INSTITUTE FOR CRITICAL CARE

ICC Post-Acute Care Primer Series

Vol. 6 | Aug. 2020

Outpatient Rehabilitation Therapy

Outpatient Rehabilitation Therapy includes a variety of clinical services to help patients to improve function and movement, to improve their ability to perform daily tasks, to improve communication or to ease pain.

Introduction

Outpatient rehabilitation therapy providers are a large, growing and critical component of the United States health system. Outpatient therapy is the natural continuum of care for many patients – particularly those recovering from serious debilitating injuries or illnesses, major orthopedic surgeries and a variety of other neurological and musculoskeletal disorders. Each year in the United States, outpatient therapy professionals — including licensed physical therapists, occupational therapists and speech-language pathologists — help millions of patients as they strive to regain function and independence and adjust to life after a serious health incident.

US Army "reconstruction aides", precursors to today's physical therapists, treating wounded soldiers at Fort Sam Houston, 1919; courtesy of the American Physical Therapy Association.

History

The origins of outpatient therapy – and today's various therapy professions – are found in the mid to late 19th century in Europe, as physicians and patients alike began to grapple with the new challenges associated with the industrialized world, improving medical treatments, and higher recovery rates. By the early twentieth century, with the advent of the worldwide poliomyelitis pandemic, and two world wars featuring weapons from an industrialized age, the need for therapy for patients became acute. Many of the pioneers of today's therapy professions began by treating children afflicted with polio, or helping combat wounded soldiers regain strength and function, or to adapt to living with the debilitating results of war – such as amputations, burns or partial loss of limb.

Current Role in the US Health System

According to the market research firm Marketdata, there were over 38,000 rehabilitation therapy clinics in the United States in 2018, and over $34 billion was spent on related services with a predicted growth rate over 6% the next 5 years.[1]

Today, most outpatient rehabilitation therapy services are provided or supervised by one of the following three therapy disciplines.

Physical Therapy: Physical therapists **("PTs")** help patients regain strength, mobility and gross motor skills after a serious injury. For example, they often help stroke patients regain balance and ambulation, or help those who have undergone joint replacement surgery or other orthopedic procedures rebuild strength and range of motion in the affected limbs and muscles. PTs are trained to help patients using manual therapy techniques and therapeutic movements. PTs develop personalized therapy plans for their patients, instruct them on how to properly do rehabilitative exercises and educate them on how to maintain their progress independently. There are approximately 209,000 licensed physical therapists in the United States.[2]

Occupational Therapy: The focus of occupational therapy **("OT")** is helping patients regain the ability to perform routine activities of daily living **("ADLs")**, such as dressing, bathing

Did You Know?

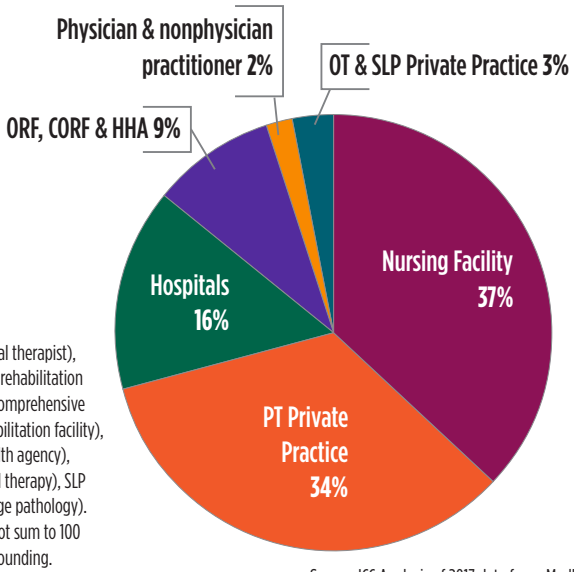
Outpatient therapy is a large and growing component of the US health care continuum.

