173 per user, but the top-spending counties spent five times as much per user as the bottom-spending counties, adjusting for differences in health status ($2,588 vs. $513). These findings raise questions about possible inappropriate use of the outpatient therapy benefit in some geographic areas.

Seven counties in Louisiana and 8 counties in Texas are among the 20 highest spending counties in the country (Table 9-6, p. 243). For example, Medicare spent almost $3,600 per beneficiary on outpatient therapy services in St. Mary's County, LA—more than three times the national average ($1,173). Spending on outpatient therapy services

FIGURE 9–2

Total Medicare spending on outpatient therapy services, 1998–2011



Note: Caps were in effect for a brief period from September 1, 2003, through December 7, 2003. Data were not available for 2005.

Source: MedPAC analysis of Medicare claims data and CMS contractor reports.

in Kings County and Queens County, NY, was also above the national average in 2011, accounting for $2,798 and $2,278 per user, respectively. These counties, which include the New York City boroughs of Brooklyn and Queens, have a combined total of about 77,000 Medicare therapy users, or 80 percent of the total number of therapy users in the 20 top-spending counties. More than 20 percent of all Part B beneficiaries in Kings County and Queens County are users of outpatient therapy services, which is higher than the national average of 15 percent. At these spending and use rates, overuse and potential fraud and abuse are concerns.

A noteworthy difference from earlier years (e.g., 2008 and 2009) is that Miami–Dade County, FL, was not a high-spending area in 2011. In 2009, Miami–Dade was the highest spending area in the country, with $4,500 in risk-adjusted spending per therapy user. In 2011, Medicare spent just under $2,000 per therapy user in Miami–Dade County. The significant drop in spending could be a result of recent press coverage and regulatory focus on fraud and abuse in outpatient therapy services in Miami–Dade. In December 2010, the *Wall Street Journal* published a story that highlighted a family practice physician in the Miami area who billed Medicare more than $1.2 million in 2008 alone (Schoofs and Tamman 2010). A large portion of his payments were for outpatient therapy services. The *Wall Street Journal* story also noted other physicians who billed for therapy at much higher rates than the average physician regularly billed for conditions that were extremely rare in the Medicare or even U.S. population, and whose Medicare

TABLE 9–6 **Twenty counties with the highest spending on outpatient therapy, 2011**

	State	County	Per user spending	Number of therapy beneficiaries	Share of FFS beneficiaries living in county who used therapy
National			$1,173	4.9 million	15%
1	LA	St. Mary's	3,582	759	10
2	TX	Jim Wells	3,293	515	11
3	LA	Avoyelles	2,799	685	10
4	NY	Kings	2,798	41,973	24
5	TX	Rusk	2,696	731	10
6	PA	Lawrence	2,653	1,193	16
7	TX	San Patricio	2,609	852	14
8	MS	Lincoln	2,581	781	13
9	TX	Hardin	2,550	662	10
10	LA	Lincoln	2,501	656	13
11	TX	Atascosa	2,492	521	12
12	TX	Angelina	2,490	1,385	11
13	FL	Okeechobee	2,478	763	16
14	TX	Upshur	2,461	537	9
15	LA	Iberia	2,328	1,067	10
16	LA	Ouachita	2,323	1,939	10
17	LA	Livingston	2,294	1,070	14
18	TX	Cherokee	2,285	684	9
19	NY	Queens	2,278	34,753	21
20	LA	Caddo	2,261	3,919	12

Note: FFS (fee-for-service). These counties had at least 500 Part B beneficiaries with spending for outpatient therapy services in 2011. Spending is risk adjusted for county health status using hierarchical condition categories risk scores.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

payments for outpatient therapy rose by millions of dollars in a year or two.

In 2010, the Office of Inspector General (OIG) at the Department of Health and Human Services reported on the growth in spending on outpatient therapy in the Miami–Dade area (Office of Inspector General 2010). The report cited therapy providers in the area who were engaging in questionable practices, such as high rates of billing above therapy caps. OIG recommended that CMS and its MACs:

- Monitor claims from high-use areas and perform further reviews and target claims with questionable billing practices (e.g., providing therapy to a high percentage of beneficiaries for all four quarters of a given year or consistently providing more than eight hours of outpatient therapy to a beneficiary on a single day).
- Review claims with questionable billing based on geographic location.
- Revise the therapy caps exceptions process.

Spending is much higher for beneficiaries who exceed the caps

In 2011, 19 percent of therapy users received services beyond the per beneficiary caps on spending (Table 9-7, p. 244). As expected, spending on and utilization by beneficiaries who exceeded the caps were dramatically higher than that of below-cap therapy users. For example, among the 19 percent of physical therapy and speech–language pathology users who exceeded the cap, average spending per user was $3,013, more than five times the spending average for below-cap physical therapy and speech–language pathology users ($542). Of the 22 percent of occupational therapy users who exceeded the

TABLE 9–7 **Spending for therapy users who did and did not exceed therapy caps, 2011**

	All users	PT and SLP users	OT users
Number of therapy users (in millions)	4.9	4.6	1.1
Percent who exceeded caps	19%	19%	22%
Mean spending			
Users who exceeded therapy cap	$3,698	$3,013	$3,026
Users who did not exceed therapy cap	576	542	475
All users	1,173	1,009	1,026

Note: PT (physical therapy), SLP (speech–language pathology), OT (occupational therapy). Spending excludes beneficiary cost sharing. In 2011, each cap was $1,870, which includes both program spending and beneficiary cost sharing. The program spending portion of each cap was $1,496. User counts for PT and SLP users and for OT users do not add to the "all users" total since beneficiaries can be counted under both the PT and SLP count and the OT count.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

cap, average spending per user was $3,026, more than six times the average spending for below-cap occupational therapy users ($475). The share of therapy users who receive services that exceed the caps has grown over time. For example, in 2008, 15 percent of physical therapy and speech–language pathology users exceeded the cap, compared with 19 percent of users in 2011.

