April 2012

Developing Outpatient Therapy Payment Alternatives (DOTPA): 2009 Utilization Report – Part II

Final Report

Prepared for

Ann Meadow, ScD
Centers for Medicare & Medicaid Services
Rapid Cycle Evaluation Group
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by

Benjamin Silver, BA
Brieanne Lyda-McDonald, MSPH
Henry Bachofer, MHSA
Barbara Gage, PhD
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

RTI Project Number 0209853.012.001.003

DEVELOPING OUTPATIENT THERAPY PAYMENT ALTERNATIVES (DOTPA): 2009 UTILIZATION REPORT – PART II

By
Benjamin Silver, BA
Brieanne Lyda-McDonald, MSPH
Henry Bachofer, MHSA
Barbara Gage, PhD

Federal Project Officer: Ann Meadow, ScD

RTI International

CMS Contract No. 500-2005-0029I/0012

April 2012

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-2005-0029I/0012. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

CONTENTS

List of Tables

[This page intentionally left blank]

SECTION 1
INTRODUCTION

1.1 Purpose

The purpose of Part II of this report is to augment the information presented by RTI International in the *Developing Outpatient Therapy Payment Alternatives: 2009 Utilization Report (Part I)* (Lyda-McDonald, Drozd, and Gage, 2011).[1] The focus of Part II is twofold. First, it describes broadly patterns of utilization by beneficiaries who obtain care in different treatment settings and provides additional data on the characteristics of those beneficiaries who exceed the therapy cap and those who do not. Second, it provides additional information on the structure of the therapy industry. Relative to Part I, Part II also uses an alternative definition of *providers* for private practices. This new definition will be outlined in greater detail in Section 2—Data Analysis Methods.

1.2 Organization of Part II

Section 2 describes the analytic data file that was used for this report, and the revisions that were made to the analytic process to develop the tables presented in Part II. Section 3 summarizes the key results presented in the report, and Section 4 presents the main results. Subsections describe calendar year (CY) 2009 outpatient therapy utilization by discipline, provider characteristics, distribution of beneficiaries who are above and below the cap, and the associated reimbursement information. The appendix of this report outlines the data analysis methodology that was used.

Accompanying Part II is a set of Microsoft Excel workbooks providing more detail on utilization than is presented in the report. The figures and tables presented in the body of Part II use data drawn from these workbooks, and workbook citations are provided in the source references for these figures and tables.

---

[1] Throughout this report, all references to *2009 Utilization Report* are citing this publication.

[This page intentionally left blank]

SECTION 2
DATA ANALYSIS METHODOLOGY

2.1 Source Data

The tables and figures in Part II were developed using the same set of data that was used for Part I of the *2009 Utilization Report*. For the figures and tables used herein, and for the accompanying Excel workbooks, RTI used 100 percent of outpatient therapy fee-for-service (FFS) claims with dates of service between January 1, 2009, and December 31, 2009, as retrieved from the Centers for Medicare & Medicaid Services (CMS) National Claims History in November 2010. See ***Appendix A*** for a complete description of the methodology used to develop the tables contained in the *2009 Utilization Report*.

2.2 Defining Providers

Throughout this report a provider is defined as a distinct Medicare-certified Hospital Outpatient Department (HOPD), (Skilled) Nursing Facility (S/NF), Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), Home Health Agency (HHA), or a Medicare-participating private practice that provides covered outpatient therapy services. HOPDs, S/NFs, CORFs, ORFs, and HHAs are identified using their CMS Certification Number (CCN). In Part I of the *2009 Utilization Report*, a noninstitutional provider (called a "private practice"), was defined as an individual clinician, identified by a unique Provider Identification Number (PIN), on the claim line level as the performing provider.[2]

As a result, in Part I, the term "provider" has different meanings when it refers to an institutional provider (HOPD, S/NF, CORF or ORF) and when it refers to a "private practice". In the case of the institutional providers, it refers to the facility. All therapy services that are billed by the institution, regardless of the specific clinician who performs the treatment, would be attributed to a single provider. In the case of "private practices", the term "provider" refers to the individual clinician. Each of the clinicians employed by (or contracting with) the practice would be counted as a separate "provider".

In contrast, in Part II, the "provider" is defined as the entity that bills for the services. Private practices are identified by the Tax Identification Number (TIN) recorded on the claim, not the individual clinician performing the therapy service. The "provider" in the Part II tables is a unique organizational entity, rather than either an organizational entity or an individual clinician (depending on the type of claim, i.e., institutional or noninstitutional). For private practices, some of these organizational entities operate facilities in multiple locations and/or in multiple states. Others may include small independent practices offering the services of a single therapist in a single location.

2.3 Defining Beneficiaries

Table 1 in Section 4 provides a summary of the total number of Medicare beneficiaries receiving outpatient therapy services and total Medicare payments under Part B for the outpatient therapy services provided to these beneficiaries. A *beneficiary* or user is defined as a unique

---

[2] For the purposes of this report, the term *private practices* includes all providers that were identified in the *2009 Utilization Report* as "Physician," "PTPP," "OTPP," and "NPP."

health insurance claim number (HICN) associated with a claim for covered outpatient therapy services.[3] Because some beneficiaries received more than one type of outpatient therapy service during the year, the total number of beneficiaries receiving *any* therapy service is less than the sum of the beneficiaries receiving each type of therapy service.

[3] Throughout this report, the terms *users*, *beneficiaries*, and *patients* are used interchangeably. All refer to a unique health insurance claim number (HICN) that is associated with a claim for an outpatient therapy service under Part B of Medicare. This count is slightly higher than the number of unique beneficiaries receiving care because the HICN used by a beneficiary may change over the course of the year.