Source: ICC Analysis of Industry and Government Reports

and cooking. OTs recommend adaptive changes to patients' living and working environments, and work with caregivers to help patients adjust to life after a serious health event. Today there are approximately 100,000 occupational therapists working across the country.[3]

Speech-Language Pathology: Speech-language pathology **("SLP")** is a therapy discipline that specializes in helping patients regain the ability to communicate through speech, and to regain the ability to swallow – often following a serious health event like a stroke. SLPs also work with children with speech impairments that may derive from physical or developmental sources. There are over 180,000 SLPs licensed in the United States.[4]

Distribution of Medicare Outpatient Therapy Spending, 2017



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

Source: ICC Analysis of 2017 data from MedPAC

Leading Outpatient Therapy Providers

- Athletico Physical Therapy (AL)
- ATI Physical Therapy (IL)
- CORA Health Services (OH)
- PT Solutions (GA)
- Pivot Physical Therapy (MD)
- Select Medical/Physiotherapy Associates (PA)
- Upstream Rehabilitation / Drayer Physical Therapy (AL)
- U.S. Physical Therapy (TX)

Therapy professionals work in a variety of outpatient settings. These include hospital outpatient departments, multidisciplinary medical practices and stand-alone therapy clinics. In addition, therapy professionals often provide services to homebound patients and residents of nursing homes, in addition to inpatients at general and specialty hospitals (such as inpatient rehabilitation facilities) The majority of therapists in the outpatient setting work in clinics with fewer than 10 practitioners. Therapists may work for themselves in private practice, be employed by a physician's office or hospital, by a school district or by a specialty therapy clinic.

Medicare Coverage Requirements

Approximately 34% of the patients in physical therapy clinics are aged 65 and over,[5] and receive therapy coverage through Medicare. As the largest insurance program in the US, the Medicare program's coverage requirements for outpatient therapy are the most influential. Private insurers often emulate many of these standards. Generally, for outpatient therapy services to be covered under Medicare the following requirements must be met:

- The patient must be under the care of a physician or Medicare-recognized non-physician practitioner **("NPP")**, who attests to the medical necessity of, and refers the patient for therapy;
- Therapy services must be provided by a qualified practitioner, defined as a licensed PT, OT or SLP, or a licensed OT assistant or PT assistant who is acting within their scope of practice;
- Services must be furnished on an outpatient basis in one of Medicare's recognized settings, such as a private therapy clinic, comprehensive outpatient rehabilitation facility **("CORF")**, outpatient rehabilitation facility **("ORF")** or hospital outpatient department, or in coordination with other Medicare-covered skilled nursing facility **("SNF")** or home health agency **("HHA")** services;
- Services must be provided in accordance with an individualized plan of care **("PoC")**, developed by a qualified therapist, physician or NPP;
- The PoC must be certified by the patient's physician or NPP, under whom the patient remains in their care, and recertified in the event of any changes to the PoC;
- In the event of extended episode of care, a patient's PoC must be recertified by their physician or NPP at least every 90 days.[6]

Recent News

- During the Covid-19 national health emergency, CMS has used its waiver authority to authorize the use of telehealth to deliver some therapy services
- Due to budget neutrality requirements now in law, and significant increases in the relative valuation of physician evaluation and management codes by the RUC, CMS has indicated that therapists and over 20 other specialties could see significant cuts to CY2021 Medicare payments – as much as 8% for PTs, OTs and SLPs

Medicare Reimbursement Overview

Cost-Sharing. Outpatient therapy services are covered under Part B of the Medicare program. As such, patients are generally required to pay cost-sharing equal to 20% of allowable charges for the services they receive – after meeting their annual Part B deductible. Medicare pays the provider of services the remaining 80% through its established payment systems and processes.

Medicare Physician Fee Schedule. Almost all reimbursement for outpatient therapy services are provided for through the Medicare Physician Fee Schedule **("PFS")**. Reimbursement may be provided directly to an enrolled therapy professional, under arrangements with a Medicare-recognized therapy provider, such as a rehabilitation agency, or as a service incident to a physician visit.

Payments for outpatient therapy services utilize a range of billable codes specified in Level II of the Healthcare Common Procedure Coding System **("HCPCS")**, also known as Current Procedural Terminology **("CPT")** codes. The CPT coding system was created in the 1960s and is the intellectual property of, and is maintained by, the American Medical Association **("AMA")**. CPT codes are used by Medicare with the permission of the AMA.

Each HCPCS Level II code (including those commonly used by therapists) is assigned a relative value through the AMA's RVS Update Committee **("RUC")**. The RUC was established to consider and set relative values for physician provided and ordered procedures prior to Medicare's transition from charge-based billing to a Resource-based Relative Value Unit Scale **("RBRVS")** payment system in the early 1990s.