Beneficiaries who exceeded the caps received many more visits for a given diagnosis than other therapy users. Further, these users tended to be older and dually eligible for Medicare and Medicaid, but without further information it is difficult to determine the degree to which service provision beyond the caps is driven by the clinical complexity of these patients and their functional status.

Recommendations

The following sections present the Commission's recommendations, their rationale, and their implications using the four criteria outlined earlier in the chapter: the effect on program spending, the potential to improve beneficiaries' access to care, the impact on quality of care, and the potential to advance payment reform—that is, move Medicare payment policy away from FFS payment and encourage a more integrated delivery system.

These recommendations were transmitted to the Congress in November 2012. Therefore, the estimated budget impacts described in this report assume adoption of the recommendations by January 1, 2013.

Ensure program integrity for outpatient therapy

The Medicare program currently lacks clear clinical guidelines as to who needs outpatient therapy, how much therapy they should receive, and how long they need services. In addition, there is limited physician oversight to determine a patient's clinical progress and whether services continue to be necessary. Data with which to judge the clinical necessity of therapy services are not collected by the Medicare program. Under these circumstances, Medicare has few tools to constrain excessive use of and spending for outpatient therapy services. In addition, after adjusting for health status, use of outpatient therapy varies across the country, suggesting inappropriate use in areas where spending far exceeds the national average. Many of the geographic areas with high spending on therapy have been associated with overuse and abuse in other Medicare sectors, such as durable medical equipment and home health care. Payment edits based on established national guidelines for appropriate therapy are needed to target aberrant therapy billers and identify geographic areas where abuse of the benefit is suspected.

To increase physician oversight of outpatient therapy plans of care, Medicare should reduce the certification period for therapy plans of care from 90 days to 45 days. A certification period of 45 days is higher than the national average therapy episode of 33 days but half of the current Medicare certification period (Table 9-4, p. 240). Once physicians or nonphysician practitioners have certified plans of care, they are not required to monitor whether the plans are carried out, nor are they

responsible for the amount of therapy provided. The lack of accountability creates the potential for unnecessary therapy services. While reducing the certification period from 90 days to 45 days may increase physician visits associated with an episode of care, it should also increase physician oversight of the plan of care by requiring that a physician see the patient to ascertain the continued necessity of therapy.

The Patient Protection and Affordable Care Act of 2010 granted the Secretary authority to address fraud and abuse in geographic areas and among providers who exhibit aberrant billing patterns. Under this new authority, the Secretary can place a temporary moratorium on enrollment of new providers, require providers to re-enroll, implement payment edits, and suspend payments altogether for providers whose billings show potential fraud. Increased scrutiny of therapy services delivered in geographic areas prone to inappropriate use is also consistent with a recent OIG recommendation on outpatient therapy (Office of Inspector General 2010).

Staff at one MAC with whom we spoke implemented payment edits and additional reviews of therapy claims that exhibit aberrant billing patterns, such as multiple therapy types (e.g., physical and occupational therapy) delivered to a single patient on the same day, and therapy spending on the same patient that exceeded two and a half times the therapy cap. This MAC also conducted site visits in two counties to verify the presence and legitimacy of therapy providers after they enrolled in Medicare.

CMS should develop national guidelines that set reasonable limits on service use to curtail excessive provision of outpatient therapy services and establish national payment edits based on these guidelines. CMS currently has some national payment edits for outpatient therapy that limit the number of untimed codes (e.g., evaluation codes) to one per session (Centers for Medicare & Medicaid Services 2006). Our recommendation would require CMS to develop guidelines and edits on the number of timed services (which compose the majority of outpatient therapy services) that patients could receive per visit. The guidelines should be based on a reasonable amount of therapy that the average beneficiary can tolerate in an outpatient setting on a given day. Two MACs currently limit the number of timed therapy services per day to 5, or about 75 minutes per day (see text box, p. 237).

Similarly, CMS should direct its MACs to conduct focused reviews of the services provided in geographic areas with a high use of therapy and profile providers who bill for therapy services at rates that far exceed those of similar providers. For example, MACs could focus on providers with a high share of patients who receive therapy for an extended period or who consistently exceed therapy caps. In reviewing areas of the country where there is evidence of systematic overuse and potential fraud, MACs could focus resources on those areas and reduce the burden on providers in areas where there is little evidence of inappropriate use. MACs should also conduct site visits for new therapy providers in these geographic areas to determine whether they are legitimate operations with the appropriate staff and necessary equipment consistent with the therapy services they deliver.

RECOMMENDATION 9-1

The Congress should direct the Secretary to:

- **reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and**
- **develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.**

RATIONALE 9-1

This recommendation would increase physicians' oversight of the patient's plan of care. It would also help restrain inappropriate use of therapy services through national guidelines and payment edits and by targeting high-use geographic areas.

IMPLICATIONS 9-1

Spending

- Based on the experience of recent program integrity activities regarding outpatient therapy, we would expect that increased physician oversight of the use of therapy and narrowing the gap between the highest spending areas and the nationwide average would reduce unnecessary program spending. Some of this reduction may be offset by an increase in the number of physician visits paid under Part B if beneficiaries who reach the 45-day limit on the certification period want to continue with their treatment.