SECTION 3
SUMMARY OF KEY RESULTS

- Medicare expenditures for therapy services under Medicare Part B were approximately 5.4 billion in CY2009. Almost three quarters (72.9 percent) of these expenditures were for physical therapy (PT), followed by 20.0 percent for occupational therapy (OT), and 7.0 percent for speech language pathology (SLP).

- There were 45,846 individual facilities and practices providing outpatient therapy services to Medicare beneficiaries in 2009. More than half (52.5 percent) of these were identified as private practices, and 31.5 percent were (skilled) nursing facilities. Virtually all (96.2 percent) of these providers had at least one claim for PT, about half (49.7 percent) provided OT to Part B patients, and approximately 41.1 percent had at least one claim for SLP.

- Approximately 4.6 million Medicare beneficiaries had at least one claim for outpatient therapy services in 2009. Of these, nearly 4.1 million had a claim for PT, whereas approximately 1 million received OT and nearly 514,000 received SLP services. Most beneficiaries receiving therapy in private practices received PT (94.5 percent), whereas only 7.9 percent received OT, and only 0.9 percent received SLP. Other settings provided OT and SLP to a greater percentage of their beneficiaries than private practices, but most beneficiaries in each setting had at least one claim for PT. S/NFs had the highest percentage of beneficiaries receiving OT and SLP, at 58.6 percent and 36.3 percent of beneficiaries, respectively.

- A total of 67,049,744 visits for therapy services covered under Medicare Part B occurred in CY2009. Of these, approximately 82.1 percent included a claim for PT services, 21.8 percent included OT, and 8.3 percent included at least one claim for SLP. The overall distribution of the visits among settings and disciplines was similar to the distribution of beneficiaries; however, 31.5 percent of the visits occurred in S/NFs whereas S/NFs provided therapy to only 18.5 percent of all beneficiaries receiving therapy, and HOPDs and private practices represented a smaller proportion of the overall number of visits (19.2 percent and 38.1 percent of visits, respectively) than their proportion of beneficiaries (32.3 percent and 44.7 percent of beneficiaries).

- The mean number of therapy visits per beneficiary was 14.5 across all settings. S/NF beneficiaries on average received therapy for 24.6 visits, which is nearly three times as many as beneficiaries in HOPDs, and twice as many as beneficiaries in private practices (12.3). OT typically involved the greatest number of visits per beneficiary (14.3 across all settings), and SLP generally required the least number of visits per beneficiary (10.9 across all settings).

- Most providers of outpatient therapy in 2009 were small units, with 48 or fewer Medicare patients, as measured by the annual patient caseloads within a discipline. By this definition, the presence of small providers varied considerably when breaking the data down by discipline: 54 percent of PT providers were small, versus 70 percent of OT providers, and 85 percent of SLP providers.

- PT users were most likely to be served in large health care units (where size is based on annual counts of Medicare PT cases), and unlikely to be served in very small ones; specifically, 4 in 10 PT users were served in large organizations (360 or more PT cases annually), and less than 1 percent of users were seen in units serving 12 or fewer Medicare PT patients annually. In contrast, OT users were primarily served in small units of 13 to 48 OT beneficiaries (29 percent), followed by units of 49 to 72 beneficiaries (17 percent). With SLP, users were even more concentrated in small units of 13 to 48 cases (47 percent), and units of 49 to 72 cases (15 percent).

- A total of 4,339,220 beneficiaries received either PT or SLP services in CY2009. Of those, 863,590 (19.9 percent) exceeded the established cap for PT and SLP services, and 241,214 of the total 1,025,629 beneficiaries receiving OT (23.5 percent) exceeded the cap for OT services. Overall, approximately 20 percent of the beneficiaries who received therapy services in CY2009 exceeded at least one of the two therapy caps, and about 3 percent exceeded both caps.

- Beneficiaries in S/NFs were the most likely to exceed either of the therapy caps individually during the calendar year. S/NF beneficiaries were also among the most likely to exceed both therapy caps (11.8 percent of beneficiaries), exceeded only by CORF beneficiaries, with 13.6 percent of their beneficiaries exceeding both caps.

- Overall, beneficiaries receiving OT were more likely to exceed the cap than those receiving PT and/or SLP. By setting, however, beneficiaries receiving PT and/or SLP entirely in HOPDs, S/NFs, or private practices were more likely to exceed the cap than those receiving OT.

- Beneficiaries who exceeded the PT/SLP cap on average received therapy for 4.4 times as many visits as those that did not, and mean allowed charges for these patients were typically 5.5 times as high. Similarly, beneficiaries who exceeded the OT cap received therapy for 5.0 times as many visits, and typically cost 6.2 times as much.

SECTION 4
CY2009 OUTPATIENT THERAPY UTILIZATION

4.1 Outpatient Therapy Utilization—Overall Results

During CY2009, a total of 4,630,593 beneficiaries received physical therapy (PT), occupational therapy (OT), or speech language pathology (SLP) services. This represents 13.5 percent of the 34,293,550 fee-for-service (FFS) beneficiaries.[4] PT had the most users at 4,096,735, followed by OT with 1,025,629 users, and SLP with 513,675 users. Note that the sum of users of PT, OT, and SLP services is greater than the total number of users because some patients receive therapy from multiple disciplines.

As detailed in ***Table 1***, in CY2009 Medicare payments for outpatient therapy services were $5,399,603,418. Of this amount,

- PT services accounted for about 73 percent ($3,941,005,259),
- OT services accounted for about 20 percent ($1,080,240,890), and
- SLP services accounted for about 7 percent ($378,357,269).