In assigning relative weights to procedural codes, the RUC considers and assigns values to three separate components for each code:

- a work component that considers the time and professional expertise required to perform the service **("Work RVU")**;
- a practice expense component, that considers the indirect costs required to provide the services, such as supplies, rented space and supporting staff **("PE RVU")** and;
- a practice expense liability component that takes into account the relative risk of the procedure and its impact on applicable professional liability premium costs **("PLI RVU")**.

The RUC revisits the relative weights assigned to each of the over ten thousand CPT codes at least once every five years. From the launch the RBRVS physician fee schedule policy until today, the Centers for Medicare and Medicaid Services **("CMS")**, the agency that administers Medicare, has elected to use the CPT coding system to manage its payments.

Once a year CMS issues a rule to make modifications to its Part B physician payment rates and policies – including those governing outpatient therapy services. CMS typically defers to the AMA's designation of CPT codes and the RUC's assigned relative weights but reserves the right to make changes.

Payment amounts for outpatient therapy services – like physician services – are based on two primary factors. The relative value of the code that is billed is multiplied by a standard conversion factor **("CF")**. This enables the relative value of each procedure to be translated into a dollar amount. For CY2020, the CF is $36.0896.[7]

Courtesy of Kindred Healthcare

Overall, CMS estimates that total Medicare covered outpatient therapy charges will exceed $4.2 billion in 2020.[8] This amounts to approximately 4.5% of the dollars paid through the Medicare PFS, and less than .005% of total projected Medicare spending, which is projected to exceed $885 billion this year.[9]

CMS makes revisions to the conversion factor annually based on requirements in law. There are two principal steps to this process.

Budget Neutrality. First, CMS is required to make adjustments to make projected spending under the new fee schedule the same as the prior year. This is referred to as the **"budget**

Specialties Most Adversely Impacted by Pending E&M Code Reweighting & the Budget Neutrality Rule

(Est. Impact on CY2021 Payments)

Anesthesiology	-7%
Cardiac Surgery	-8%
Chiropractors	-9%
Clinical Psychology	-7%
Emergency Medicine	-7%
Nurse Anesthetists	-9%
Ophthalmology	-10%
Pathology	-8%
Physical/Occupational Therapy	-8%
Radiology	-8%
Thoracic Surgery	-7%

neutrality" requirement. In implementing this provision, CMS takes in account the revised weights for each HCPCS code and any projected changes in volume of services by code for the upcoming year. If some codes are expected to have a significantly higher value or weight, or the volume of some codes is expected to rise, CMS must make offsetting adjustments to the conversion factor so that total projected spending remains the same.

Pending CY2021 Budget Neutrality Cuts. In 2021, the budget neutrality requirement is expected to force unprecedentedly large revisions to Medicare payments for many health specialties. This is due primarily to a long-awaited reassessment of the relative weights assigned to evaluation and management codes **("E&M codes")** by the RUC. These E&M codes are the majority of the codes billed by primary care clinicans when seeing patients in most routine office visits. As such, the volume of E&M codes paid for by Medicare each year is enormous – accounting for approximately 40% of all Medicare PFS allowed charges in 2020.[10] In 2021 the relative weights of the E&M codes are scheduled to increase significantly. Because the budget neutrality rule requires offsetting changes, this is forecast to result in significant decreases in reimbursement amounts for therapists, surgeons and a host of other professionals who don't typically bill a lot of E&M codes. Because of this policy, outpatient therapy providers are currently projected to receive an 8% cut in reimbursements in 2021. Other specialties expected to be adversely impacted by this development are listed in the chart below.[11]

Conversion Factor Updates. After the required budget neutrality adjustments are made, CMS applies a statutorily prescribed update factor. This factor represents Congress' expected increase in total spending through the Medicare PFS. In recent years this update factor has been essentially flat, with a .5% update authorized in 2018, a .25% update paid in 2019, and a 0% update required for the years 2020-2025.[12]

Medicare Policies Impacting Therapy

In recent years there have been several policies implemented though the Medicare PFS rule that have impacted therapy providers.