Access

- We do not expect this recommendation to adversely affect beneficiaries' access to necessary outpatient therapy services.

TABLE 9–8

Distribution of Medicare outpatient therapy spending per user among occupational therapy users, 2011

Amount per user	Percent of: Occupational therapy beneficiaries	Medicare spending on occupational therapy
< $1,200	67%	21%
$1,200–$1,440	5	6
$1,440–$1,800	7	9
> $1,800	21	64

Note: Dollar values shown are allowed charges based on Medicare program payment amounts.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

Quality

- We cannot assess the impact of this recommendation on the quality of outpatient therapy services provided to Medicare beneficiaries since the program does not currently collect robust quality measures.[9]

Delivery system reform

- We anticipate that this recommendation will have no implications for delivery system reform.

Balance beneficiaries' access to outpatient therapy services with the need to manage program spending

While we have identified program integrity weaknesses in Medicare's outpatient therapy benefit, the Commission recognizes that outpatient therapy services can be an important part of the care beneficiaries need to restore and maintain their level of function and live independently. At the time the Commission forwarded its recommendations to the Congress, hard caps without exceptions for receiving services above those caps were scheduled for implementation starting January 1, 2013. Placing such an absolute limit on therapy services would be inconsistent with the goal of ensuring appropriate access to important services for beneficiaries.

To mitigate the hard cap on spending for outpatient therapy services, the Commission's four-part recommendation seeks to strike a balance between managing spending on therapy services and ensuring that beneficiaries continue to have access to needed services. The recommendation would (1) reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to $1,270 in allowed charges in 2013; the caps should continue to be updated each year according to the Medicare Economic Index; (2) implement a manual review process for requests to exceed cap amounts and provide resources to CMS for this purpose; (3) permanently include services delivered in hospital outpatient departments under the therapy caps; and (4) apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day. The Commission also identified three additional tools that could be used if spending on outpatient therapy is projected to be above current law and the Congress wishes to further constrain spending (see text box). These options are not part of Recommendation 9-2.

Reduce therapy cap limits to $1,270 in 2013

In 2012, the spending cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy was $1,880 in allowed charges ($1,496 in program payments).[10]

Reducing the therapy cap to $1,270 (in allowed charges) for physical therapy and speech–language pathology services combined and for occupational therapy separately would accommodate the annual therapy needs of most beneficiaries while providing a check on excessive utilization. This number was chosen using historical spending trends. The reduced cap would permit about two-thirds of therapy users to receive therapy services without exceeding the caps and without any need to obtain exceptions to use additional services. Caps set at $1,270 in allowed charges would allow for roughly 14 physical therapy and speech–language pathology visits and 14 visits for occupational therapy before users reached either cap. The two caps combined would permit up to 28 visits for all outpatient therapy services per year—although the benefit is not administered as a combined cap for all three services. This amount is within the range of 20 to 30 visits allowed by many private plans before providers are required to obtain authorization to deliver additional services (see text box, p. 234).

If the therapy cap were reduced even lower to $1,200, 67 percent of occupational therapy users would be unaffected (Table 9-8). Further, users who spend above $1,200 on occupational therapy represent a disproportionate amount of spending—33 percent of occupational therapy users spent more than $1,200 but represented 79 percent of Medicare spending on occupational therapy in 2011. The distribution of occupational therapy–only users is similar

Additional tools to address spending growth for outpatient therapy services

The Commission identified three tools that could be used if Medicare spending for outpatient therapy is projected to be above current law and the Congress wishes to further reduce this spending. They are as follows:

- ***Lower payment rates*—**Lowering providers' per service payment rates could reduce spending and potentially reduce the need for manual reviews above the spending caps. Payment rates could be reduced by a certain amount (e.g., 20 percent) when spending per episode exceeds a certain threshold (e.g., 75th percentile of the distribution of therapy spending per user). For example, payment rates could start to decline after spending reaches the 75th percentile.
- ***Further reduce therapy caps*—**Lowering thresholds for the outpatient therapy caps would further reduce spending. Requests for additional services, subject to manual medical review, would be permitted in order to ensure access to necessary services above cap levels. Under this option, CMS and its Medicare administrative contractors would likely experience an increase in the number of manual reviews relative to Recommendation 9-2, which would increase their workload.
- ***Increase beneficiaries' cost sharing for longer episodes*—**Increased cost sharing for beneficiaries with longer episodes could encourage more judicious use of therapy and could lower program spending on outpatient therapy services. Higher levels of cost sharing could encourage beneficiaries to more carefully assess the value of these services. The increased cost-sharing increments could be set so that they would not apply to the majority of beneficiaries.

A new cost-sharing requirement could be linked to the number of visits per episode and rise incrementally with an increase in visits. For example, beneficiaries could be responsible for the standard 20 percent coinsurance for the first 20 visits of an episode. Subsequent blocks of visits (e.g., the next five visits) could be subject to 25 percent coinsurance, and an additional five visits could be subject to 30 percent coinsurance. (The initiation of a new episode of care after prior use of therapy services would revert back to the standard coinsurance rate of 20 percent.)

However, in an environment where supplemental plans continue to cover most beneficiaries' costs, the effect of higher coinsurance on therapy services would be limited. Supplemental insurance plans would eventually cover the higher cost sharing, and beneficiaries would pay higher premiums for supplemental plans. Beneficiaries covered under Medicaid would similarly be protected from additional out-of-pocket costs. Therapy users would continue to be largely insulated from the cost of additional therapy services unless measures were taken to preclude third-party payers from covering beneficiaries' cost sharing above a certain level. ■

to the distributions for physical therapy and speech–language pathology users.