Table 1
Summary of outpatient therapy expenditures, CY2009

Discipline	Outpatient therapy users	Percent of users	Total paid (thousands)	Percent of paid	Mean payment per user
All[1]	4,630,593	100.00	$5,399,603	100.00	$1,166
PT	4,096,735	88.47	$3,941,005	72.99	$962
OT	1,025,629	22.15	$1,080,241	20.01	$1,053
SLP	513,675	11.09	$378,357	7.01	$737

[1] The sum of numbers of therapy users for each discipline exceeds the total number of users because some users receive therapy from multiple disciplines. Likewise, the sum of the discipline-specific percentage of users exceeds 100 percent.

NOTES: OT = occupational therapy; PT = physical therapy; SLP = speech language pathology.

SOURCE: Lyda-McDonald, Drozd, and Gage, 2011. *Table 1—Summary of Outpatient Therapy Expenditures, CY2009.*

[4] This number represents the total number of unique values of HICN in the denominator file. This value may be overstated, as it does not take into account that an individual beneficiary's HICN may change over the course of the calendar year.

The largest fraction (88.47 percent) of therapy users received PT services, followed by OT with 22.15 percent of users and SLP with 11.09 percent of users. OT had the highest mean payments per user ($1,053), followed by PT ($962) and SLP ($737). PT had the highest median payments per user ($602), followed by OT ($568) then SLP ($378). OT also had the highest mean payment per episode ($918), followed by PT ($830) and SLP ($655).[5]

For additional information on the total populations of patients receiving outpatient therapy services under Medicare Part B in CY2009, please see the *2009 Utilization Report*.

4.2 Types of Outpatient Therapy Providers

Table 2 describes the universe of providers of outpatient therapy services covered by Medicare Part B. Currently Part B covers 45,846 providers of therapy services. The largest group is private practices, with a total of 24,059 providing some form of therapy services. The majority of these practices (22,599) provide physical therapy. Only 3,255 of private practices identified had at least one claim for OT, and 674 practices provided SLP to at least one patient. The second-largest provider of Part B therapy services is S/NFs. A total of 14,447 of these facilities had at least one Medicare Part B therapy claim in CY2009, and of these nearly all of them had a claim in each of the three disciplines.[6]

A total of 4,777 hospital outpatient departments (HOPD) had at least one claim for therapy services covered under Medicare Part B in CY2009. Of these, nearly all submitted at least one claim for physical therapy; 3,969 submitted at least one claim for OT; and 3,700 had at least one claim for SLP. In addition, 350 Comprehensive Outpatient Rehabilitation Facilities (CORF), 2,060 Outpatient Rehabilitation Facilities (ORF), and 173 Home Health Agencies (HHA) had at least one claim for therapy services covered under Medicare Part B. Of these, nearly all had at least one claim for PT services (346, CORF; 1,992, ORF; and 161, HHA). Approximately half of the ORFs and HHAs identified had a claim for OT, and a slightly larger proportion of CORFs (237) had at least one claim for OT. Approximately one quarter of the CORFs, ORFs, and HHAs identified had at least one claim for SLP. Nearly all of the providers identified had at least one claim for either PT or SLP. Complete details for this information are listed in ***Table 2***.

---

5 Median payments per user and mean payments per episode are not shown but can be found in Lyda-McDonald, Drozd, and Gage, 2011.

6 Some S/NFs exist in Continuum of Care Communities that also provide rehabilitation services for independent living and Assisted Living Facility (ALF) patients. The services for ALF patients may be billed through the S/NF NPI. Therefore, some of these less-complex patients are reflected in values presented for S/NFs.

Table 2
Total number of providers, by discipline and setting, CY2009

Provider Type[1]	Total provider count	Providers with a PT claim	Providers with an OT claim	Providers with an SLP claim	Providers with PT or SLP claims[2]
Total	45,846	44,137	22,784	18,854	44,639
HOPD	4,777	4,656	3,969	3,700	4,696
S/NF	14,447	14,401	14,237	13,819	14,428
CORF	350	346	237	84	348
ORF	2,060	1,992	1,010	532	2,043
HHA	173	161	92	47	164
PP	24,059	22,599	3,255	674	22,978

[1] Providers in this table were identified from both the carrier and outpatient files for CY2009. Providers in the outpatient file were identified by CMS certification number (CCN), and providers in the carrier file were identified using their billing Tax Identification Number.

[2] The total number of providers identified with PT or SLP claims does not equal the sum of the provider counts for PT and SLP, because some providers may perform both PT and SLP.

NOTES: CORF = Comprehensive Outpatient Rehabilitation Facility; HHA = Home Health Agency; HOPD = Hospital Outpatient Department; NPP = Non-physician practitioner; ORF = Outpatient Rehabilitation Facility; OT = occupational therapy; OTPP = occupational therapist in private practice; PP = private practice; PT = physical therapy; PTPP = physical therapist in private practice; SLP = speech language pathology; and S/NF = (skilled) nursing facility.

SOURCE: 2009 Utilization Report Part II.xls: Table 1 - Total Number of Providers of Medicare Part B Therapy Services [Excel workbook accompanying this report].

The count of private practices presented in Table 2 represents the total number of private practice settings in which therapy was provided to Medicare beneficiaries in CY2009. Providers in the Carrier file are also identified as individually practicing clinicians. They are identified on claims using the Provider Identification Number (PIN) at the claim line level, and their discipline is identified using the Health Care Financing Administration (HCFA) specialty code. The following clinicians provided therapy to Medicare beneficiaries in CY2009 (these values were also presented in Part 1 of this report):

- Physical Therapists (PTPP): 33,704
- Occupational Therapists (OTPP): 3,790
- Non-Physician Practitioners (NPP): 892
- Physicians: 32,205

Note: Because speech language pathologists were unable to bill for therapy services independently until July 2009, it was not possible to identify these clinicians in the data.