Outpatient Therapy Caps. From the late 1970s until 2018, there was a statutory limit on the amount of outpatient therapy benefits a Medicare beneficiary could receive in a calendar year. The therapy benefit was capped at various levels between $100 and $3,700 during this period.[13] While in place, therapy caps were consistently criticized as an arbitrary and dangerous policy, and an impediment to the recovery of seriously ill and injured patients. Throughout most of this period application of the caps was effectively suspended or waived due to either temporary statutory provisions, administrative delays, pending litigation, or a congressionally authorized patient-level exceptions process.

Finally, as part of the Balanced Budget Act of 2018, Congress permanently repealed the hard caps on the outpatient therapy benefit. Instead, the law institutionalized a mandatory, targeted medical review process that requires CMS contractors to examine the appropriateness of claims once a patient's annual outpatient therapy costs exceed a statutorily defined threshold. For 2020 the review threshold is set at $2,080.[14]

Courtesy of Encompass Health

Multiple Procedure Payment Reduction. The Affordable Care Act of 2010 required CMS to undertake a new mis-valued code review initiative. Among other things, CMS was instructed to examine the appropriateness of reimbursements for codes which

Key Medicare Policy Changes

- **1979—**Therapy caps begin with authorization of PT billing
- **1992—**Enactment of RBRVS physician fee schedule
- **1996—**Full implementation of physician fee schedule
- **2011—**Multiple Procedure Payment Reduction initiative begins
- **2015—**Passage of MACRA
- **2018—**Therapy cap repeal
- **2021—**Scheduled cuts in therapy reimbursements due to E&M codes revaluations
- **2022—**Therapy assistants 15% reimbursement reductions to begin

are frequently billed in conjunction with each other when furnishing a single service. This led CMS to initiate its Multiple Procedure Payment Reduction **("MPPR")** policy beginning in 2011. Under the MPPR initiative, CMS has reduced payments for many therapy services including time-based therapeutic activity and other therapy-only codes. Under the MPPR policy, CMS discounts the PE RVU component of secondary codes that are billed on the same day as a primary therapy code by 50%.

Therapy Assistants Payment Policy. In conjunction with the repeal of therapy benefit caps, the Balanced Budget Act of 2018 included another provision requiring a reduction in payments for services provided in whole or in part by a physical therapy assistant **("PTA")** or an occupational therapy assistant **("OTA")**. Beginning in 2022, services provided entirely by a PTA or an OTA, as well as those for which the PTA's or OTA's services account for 10 percent or more of the total minutes devoted to the service, will be paid at 85% of the otherwise applicable reimbursement rate.[15]

Medicare Physician Payment Reform

Lastly, no review of outpatient therapy reimbursement policy is complete without a discussion of the ongoing structural changes made to the Medicare physician payment system by the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 **("MACRA")**. MACRA contains the most significant changes to Medicare's payment policies for physicians (and other covered professionals like PTs, OTs and SLPs) since the creation of the RVRBS system in 1992.

The primary objective of MACRA was to replace the prior structure for updating the pool of budgeted funds available to pay claims through the Medicare PFS. That system, known as the Sustainable Growth Rate **("SGR")**, had fixed total, allowable, annual Part B physician spending to a derivative of general economic growth, and was widely viewed as unsustainable in a time of significant Medicare population expansion. Without changes, the SGR system would have resulted in increasingly large cuts in physician reimbursements each year. MACRA replaced the SGR system with a more sustainable – albeit relatively flat – comprehensive budgeting trajectory for Medicare PFS services.

In conjunction with this fix, MACRA included a fundamental restructuring and consolidation of Medicare's Part B quality improvement programs. These changes are just now being fully implemented and will have a growing impact on therapy professionals in the coming years.

Quality Payment Program. MACRA included a new mandatory, quality reporting and performance-based reimbursement system that applies to every physician and other clinician that bills through the Medicare PFS. The program is referred to as the Quality Payment Program **("QPP")**.

Under the QPP, clinicians who bill Part B will have an increasing percentage of their Medicare reimbursements adjusted each year based on a variety of relative performance measures. Those who perform well relative to their peers will receive bonuses. Those who perform poorly will see commensurate levels of cuts.

Under MACRA, clinicians have two options for participating in the QPP. They can either participate in the Merit-based Incentive Payment System **("MIPS")** or be enrolled in an Advanced Payment Model **("APM")**, such as an accountable care organization. Given the slow growth of APMs, and their more comprehensive integration requirements, it is currently projected that most clinicians will participate in the MIPS program.