Adopt a streamlined manual medical review of requests to exceed therapy cap limits

Medicare needs a streamlined process to review claims that exceed either of the therapy caps.[11] From October through December 2012, CMS conducted manual medical reviews for services above the $3,700 threshold. There were several issues regarding the reviews, including delays in processing requests and delays in approvals due to difficulties with submissions by mail and fax.

To conduct a more efficient and effective manual medical review, the process should allow for the following:

- MACs should accept requests for medical reviews electronically in addition to mail and fax.
- Providers should receive immediate confirmation that their requests have been received.
- Reviews should be completed and acceptances and denials should be issued within 10 business days.
- Within the 10 days, beneficiaries should be allowed two visits for which the therapist bears financial

responsibility if services are deemed medically unnecessary.

- Consider having one or two MACs conduct all manual medical reviews nationwide for consistency in the review process.

CMS will need additional resources to successfully implement a streamlined medical review of requests to exceed cap levels. Without the needed resources, CMS will be unable to process and approve requests to exceed the caps in a timely manner. Streamlining the review process will make the decision to continue (or not continue) therapy services more consistent and transparent because providers could justify the need for additional therapy services and MACs could use national guidelines to evaluate these requests (see Recommendation 9-1)

Include hospital outpatient departments under therapy caps

The Congress initially excluded HOPDs from the therapy caps to preserve access for beneficiaries who needed additional therapy services after reaching the annual caps threshold (before an exceptions process was adopted). As of October 1, 2012, services provided in HOPDs are counted toward the caps. However, with our recommendation to adopt a permanent, streamlined review process for requests to exceed the caps, beneficiaries would receive services above the spending cap when medically necessary regardless of the setting. The Congress should apply the policy of annual caps to all therapy settings—including HOPDs—to ensure that no setting has an unfair advantage.

Increase the multiple procedure payment reduction for practice expense portion of outpatient therapy services

Medicare currently applies a multiple procedure payment reduction (MPPR) to the practice expense component of therapy services when multiple services are furnished by the same provider to a patient on the same day. The rationale for the MPPR policy is that efficiencies in practice expense occur when multiple therapy services are furnished in a single session because certain clinical staff activities are not performed twice, such as cleaning the room and equipment, greeting and gowning the patient, obtaining patient measurements, conducting patient education, and coordinating home care. In addition, there are efficiencies in the use of certain supplies during the patient visit.

Although the RVUs of many therapy services already account for some duplications in practice expense, CMS recently found that the current practice expense values do not reflect substantial efficiencies (Centers for Medicare & Medicaid Services 2011). Many therapy services were originally valued based on the assumption that three units of service (two procedures and one modality) were provided per visit. However, CMS determined that four was the median number of therapy services on claims with multiple units of service. This means that the clinical staff time associated with an activity that occurs once per visit (such as greeting and gowning the patient) should be spread across more units of service, and the amount of time allocated to each unit should be lower. In the Part B rule for 2011, CMS examined five high-volume pairs of therapy codes billed in a single session and found efficiencies in clinical labor and supplies that justified reductions to the practice expense payment ranging from 28 percent to 56 percent for the lower paid code (Centers for Medicare & Medicaid Services 2010b).

Based on this analysis, CMS proposed a 50 percent reduction to the practice expense payments for the second and subsequent therapy services. CMS received many public comments opposed to this policy. Consequently, in the final Part B rule for 2011, CMS adopted a 25 percent reduction as an "appropriate and conservative first step" (Centers for Medicare & Medicaid Services 2010a). However, CMS maintained its view that, based on its analysis, a 50 percent reduction may be appropriate. The MPPR applies to therapy services provided in both private practice settings (such as therapists' offices) and facility settings (such as HOPDs and nursing facilities) because the fee schedule determines the payment amounts for therapy in all settings. CMS was required by statute to implement this policy in a budget-neutral manner for therapy services provided in private practice settings; therefore, the savings from therapy delivered in these settings were redistributed to other fee schedule services. However, the statute does not require CMS to redistribute savings from therapy services provided in facility settings to other services; therefore, these savings reduced aggregate Medicare spending.

The Physician Payment and Therapy Relief Act of 2010 changed the MPPR reduction from 25 percent to 20 percent for outpatient therapy provided in private practice settings but maintained the 25 percent reduction for facility settings. This legislation also mandated that the savings from therapy services provided in private practice settings would no longer be budget neutral (i.e., the savings would not be redistributed to other fee schedule services).

Based on CMS's analysis of the efficiencies that occur when multiple therapy codes are provided in a single

session, which justified reductions to the practice expense payment ranging from 28 percent to 56 percent for the lower paid code, the Commission recommends applying a uniform 50 percent MPPR to therapy services provided in all settings. Similar to the current reduction of 20 percent or 25 percent, the 50 percent reduction should apply to all therapy services furnished by the same provider to the same patient on the same day. In addition, the savings from the 50 percent reduction should be used to partly offset the cost of eliminating a hard cap on therapy spending. This recommendation is consistent with previous Commission recommendations that Medicare apply an MPPR to multiple imaging services that are provided during the same session (Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2005).