4.3 Beneficiaries Receiving Outpatient Therapy Services

Table 3 describes the number of beneficiaries receiving each type of outpatient therapy service in different provider settings. A total of 4,630,593 beneficiaries had at least one claim for therapy services in CY2009. The greatest number of beneficiaries, a total of 2,073,027, received therapy in private practices. Of these, nearly all had at least one claim for PT services (1,958,479); however, only 164,041 received OT (7.9 percent), and 18,448 had a claim for SLP (0.9 percent). Furthermore, a total of 1,973,135 beneficiaries had a claim for either PT or SLP services from private practices, with only 0.2 percent (3,792)[7] of these beneficiaries receiving both PT and SLP from a private practice in CY2009.

Table 3
Total number of beneficiaries receiving therapy, by discipline and setting, CY2009

Provider type	Total beneficiary count[1]	Number of beneficiaries with a PT claim (%)	Number of beneficiaries with an OT claim (%)	Number of beneficiaries with an SLP claim (%)	Number of beneficiaries with PT or SLP claims (%)
Total	4,630,593	4,096,735 (88.47)	1,025,629 (22.15)	513,675 (11.09)	4,339,220 (93.71)
HOPD	1,494,392	1,251,943 (83.78)	285,701 (19.12)	184,203 (12.33)	1,380,741 (92.39)
S/NF	858,213	640,052 (74.58)	502,542 (58.56)	311,200 (36.26)	769,122 (89.62)
CORF	54,285	51,379 (94.65)	22,185 (40.87)	1,405 (2.59)	52,008 (95.81)
ORF	466,744	435,712 (93.35)	83,310 (17.85)	19,051 (4.08)	442,760 (94.86)
HHA	3,903	3,482 (89.21)	977 (25.03)	270 (6.92)	3,581 (91.75)
PP	2,073,027	1,958,479 (94.47)	164,041 (7.91)	18,448 (0.89)	1,973,135 (95.18)

[1] The total number of beneficiaries will not equal the sum of total beneficiaries from each category, because a beneficiary may have visited multiple settings in the year.

NOTES: CORF = Comprehensive Outpatient Rehabilitation Facility; HHA = Home Health Agency; HOPD = Hospital Outpatient Department; ORF = Outpatient Rehabilitation Facility; OT = occupational therapy; PP = private practice; PT = physical therapy; SLP = speech language pathology; and S/NF = (skilled) nursing facility.

SOURCE: 2009 Utilization Report Part II.xls: Table 2 - Total Number of Beneficiaries receiving Medicare Part B Therapy Services [Excel workbook accompanying this report].

[7] [Number of beneficiaries with PT claim in private practice (1,958,479) + Number of beneficiaries with SLP claim in private practice (18,448)] – Number of beneficiaries with PT or SLP claims in private practice (1,973,135) = 3,792 beneficiaries.

Other settings exhibited similarly high levels of PT as a proportion of total number of beneficiaries treated, and also higher proportional levels of OT and SLP utilization than private practices. Hospital Outpatient Departments provided therapy to the next-largest group of beneficiaries, a total of 1,494,392 in CY2009. Of these, 1,251,943 received physical therapy, 285,701 received OT, and 184,203 had at least one claim for SLP. S/NFs and CORFs had the highest proportion of their patient populations receiving OT or SLP. A total of 858,213 beneficiaries received therapy from S/NFs, and 54,285 received therapy from CORFs in CY2009. Of these, in S/NFs, 502,542 beneficiaries received OT and 311,200 received SLP. In CORFs, 22,185 beneficiaries received OT and 1,405 received SLP. Complete details of this information are listed in Table 3.

A total of 67,049,744 visits for therapy services covered under Medicare Part B occurred in CY2009. For the purposes of this report, a visit for therapy services is identified as a single calendar day in which a beneficiary receives therapy services under Medicare Part B. A therapy visit is calculated by identifying claims with unique combinations of the beneficiary's Health Insurance Claim Number (HICN) and the date of service recorded on the claim. Setting-specific therapy visits were calculated by identifying claims with unique combinations of HICN, date of service, and setting type; discipline-specific therapy visits were calculated by identifying unique combinations of HICN, date of service, and therapy discipline. If a beneficiary receives multiple therapy disciplines in a single day, this is counted as a single visit in the overall total, and also once under each individual discipline in which services are provided.

Of the 67,049,744 visits for therapy services billed under Medicare Part B, PT was involved in 55,017,110 visits; 14,617,073 included at least one claim for OT; and SLP was involved in 5,594,374 of these visits.

The discipline-specific visits outlined in Table 4 indicate that the majority of visits for therapy services involved only a single discipline. Overall, only 10.9 percent of discipline-specific therapy visits occurred on the same day as another discipline for the same beneficiary.[8] CORFs and S/NFs had the highest percentage of discipline-specific visits occurring on the same calendar day as at least one other discipline (29.3 percent and 21.9 percent, respectively). Beneficiaries in private practices were the least likely to receive multiple-therapy disciplines in a single day, with 0.9 percent of discipline-specific visits occurring on the same day as a different discipline.

The distribution of these visits across disciplines and settings is generally proportionate to the total number of beneficiaries in Table 3. An exception to this pattern is S/NFs, with a total of 31.5 percent of all therapy visits (21,108,875 visits in CY2009), contrasted with S/NFs seeing only 18.5 percent of beneficiaries (858,213 beneficiaries out of a total 4,630,593). Private practices and HOPDs represent a smaller proportion of total therapy visits than total beneficiaries. Hospital outpatient departments had a total of 12,849,143 visits, or 19.2 percent, but account for 32.3 percent of beneficiaries; and private practices had a total of 25,556,197 visits, or 38.1 percent, but account for 44.7 percent of beneficiaries. (Percentages are included in the accompanying workbook.)