Key Regulatory Leaders

- **Seema Verma**, *Administrator,* Centers for Medicare and Medicaid Services
- **Demetrious Kouzoukas**, *CMS Principal Deputy Administrator and Director,* Center for Medicare
- **Ing Jye Cheng**, *Acting Director,* Hospital and Ambulatory Policy Group
- **Tiffany Swygert**, *Director,* CMS Division of Outpatient Care
- **John Pilotte**, *Director,* CMS Performance-based Payment Policy Group

Merit-based Incentive Payment System. Under MACRA, clinicians began reporting performance data across four domains in 2017. The data collected pertains to quality, resource use (or cost), health improvement activities, and electronic data sharing (through electronic health records or **"EHRs"**). Based on this data Medicare payments to physicians were adjusted for the first time in 2018. Per MACRA, the lowest performing clinicians in MIPS may receive negative payment updates of -5% in 2020. This percentage is slated to grow to as much as -9% by 2022. By contrast, the best performing clinicians can theoretically obtain higher positive updates—or bonuses.[16] However, due to a lack of differentiation in most participating clinicians' performance scores, almost all received slightly positive updates – but none more than 1.7%.[17]

Advanced Payment Models. To be eligible for the APM performance track, clinicians must participate in a qualifying APM. For an APM to qualify, it must—among other things—have at least 75% of its clinicians actively using integrated EHRs and bear more than nominal risk for the overall cost of care for the patients it serves. Participating clinicians in an APM must be eligible for performance bonuses of at least 5% over the initial five years of the program (2019-2024) and are generally expected to have a higher percentage at risk in future years. MACRA creates incentives over the long term for clinicians to join an APM. Participants in APMs are set to receive future CF updates of .75% a year beginning in 2026, while those participating in MIPS are only scheduled to receive .25% annual updates.[18]

Future of Outpatient Therapy Services

As the US health system continues to evolve, and the Medicare population continues to increase as the baby boomer generation retires and ages, the need for outpatient therapy services is only expected to grow too – although change is inevitable.
As Medicare and other payers seek to encourage greater data sharing and move toward greater contractual integration, it is likely that therapy providers may see both increasing demand for services and increasing demands for more advanced data reporting and accountability for outcomes. Similarly, as the focus on cost reduction increases, it is likely that therapists – like all health professionals – will face ongoing economic pressures from both Medicare and private payers or be driven to perform more of their services in lower-cost settings – such as the home.

Nevertheless, because the United States has a very large and aging population, and a growing population of both chronic disease patients and acute illness survivors, the value and importance of outpatient therapy services to the system is expected to only increase as well.

References

1. U.S. Physical Therapy Clinics: An Industry Analysis, *MarketData LLC*, Jul 2019
2. American Physical Therapy Association
3. American Occupational Therapy Association
4. American Speech-Language-Hearing Association
5. U.S. Physical Therapy Clinics: An Industry Analysis, *MarketData LLC*, Jul 2019
6. See 42 C.F.R. §410.60, §410.61, §485.711 and §485.713
7. CY2020 Medicare Physician Fee Schedule Final Rule, 84 Fed.Reg. 63152
8. 84 Fed. Reg. 63153
9. CMS: US health spending will reach $4 trillion in 2020, *Advisory Board Daily Briefing*, Apr 3, 2020, accessed at https://www.advisory.com/daily-briefing/2020/04/03/health-spending
10. 84 Fed. Reg. 62844
11. 84 Fed. Reg. 63156-7
12. Social Security Act §1848(d)(18)-(19).
13. History of Medicare Therapy Caps, *American Physical Therapy Assn*, https://www.apta.org/FederalIssues/TherapyCap/History/
14. 84 Fed. Reg. 62709
15. 84 Fed. Reg. 63191
16. See Merit-Based Incentive Payment System and Alternative Payment Model final rule, 81 Fed. Reg. 77008
17. 98% of MIPS participants earned a bonus for 2020 – but don't expect a big payout, *Advisory Board Daily Briefing*, Jan 7, 2020.
18. See 81 Fed. Reg. 77008

INSTITUTE FOR
CRITICAL CARE

1420 Spring Hill Road, Suite 600
McLean, VA 22102
Tel: +1 (703) 442-5300
instituteforcriticalcare.org