Consistent with the current MPPR for therapy services, a 50 percent MPPR should apply to all services furnished by the same provider to the same patient on the same day, even if the services are furnished in more than one session on that day or if services are in different therapy disciplines. As CMS discussed when it finalized the current MPPR policy, some practice expenses (such as patient education) overlap when multiple therapy sessions are provided on a single day to the same patient (Centers for Medicare & Medicaid Services 2011).

Another issue is whether the MPPR should apply when services from multiple therapy disciplines (e.g., physical therapy and occupational therapy) are furnished by the same provider to the same patient on the same day. CMS found that this scenario is uncommon but when it occurs, the MPPR policy should still apply because certain activities overlap, such as greeting the patient, obtaining vital signs, and making postvisit phone calls.

In addition to increasing the MPPR, CMS could also begin to combine therapy codes that are commonly performed together into single comprehensive codes. The payment rates for these comprehensive codes should reflect efficiencies associated with performing multiple therapy services during the same visit. CMS has recently done this for other types of services, such as certain imaging studies and procedures (Medicare Payment Advisory Commission 2011a).

RECOMMENDATION 9-2

To avoid caps without exceptions, the Congress should:

- **reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index.**
- **direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose.**
- **permanently include services delivered in hospital outpatient departments under therapy caps.**
- **apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.**

RATIONALE 9-2

The Commission believes that a policy of hard caps on therapy spending without an exception may unduly compromise beneficiaries' access to medically necessary services. However, the current automatic exceptions process may be too loose and permit the delivery of excessive amounts of therapy without any way to establish the necessity of these treatments. This recommendation for a manual review of therapy claims exceeding the spending caps offers a middle ground.

IMPLICATIONS 9-2

Spending

- At the time this recommendation was approved, we expected that it would result in an increase in Medicare spending relative to current law, which mandated a cap without an exceptions process. The recommendation would restrain spending by reducing the cap amount and increasing the MPPR, but these savings would likely be offset by the cost of additional outpatient therapy services that would be permitted through a manual review process.

Access

- We expect higher use of outpatient therapy services relative to a therapy cap without exceptions. Further, the manual medical review would permit beneficiaries who need greater amounts of therapy to receive it, while deterring overuse.

Quality

- We cannot assess the impact of this recommendation on the quality of outpatient therapy services provided to beneficiaries because the program does not currently collect robust quality measures.

Delivery system reform

- We do not anticipate that this recommendation will significantly affect delivery system reform.

TABLE 9–9 **Top 10 ICD–9 codes for all outpatient therapy, 2011**

ICD–9 code	Code description	Total payments (in millions)	Percent of total payments
V57.1	Nonspecific, other physical therapy	$466	8%
728.87	Muscle weakness (generalized)	278	5
724.2	Lumbago, low back pain	276	5
781.2	Abnormality of gait	265	5
719.7	Difficulty in walking	233	4
V57.89	Other, multiple training or therapy	216	4
719.41	Pain in joint, shoulder region	165	3
719.46	Pain in joint, lower leg	151	3
723.1	Cervicalgia (pain in neck)	109	2
781.3	Lack of coordination	107	2
	Total	2,267	40

Note: ICD–9 (International Classification of Diseases, Ninth Revision). Amounts may not sum to totals due to rounding.

Source: MedPAC analysis of 100 percent Medicare Part B therapy claims, 2011.

Improve longer term management of the benefit

The Medicare program does not have adequate data with which to evaluate the medical necessity and outcomes of outpatient therapy. Medicare's primary source of information on therapy services is claims data, but the diagnosis information currently required for Medicare payment does not permit any meaningful assessment of how a given therapy regimen relates to a given diagnosis. Claims data also lack measures of functional status, which could help determine the impact of therapy services on the patient's physical function. The Commission's third recommendation aims to improve the longer term management of the benefit, with a specific focus on improving the quality of claims data and developing a tool to collect data on functional status.

Improve accuracy of diagnosis codes

Medicare does not have adequate clinical data to determine the medical necessity or the outcomes of care once therapy is initiated. V codes are largely descriptive of services provided but do not describe the patient's clinical condition or disease. In 2011, two V codes taken together (V57.1 and V57.89) accounted for over $680 million, or about 12 percent of outpatient therapy payments (Table 9-9). The use of V codes is extensive; about 10 percent of physical therapy and occupational therapy claims list a V code as the principal diagnosis.

Tightening diagnosis coding practices would improve the specificity of the diagnosis used in claims. CMS should automatically deny claims that have V codes for a principal diagnosis for therapy. Discontinued use of V codes would require therapists and other professionals to use more clinically relevant medical diagnosis codes. For example, if the primary reason for therapy is to recover from a knee injury, providers could use codes to indicate that there was a tear or injury to the knee that necessitated physical therapy. The private sector provides precedents for the denial of V codes in therapy claims. We found that at least one large private benefit manager with contracts to manage therapy benefits for several million patients does not accept V codes for a principal diagnosis on therapy claims.

It is unclear to what extent ICD–10 codes, which expand on the ICD–9 diagnosis codes, will yield better clinical information. Under ICD–10 coding, "abnormality of gait" extends to four conditions: (1) ataxic gait, (2) paralytic gait, (3) other abnormalities of gait and mobility, and (4) unspecific abnormalities of gait and mobility. These codes allow the provider to describe the functional impairment more specifically, though they do not add any information pertaining to the underlying diagnosis.