---

[8] Percentage of multidisciplinary visits was calculated by summing the total number of visits for each discipline, subtracting the total visit count from this value, and then dividing the difference by the sum of the discipline-specific visits. Percent = ([PT+OT+SLP]-Total Visit Count) / (PT+OT+SLP).

Table 4
Total number of visits for therapy services, by discipline and setting, CY2009

Provider type	Total visit count[1]	Sum of discipline-specific visits	Percent of discipline-specific visits concurrent with another discipline	Number of visits for PT services	Number of visits for OT services	Number of visits for SLP services	Number of visits for PT and SLP services[2]
Total	67,049,744	75,282,557	10.94	55,071,110	14,617,073	5,594,374	60,665,484
HOPD	12,849,143	13,709,095	6.27	11,098,812	1,804,835	805,448	11,904,260
S/NF	21,108,875	27,054,380	21.98	13,071,284	9,543,337	4,439,759	17,511,043
CORF	862,539	1,219,311	29.26	794,640	408,028	16,643	811,283
ORF	6,635,480	7,472,199	11.20	5,856,843	1,344,319	271,037	6,127,880
HHA	37,510	41,690	10.03	28,933	10,308	2,449	31,382
PP	25,556,197	25,786,149	0.89	24,220,724	1,506,305	59,120	24,279,844

[1] The Total Visit Count equals the total number of days on which all individual beneficiaries had at least one claim for therapy services, regardless of discipline. Because beneficiaries may receive services in more than one discipline in a single day, this value will equal less than the sum of the discipline-specific visit counts.

[2] This column represents the sum of visits for PT and SLP services.

NOTES: CORF = Comprehensive Outpatient Rehabilitation Facility; HHA = Home Health Agency; HOPD = Hospital Outpatient Department; ORF = Outpatient Rehabilitation Facility; OT = occupational therapy; PP = private practice; PT = physical therapy; SLP = speech language pathology; and S/NF = (skilled) nursing facility.

SOURCE: 2009 Utilization Report Part II.xls: Table 3 – Total Number of Visits for Medicare Part B Therapy Services [Excel workbook accompanying this report].

The average beneficiary receiving therapy services under Medicare Part B received therapy over 14.5 total visits, as shown in ***Table 5***. The value, however, varies considerably across settings and disciplines. The mean number of therapy visits per beneficiary provided by S/NFs was 24.6 visits. This is nearly three times as many visits as were provided on average to beneficiaries by HOPDs (9.6), and twice as many as the mean number of visits for beneficiaries by private practices (12.3). OT generally involved the greatest number of visits per beneficiary (14.3 across all settings), with the exception of private practices, HOPDs, and S/NFs where PT involved the greatest mean number of visits (12.4 in private practices, 6.3 in HOPDs, and 20.4 in S/NFs). SLP generally accounted for the smallest number of visits per beneficiary (10.9 across all settings), with the exception of ORFs (14.2 SLP visits per beneficiary), where PT accounted for the lowest mean number of visits per beneficiary (13.4). When looking at the combination of PT and SLP, beneficiaries generally received 14.0 visits each in CY2009. Across settings, these values were generally similar to (in most cases, slightly higher than) the number of PT visits per beneficiary needed in each setting. As with other individual disciplines, the mean number of visits per beneficiary was greatest in S/NFs (22.8), CORFs (15.6), and ORFs (13.8) visits.

Table 5
Mean number of visits per beneficiary, by discipline and setting, CY2009

Setting	Total beneficiary count	Mean number of visits per beneficiary	Mean number of PT visits per beneficiary	Mean number of OT visits per beneficiary	Mean number of SLP visits per beneficiary	Mean number of PT/SLP visits per beneficiary[1]
Total	4,630,593	14.5	13.4	14.3	10.9	14.0
HOPD	1,494,392	8.6	8.9	6.3	4.4	8.6
S/NF	858,213	24.6	20.4	19.0	14.3	22.8
CORF	54,285	15.9	15.5	18.4	11.8	15.6
ORF	466,744	14.2	13.4	16.1	14.2	13.8
HHA	3,903	9.6	8.3	10.6	9.1	8.8
PP	2,073,027	12.3	12.4	9.2	3.2	12.3

[1] This value is equal to the mean number of visits per beneficiary for a combination of PT and SLP services. Because an individual beneficiary may receive both PT and SLP over the course of the year, this value will not directly correspond to the mean values and total beneficiary counts presented for PT and SLP individually.

NOTES: CORF = Comprehensive Outpatient Rehabilitation Facility; HHA = Home Health Agency; HOPD = Hospital Outpatient Department; ORF = Outpatient Rehabilitation Facility; OT = occupational therapy; PP = private practice; PT = physical therapy; SLP = speech language pathology; and S/NF = (skilled) nursing facility.

SOURCE: 2009 Utilization Report Part II.xls: Table 4 – Mean Number of Visits Per Beneficiary [Excel workbook accompanying this report].

The accompanying workbook displays additional detail as to the distribution of beneficiary and visit volume by setting. Workbook tables 10, 11, and 12 display the number of providers with different Medicare Part B therapy user volumes in CY2009 (PT, OT, and SLP, respectively). Panel A on each of the three tables shows the distribution of providers, and panels B and C display the number of beneficiaries and visits, respectively, that occur with the corresponding providers in Panel A. Workbook tables 13 and 14 display the same distribution for providers with a claim for PT or SLP services, and PT and OT services, respectively.

The general results from these workbook tables show that a plurality of outpatient therapy occurred in relatively large organizations, even though most providers of outpatient therapy in 2009 were small (48 or fewer Medicare patients), as measured by the annual patient caseloads within a discipline. The presence of small providers varied considerably when breaking the data down by discipline: 54 percent of PT providers were small, versus 70 percent of OT providers, and 85 percent of SLP providers. PT users were most likely to be served in large health care units, and unlikely to be served in very small ones; specifically, 4 in 10 PT users were served in large organizations (360 or more PT cases annually), and less than 1 percent of users were seen in units serving 12 or fewer Medicare PT patients annually. In contrast, OT

users were primarily served in small units of 13 to 48 OT beneficiaries (29 percent), followed by units of 49 to 72 beneficiaries (17 percent). With SLP, utilization was even more concentrated in small units of 13 to 48 cases (47 percent), and units of 49 to 72 cases (15 percent).

Workbook Table 10 shows the results separately by provider setting. Overall, for providers of PT services, the greatest number saw between 13 and 48 beneficiaries each for PT in CY2009 (14,470 total). S/NFs, CORFs, and ORFs followed this trend. The greatest number of HOPDs (1,257) saw more than 360 PT beneficiaries each, but a slightly smaller number of HOPDs (1,180) saw 12 or fewer beneficiaries. The greatest number of HHA and PP providers saw 12 or fewer beneficiaries for PT. Overall, the largest portion of beneficiaries was treated in settings with more than 360 beneficiaries per year (1,919,175). Exceptions to this pattern were S/NFs and HHAs, where the most beneficiaries were seen in settings that provided therapy to 13 to 48 PT beneficiaries in CY2009 (235,568 in S/NFs; and 1,054 in HHAs). The greatest number of visits also occurred in settings with more than 360 PT beneficiaries, and, as with the distribution of beneficiaries, the greatest number of S/NF and HHA visits occurred in settings with 13 to 48 PT beneficiaries seen in CY2009 (4,579,830 S/NF; and 6,917 HHA).

As workbook Table 11 shows, the plurality of OT providers across all settings treated from 13 to 48 OT beneficiaries each in CY2009 (10,854). This value is largely due to S/NFs, in which 8,460 of the total 14,237 S/NFs providing OT services provided therapy to between 13 and 48 OT beneficiaries. For all other settings, the plurality of providers saw 12 or fewer OT beneficiaries in CY2009. The plurality of beneficiaries in settings with OT were also seen by providers with a volume of 13 to 48 OT beneficiaries in CY2009. Exceptions to this trend were HOPDs, in which the greatest number of beneficiaries (55,154) were seen in settings with 121 to 180 OT beneficiaries each; and CORFs and ORFs, where the plurality (8,180 for CORFs and 31,627 for ORFs) were seen in settings with more than 360 OT beneficiaries each in CY2009. The distribution of OT visits by provider volume across the different settings is similar to the distribution of beneficiaries by setting.

As outlined in workbook Table 12, the plurality of providers with at least one claim for SLP saw from 13 to 48 beneficiaries for SLP in CY2009. By setting, this is true of HOPDs (1,223) and S/NFs (8,252); however, the greatest number of CORFs (59), ORFs (268), HHAs (42), and private practices (439) saw 12 or fewer beneficiaries for SLP in CY2009. Across nearly all settings, the largest group of beneficiaries was also seen by providers with a volume of 13 to 48 SLP beneficiaries in CY2009 (258,304). The only exception to this pattern was HHAs, in which the greatest number of beneficiaries (120) were seen by providers with a volume of 49 to 72 SLP beneficiaries in CY2009. Also, for HOPDs, 35,764 served 121 to 180 beneficiaries, a number similar to that for HOPDs serving 13 to 48 beneficiaries (35,944). The plurality of visits for providers of SLP services occurred in settings that saw 13 to 48 SLP beneficiaries in CY2009 (3,299,629). However, in ORFs, the greatest number of beneficiaries were seen by providers with a volume of more than 360 beneficiaries in CY2009 (47,260); and in HHAs, the greatest number of beneficiaries (1,417) were seen by providers with a volume of 49 to 72 beneficiaries. In HOPDs, similar numbers of beneficiaries were seen in two size classes (13 to 48 and 121 to 180).

The distribution of providers, beneficiaries, and visits across provider types and beneficiary volumes for providers of PT or SLP services appears similar to the distribution for providers with a claim for PT. As shown in workbook Table 13, the plurality of providers saw from 13 to 48 beneficiaries each in CY2009, with the exceptions again being HHAs and private

practices, in which the greatest number of providers saw 12 or fewer beneficiaries each (104, HHAs; and 6,571, private practices) and HOPDs, with the greatest number of providers seeing more than 360 beneficiaries per year (1,402). Similar trends to providers with PT were observed for the distribution of beneficiaries and visits in providers of PT or SLP. The total number of providers with at least one claim for PT or SLP is only 502 more than the total number of providers for PT. This represents 2.7 percent of the total number providers identified with at least one claim for SLP, and indicates that overall, the majority of SLP providers (97.3 percent) also provide PT. This trend appears similar across most settings (range from 99.8 percent to 90.4 percent), with the exception of private practices, where only 43.8 percent of SLP providers also provide PT services.