Develop and collect measures of functional status for outpatient therapy users

Measures of functional status reflect the extent to which patients experience limitations in their ability to perform

TABLE 9–10

Information for a streamlined, standardized tool to measure functional status for outpatient therapy services

Domains	Sample measures
Demographic information	• Age • Sex
Diagnosis	• Reason for therapy services (e.g., change in physical function, change in cognitive function) • Therapy-specific diagnosis (e.g., aphasia, osteoarthritis) • Duration of the patient's condition
Severity	• Prior surgery or hospitalization for the condition • Use of assistive device (e.g., rails) • Current medication use for condition (e.g., number of medications for therapy condition)
Affected body structures and functions	• Body functions (e.g., muscle functions related to power or strength, movement functions such as gait, hearing, pain) • Body structures (e.g., head, cervical spine, left or right hip, shoulder, mouth)
Limitations with activities of daily living and participation	• Communication (e.g., spoken communication, sensory experiences like watching) • Self-care (e.g., preparing meals, dressing) • Carrying objects or maintaining body positions • Ability to continue work or community life

daily tasks and need assistance. Measures of functional improvement help clinicians assess the effectiveness of their treatments and determine the most efficient therapy interventions (Higginson and Carr 2001). Measurement can also show progress during the course of therapy and allow practitioners to direct resources in a more targeted manner. Collected over the duration of therapy services from admission to discharge, this information would allow CMS to assess functional improvement over time. Unlike inpatient therapy settings (i.e., SNFs and inpatient rehabilitation facilities) or home health care, Medicare does not collect information on the clinical and demographic characteristics of therapy users. Such information, along with improved information on therapy patients' diagnoses (discussed above), is essential to redesigning Medicare's payment system for outpatient therapy. The current payment system has strong incentives to provide more therapy services and few controls in place to check inappropriate use. In addition, Medicare pays for these services without information pertaining to their outcomes. Over the long term, Medicare could consider improving the way it pays for therapy by bundling therapy with episodes of care and tying payments to a patient's functional improvement. The program currently does not have the information necessary to move the payment system in this direction.

In July 2012, the Commission convened a panel of practitioners of outpatient therapy and clinical researchers to obtain their input on some of the questions raised by our mandate to produce this report. The panelists indicated that many of the data elements that they have found to be useful predictors of patients' resource needs are being evaluated under CMS's Developing Outpatient Therapy Payment Alternatives (DOTPA) study. The DOTPA study evaluated two Continuity Assessment Record and Evaluation (CARE) tools for outpatient therapy. One tool, CARE–C, targets community providers such as private practice therapists, while the CARE–F tool targets measurement in facilities. CMS expects the study, scheduled to be completed at the end of 2013, will validate some items for a potential assessment tool for outpatient therapy services. Specifically, panelists thought that the "reason for therapy" section of the two patient assessment tools under study in the DOTPA project contains much of the information Medicare would need to begin to transform the way the program pays for outpatient therapy (Table 9-10).

Existing tools for collecting functional status measures

CMS has recognized three instruments for providers to document physical and occupational therapy: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL), Patient Inquiry© tool by Focus On Therapeutic Outcomes, Inc. (FOTO), and Activity Measure for Post-Acute Care (AM–PAC). CMS has also recognized the National Outcomes Measurement System (NOMS) to measure the functional status of speech–language pathology patients. CMS has not explicitly endorsed or required any of them for the purposes of collecting functional status measures.

The three tools recommended for physical and occupational therapy assessment vary in how extensively they are used and in their assessment methods. OPTIMAL (for physical therapy) assesses patients with musculoskeletal conditions in outpatient settings. It assesses a patient's ability and confidence in performing 21 mobility actions such as standing, walking, bending, and climbing stairs (Guccione et al. 2005). FOTO, a robust computer-adaptive tool, also assesses a patient's functional status and improvement, as well as the number of visits needed for a specific functional improvement. The predictive model for therapy needs under FOTO considers patients' age, sex, diagnosis, impairment, acuity, severity, and surgical history to estimate the number of visits and expected functional improvement given a specified duration. We found that some private benefit managers (vendors that contract with health plans to manage their outpatient therapy benefits) use FOTO because of its ease of use. The AM–PAC tool also uses computer-adaptive technology to assess a patient's ability to perform three types of physical, personal, and instrumental activities as well as applied cognitive activities (Haley et al. 2006). AM–PAC, FOTO, and OPTIMAL tools assess function more accurately for physical and occupational therapy patients than for speech–language pathology patients (Ciolek and Hwang 2010).

The NOMS tool for speech–language pathology measures function in patients with substantial speech, cognitive, or communication impairments. The tool assesses up to 15 functional communication measures, such as memory, spoken language comprehension and expression, and swallowing difficulty. Assessments based on the NOMS tool help determine severity, complexity, and treatment goals based on demographic information, diagnoses, and level of functional communication and swallowing. ■

CMS could use a variant of this section to collect data on functional status and other information believed to help predict therapy needs, such as medication use and prior surgeries. With this information, CMS could begin to redesign the payment system so that it rewards practitioners' abilities to achieve positive outcomes for their patients rather than providing more services. Further, this could also help establish the necessity of a given amount of therapy. Because the information needed is relatively succinct, it would impose a minimal reporting burden on providers of outpatient therapy. CMS could use an assessment based on the DOTPA "reason for therapy" section across all types of outpatient therapy (physical therapy, occupational therapy, and speech–language pathology services). Such an instrument would not replace the more detailed clinical assessment tools that therapists currently use to track patients' conditions (see text box, this page). We believe this streamlined instrument for assessing functional gains and patients' need for therapy would be superior to the approach recently adopted by CMS to collect information about patients' functional status (see text box, facing page).