Workbook Table 14 outlines the distribution for providers who provided therapy to beneficiaries who received both PT and OT in CY 2009. Overall, the greatest number of these providers saw fewer than 12 beneficiaries with PT and OT in CY2009. As with OT providers, the greatest number of S/NFs (9,006 of the 14,245 total) in this category saw 13 to 48 beneficiaries in CY2009. The plurality of providers in all other categories saw 12 or fewer beneficiaries with PT and OT in CY2009. Overall, the greatest number of PT and OT beneficiaries seen in these settings (318,675) were seen by providers with 13 to 48 PT and OT beneficiaries on average in CY2009. The trend varied by provider type: HHAs saw the largest group of beneficiaries (304) by providers that treated 12 or fewer beneficiaries; for CORFs and ORFs, the largest group of beneficiaries (8,099 for CORFs and 24,928 for ORFs) was seen by providers that treated more than 360 beneficiaries each in CY2009; and for HOPDs, the largest group of beneficiaries (38,752) was seen by providers that treated 121 to 180 PT and OT beneficiaries per year. The distribution of these visits shows HOPDs, S/NFs, HHAs, and private practices having the largest majority of visits with providers that saw 13 to 48 beneficiaries with PT and OT in CY2009. CORFs and ORFs had the highest number of visits in sites with 360 or more PT (152,223) and OT (692,999) beneficiaries per year.

4.4 Outpatient Therapy Utilization—Patients Who Did/Did Not Exceed the Cap

In 2009, the cap for outpatient therapy was $1,840 in allowed charges. Separate $1,840 caps were in effect: one covering occupational therapy, and the other covering physical therapy and speech language pathology combined. Therapy services provided by any type of setting are subject to these caps with the exception of Hospital Outpatient Departments, which are exempt. For the purposes of this report, patients receiving therapy from HOPDs are also counted as having exceeded the cap if their therapy utilization exceeds $1,840 in a particular category.

Of the 4,630,593 beneficiaries who received therapy services under Medicare Part B in 2009, a total of 932,585 (20.1 percent) reached or exceeded at least one of the two therapy caps (***Table 6***). Of those receiving OT, 241,214 (23.5 percent), exceeded the OT therapy cap, and of those receiving either PT or SLP, 863,590 (19.9 percent), reached or exceeded the PT/SLP cap.

Table 6
Number of patients exceeding the therapy cap, by discipline, CY2009

Discipline	Number of patients with a claim	Number of patients above the cap	Percent above the cap	Number of patients below the cap	Percent below the cap
All	4,630,593	932,585 (either) 172,219 (both)	20.14% (either) 3.71% (both)	3,698,008 (both) 4,458,374 (either)	79.86% (both) 96.28% (either)
OT	1,025,629	241,214	23.52%	784,415	76.48%
PT/SLP	4,339,220	863,590	19.90%	3,475,630	80.10%

NOTES: OT = occupational therapy; PT = physical therapy; SLP = speech language pathology.

SOURCE: 2009 Utilization Report Part II.xls: Table 5- Number of Beneficiaries Who Exceed the Cap by Setting [Excel workbook accompanying this report].

Table 7 outlines the distribution of patients (beneficiaries receiving the specified type of service in the specified type of setting) who exceeded either one or both of the two caps by setting. In this table, the total number of patients listed represents the total number of beneficiaries with at least one claim for therapy in each setting, and the total number of patients exceeding the cap in each setting represents those beneficiaries who exceeded the cap entirely from therapy provided in that setting. A beneficiary may receive treatment in more than one setting and is counted as a patient in each setting in which she or he received treatment. For example, a total of 4,630,593 beneficiaries received PT, OT, or SLP services in any setting in CY2009. Of these, 1,494,392 received treatment in a HOPD and 2,073,027 received treatment in a private practice. Some of the beneficiaries receiving treatment in a HOPD would also have received treatment in a private practice and are counted as patients in both settings.

Private practices provided therapy to the greatest number of beneficiaries who exceeded at least one of the therapy caps in 2009, but they did not account for the highest percentage of patients in one setting that exceeded either therapy cap. About 33 percent of beneficiaries receiving therapy in (skilled) nursing facilities exceeded one or more of the therapy caps, based solely on the services received from S/NFs. Sixteen percent of beneficiaries receiving therapy from private practices exceeded one or more of the therapy caps, based solely on the services received from those practices. S/NFs however, provided therapy to only 858,213 beneficiaries as compared with 2,073,027 in private practices.

Overall, beneficiaries receiving OT were more likely to exceed that cap than those receiving PT and/or SLP. The distribution of cases that exceeded each of the caps was very different across settings, however. Beneficiaries in HOPDs, S/NFs, and private practices more often exceeded the PT/SLP cap than the OT cap (6.1 percent and 5.2 percent for HOPD; 31.7 percent and 28 percent for S/NF; and 16.2 percent and 12.9 percent for private practice, respectively). OT patients in CORFs, ORFs, and HHAs were more likely to exceed the cap than PT/SLP patients, with 37.1 percent, 27.4 percent, and 16.3 percent of OT patients exceeding the cap, respectively. In these settings, 26.6 percent, 17.8 percent, and 8.8 percent of PT/SLP patients exceeded the cap, respectively.

Table 7
Number of patients exceeding the therapy cap, by setting, CY2009

Setting	Total patients	PT/SLP patients[1]	OT patients[1]	Number of patients over either cap (%)[2]	Number of patients over the PT/SLP cap (%)[2]	Number of patients over the OT cap (%)[2]	Number of patients over both caps (%)[2]
Total	4,630,593	4,339,220	1,025,629	932,585 (20.14)	863,590 (19.90%)	241,214 (23.52%)	172,219 (3.72%)
HOPD	1,494,392	1,380,741	285,701	92,312 (6.18%)	84,111 (6.09%)	14,842 (5.19%)	6,641 (0.44%)
S/NF	858,213	769,122	502,542	282,242 (32.89%)	243,688 (31.68%)	140,208 (27.90%)	101,654 (11.84%)
CORF	54,285	52,008	22,185	14,653 (26.99%)	13,809 (26.55%)	8,239 (37.14%)	7,395 (13.62%)
ORF	466,744	442,760	83,310	83,480 (17.89%)	78,758 (17.79%)	22,813 (27.38%)	18,091 (3.88%)
HHA	3,903	3,581	977	353 (9.04%)	314 (8.77%)	159 (16.27%)	120 (3.07%)
PP	2,073,027	1,973,135	164,041	330,925 (15.96%)	319,733 (16.20%)	21,078 (12.85%)	9,886 (0.48%)
Multiple Settings	—	—	—	128,620	123,177	33,875	28,432

[1] Setting specific counts show the total number of beneficiaries with at least one claim for therapy services in each setting. Counts of beneficiaries receiving PT/SLP and OT will not sum to the total count of beneficiaries because an individual beneficiary may have received multiple therapy disciplines over the course of CY2009.