Without better information about clinical diagnoses and functional status, it is difficult to determine from claims data how much therapy is required for the conditions specified, which is the first step toward developing standards for appropriate use and measuring outcomes.

RECOMMENDATION 9-3

The Congress should direct the Secretary to:

- **prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and**
- **collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and**

CMS's method for collecting data on functional status

The Middle Class Tax Relief and Job Creation Act of 2012 required CMS to develop a method of collecting functional status information from claims data by January 1, 2013. CMS adopted an approach in which providers report functional status using 11 categories of specific functional limitations (e.g., walking and moving around, spoken language comprehension) and three general categories (one category for each therapy type) for limitations that do not fit within the 11 specified categories. Providers report this information using G codes. Providers are expected to report functional limitations at the outset of the therapy episode, at some point during treatment, and at the conclusion of the therapy episode. CMS also adopted a seven-point scale of modifiers that would accompany each G code to indicate the level of severity and impairment (e.g., 50 percent impairment in the ability to walk and move around). Tracking functional limitations throughout an episode could provide information about outcomes that, when combined with clinical diagnoses, could inform further payment design decisions.

Although this approach will improve the data available to CMS, this method lacks a standardized approach to measuring functional impairment. A 30 percent impairment assessed by one physical therapist could be judged as a 40 percent impairment by another therapist. Excessive variation in how patients are assessed could threaten the reliability of the data and would make it difficult to compare outcomes across patients and providers. ■

functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.

RATIONALE 9-3

The Medicare program has inadequate data with which to evaluate the medical necessity of therapy services. Improving diagnosis codes and collecting information about functional status during the course of therapy would improve Medicare's ability to classify patients by severity of condition and ultimately pay therapy providers for performance. Improved functional data would facilitate Medicare's ability to include outpatient therapy services in new payment and delivery models such as accountable care organizations in the future.

IMPLICATIONS 9-3

Spending

- At the time this recommendation was approved, we expected that it would have no impact on program spending.

Access

- We do not expect that this recommendation will adversely affect beneficiaries' access to needed care.

Quality

- Over the long term, we expect this recommendation will allow clinicians and the program to better assess the effect of outpatient therapy on functional outcomes and tie reimbursement to functional improvement.

Delivery system reform

- The recommendation is consistent with the Commission's goals of reforming the health care delivery system by allowing Medicare to construct larger payment units for outpatient therapy services and eventually tying payments for these services to patients' functional improvement. ■

Endnotes

1 In January 2013, a Medicare legal settlement (Jimmo v. Sebelius, D. Vt, No. 5:11–cv–00017–cr) required CMS to clarify that the potential for improvement in a patient's condition is not a requirement for Medicare coverage. At the time of the writing of this report, Medicare's provider manuals and other subregulatory guidance did not reflect this change.

2 V codes often are used as primary diagnosis codes in the outpatient therapy setting. These codes do not describe the patient's medical condition (e.g., knee injury) but rather describe the type of therapy received, such as V57.1 for nonspecific care involving other physical therapy or V57.21 for nonspecific care involving other occupational therapy.

3 Nonresidents may include walk-ins from the community and residents in assisted living facilities.

4 For one high-volume therapy service, Current Procedural Terminology (CPT) 97110 (therapeutic procedure: 1 or more areas, 15 minutes each, therapeutic exercises to develop strength, range of motion, and flexibility), the practice expense RVUs account for 51 percent of the total payment, the work RVUs account for 48 percent of the total, and the professional liability insurance RVUs account for 1 percent of the total. Similarly, for CPT 97112 (therapeutic procedure: 1 or more areas, 15 minutes each, neuromuscular reeducation), the practice expense RVUs account for 53 percent of the total payment, the work RVUs account for 46 percent of the total, and the professional liability insurance RVUs account for 1 percent of the total. When multiple services are furnished by the same provider to the same patient on the same day, a multiple procedure payment reduction applies to the practice expense component of the lower paid codes.

5 NCDs apply to all MACs, but LCDs can vary from MAC to MAC.

6 First Coast Service Options allows additional treatments if they meet medical necessity requirements.

7 These limits reflect total payments and include deductibles and coinsurance paid by beneficiaries.

8 MACs have some discretion in how often they review therapy claims and medical records for medical necessity to support the use of the modifier. We learned through our discussions with MAC staff that additional reviews are rarely conducted for therapy services.

9 Physical therapists in private practice may report quality measures as part of the Physician Quality Reporting System (PQRS) and in the future will be subject to penalties when these quality measures are not reported on claims. However, the PQRS measures are process measures and do not measure outcomes such as functional improvement. In addition, these measures are not reported by other providers such as skilled nursing facilities.

10 Program payments are 80 percent of allowed charges. The other 20 percent of the allowed charge is the beneficiary deductible and coinsurance payment.

11 In 2010, OIG also recommended revising the therapy cap exceptions process (Office of Inspector General 2010).

References

Bhogal, S. K., R. Teasell, and M. Speechley. 2003. Intensity of aphasia therapy, impact on recovery. *Stroke* 34, no. 4 (April): 987–993.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2012. *2012 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds.* Washington, DC: Boards of Trustees.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012a. Local coverage determination (LCD) for outpatient rehabilitation therapy services billed to Medicare Part B (L28531). Wisconsin Physicians Service Insurance Corporation. http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28531&ContrId=48&ver=24&ContrVer=1&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Illinois&KeyWord=therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABAAAAAA&.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012b. Local coverage determination (LCD) for therapy and rehabilitation services (L29289): First Coast Service Options, Inc. For services performed on or after 03/01/2012. http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=29289&ContrId=197&ver=19&ContrVer=1&bc=AgIAAAAAAAAA&.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012c. Local coverage determination (LCD) for therapy services (PT, OT, SLP) – 4Y-26AB – R10 (L26832): TrailBlazer Health Enterprises, LLC. For services performed on or after 10/01/2011. http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=26832&ContrId=153&ver=96&ContrVer=1&bc=AgIAAAAAAAAA&.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012d. National coverage determination (NCD) for infrared therapy devices (270.6). Publication number 100–3. Manual section number 270.6. Transmittal number 62. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=315&ncdver=1&NCAId=176&NcaName=Infrared+Therapy+Devices&IsPopup=y&bc=AAAAAAAAIAAA&.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. Medicare program; payment policies under the physician fee schedule, five-year review of work relative value units, clinical laboratory fee schedule: Signature on requisition, and other revisions to Part B for CY 2012. Final rule. *Federal Register* 76, no. 228 (November 28): 73026–73474.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010a. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. *Federal Register* 75, no. 228 (November 29): 73169–73860.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010b. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Proposed rule. *Federal Register* 75, no. 133 (July 13): 40039–40718.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2009. *Medicare benefit policy manual.* Chapter 15: Covered medical and other health services. Accessed August 13. Baltimore, MD: CMS. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2006. Medicare program; revisions to payment policies under the physician fee schedule for calendar year 2007 and other changes to payment under Part B. Proposed rule. *Federal Register* 71, no. 162 (August 22): 48982–49252.

Ciolek, D., and W. Hwang. 2010. *CY 2008 outpatient therapy utilization report.* Report prepared for the Centers for Medicare & Medicaid Services. Baltimore, MD: Computer Sciences Corporation.

de Angelis, E. C., L. F. Mourao, H. B. Ferraz, et al. 1997. Effect of voice rehabilitation on oral communication of Parkinson's disease patients. *Acta Neurologica Scandinavica* 96, no. 4 (October): 199–205.

Donnelly, C., and A. Carswell. 2002. Individualized outcome measures: A review of the literature. *Canadian Journal of Occupational Therapy* 69, no. 2 (April): 84–94.

Elixhauser, A., and E. M. McCarthy. 1996. *Clinical classifications for health policy research, version 2: Hospital inpatient statistics.* Healthcare Cost and Utilization Project (HCUP 3) research note 1. AHCPR publication no. 96 0017. Rockville, MD: Agency for Health Care Policy and Research.

Guccione, A. A., T. J. Mielenz, R. F. Devellis, et al. 2005. Development and testing of a self-report instrument to measure actions: Outpatient physical therapy improvement in movement assessment log (OPTIMAL). *Physical Therapy* 85, no. 6 (June): 515–530.

Haley, S. M., P. Ni, R. K. Hambleton, et al. 2006. Computer adaptive testing improved accuracy and precision of scores over random item selection in a physical functioning item bank. *Journal of Clinical Epidemiology* 59, no. 11 (November): 1174–1182.

Hayden, J. A., M. W. van Tulder, and G. Tomlinson. 2005. Systematic review: Strategies for using exercise therapy to improve outcomes in chronic low back pain. *Annals of Internal Medicine* 142, no. 9 (May 3): 776–785.

Higginson, I. J., and A. J. Carr. 2001. Measuring the quality of life: Using quality of life measures in the clinical setting. *BMJ* 322: 1297–1300.

Legg, L., A. Drummond, J. Leonardi-Bee, et al. 2007. Occupational therapy for patients with problems in personal activities of daily living after stroke: Systematic review of randomised trials. *BMJ* 335, no. 7626 (November 3): 922.

Maxwell, S., C. Basseggio, and M. Storeygard. 2001. *Part B therapy services under Medicare, 1998–2000: Impact of extending fee schedule payments and coverage limits.* Washington, DC: Urban Institute.

Medicare Payment Advisory Commission. 2012. *A data book: Health care spending and the Medicare program.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011a. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2006. *Report to the Congress: Increasing the value of Medicare.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Michael, Y. L., E. P. Whitlock, J. S. Lin, et al. 2010. Primary care-relevant interventions to prevent falling in older adults: A systematic evidence review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine* 153, no. 12: 815–825.

Office of Inspector General, Department of Health and Human Services. 2010. *Questionable billing for Medicare outpatient therapy services.* Report # OEI–04–09–00540. Washington, DC: OIG.

Robbins, J., S. G. Butler, S. K. Daniels, et al. 2008. Swallowing and dysphagia rehabilitation: Translating principles of neural plasticity into clinically oriented evidence. *Journal of Speech Language and Hearing Research* 51, no. 1 (February): S276–300.

Schoofs, M., and M. Tamman. 2010. Confidentiality cloaks Medicare abuse. *Wall Street Journal,* December 22.

Steultjens, E. M., J. Dekker, L. M. Bouter, et al. 2004. Occupational therapy for community dwelling elderly people: A systematic review. *Age and Ageing* 33, no. 5 (September): 453–460.

Steultjens, E. M., J. Dekker, L. M. Bouter, et al. 2002. Occupational therapy for rheumatoid arthritis: A systematic review. *Arthritis & Rheumatism* 47, no. 6 (December 15): 672–685.

Van Peppen, R. P., G. Kwakkel, S. Wood-Dauphinee, et al. 2004. The impact of physical therapy on functional outcomes after stroke: What's the evidence? *Clinical Rehabilitation* 18, no. 8 (December): 833–862.