[2] Setting specific counts show the total number of beneficiaries who reached or exceeded the cap entirely from claims in that setting. Percentages were established using the total number of beneficiaries with a claim for the therapy service(s) associated with the cap being described. As such, the percentage of patients over the PT/SLP and/or OT caps was established based on the total number of patients with at least one claim for those services. The percentage of patients over either and/or both caps was established based on the total number of Part B therapy patients in CY2009.

NOTES: CORF = Comprehensive Outpatient Rehabilitation Facility; HHA = Home Health Agency; HOPD = Hospital Outpatient Department; ORF = Outpatient Rehabilitation Facility; OT = occupational therapy; PP = private practice; PT = physical therapy; SLP = speech language pathology; and S/NF = (skilled) nursing facility.

SOURCE: 2009 Utilization Report Part II.xls: Table 5- Number of Beneficiaries Who Exceed the Cap by Setting [Excel workbook accompanying this report] .

[This page intentionally left blank]

As outlined in ***Table 8***, beneficiaries who exceeded the cap on average had a substantially higher number of visits than those who did not. The mean number of visits for a beneficiary who exceeded the PT/SLP cap was 35.7, and the mean number of visits for beneficiaries below that cap was 8.2. For the OT cap, the mean number of visits for a beneficiary who exceeded was 36.8, whereas those beneficiaries who did not exceed the cap had 7.3 visits on average.

Consequently, beneficiaries who exceeded the cap also had a much higher total payment over the course of the year than those who did not. The mean total payment for beneficiaries who exceeded the PT/SLP cap was $3,634.35, whereas the mean total payment for those who did not was $660.51. The mean payment for beneficiaries who exceeded the OT cap was $3,695.38, whereas those who did not on average received only $592.75 worth of care.

A setting-specific breakdown can be found in the workbook accompanying this report.

Table 8
Outpatient therapy expenditures for patients who did/did not exceed the cap, CY2009

Therapy cap status	Number of patients	Mean number of visits	Mean payment
Above the PT/SLP cap	863,590	35.7	$3,634.35
Below the PT/SLP cap	3,458,528	8.2	$660.51
Above the OT cap	241,214	36.8	$3,695.38
Below the OT cap	782,241	7.3	$592.75

NOTES: OT = occupational therapy; PT = physical therapy; SLP = speech language pathology.

SOURCE: 2009 Utilization Report Part II.xls: Table 6 – Beneficiaries Who Reach or Exceed the PT/SLP Cap; Table 7 – Beneficiaries Who Reach or Exceed the OT Cap; Table 8 – Beneficiaries with PT/SLP Who Did Not Exceed the Cap; Table 9 – Beneficiaries with OT Who Did Not Exceed the Cap [Excel workbook accompanying this report].

[This page intentionally left blank]

REFERENCES

Lyda-McDonald, B., Drozd, E., and Gage, B.: Developing Outpatient Therapy Payment Alternatives: 2009 Utilization Report (Part I). Contract No. 500-2005-0029I/0012. Research Triangle Park, NC: RTI International, 2011.

[This page intentionally left blank]

APPENDIX A
DATA ANALYSIS METHODOLOGY FROM 2009 UTILIZATION REPORT

A.1 Source of Data

For the figures and tables used in this report, and for the Excel tables that accompany this report, RTI used 100 percent of outpatient therapy fee for service (FFS) claims with dates of service between January 1, 2009, and December 31, 2009, as retrieved from the Centers for Medicare & Medicaid Services (CMS) National Claims History in November 2010. For outpatient therapy occurring in a facility—that is, hospital, skilled or other nursing facility (S/NF), comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF), or home health agency (HHA)—therapy claims come from the Outpatient file. For outpatient therapy occurring in a private practice or physician's office[1]—that is, physical therapist in private practice (PTPP), occupational therapist in private practice (OTPP), physician, and non-physician practitioner (NPP)—therapy claims come from the Carrier/Noninstitutional file.

To identify outpatient therapy claims in the Outpatient file, we used the method used by Ciolek and Hwang (2006, 2008), which uses outpatient therapy billing requirements published in Chapter 5 of the Medicare Claims Processing Manual (CMS, 2009b). Claims submitted by institutional providers using a UB-04 form with one or more revenue center codes in the 042x, 043x, and 044x series (physical therapy, occupational therapy, and speech/language pathology revenue center codes, respectively), or with one or more Healthcare Common Procedure Coding System (HCPCS) codes in the CMS Therapy Code List for 2009 (see Table 1)[2] were retrieved through the CMS Data Extract System (DESY). Claims submitted by non-institutional providers using a CMS-1500 form with a specialty code of 65 (physical therapy) or 67 (occupational therapy), or with one or more HCPCS codes in the CMS Therapy Code List, were retrieved through DESY.[3] Further, only services on the CMS Therapy Code List with the required therapy modifiers (GN for speech/language pathology, GO for occupational therapy, and GP for physical therapy) were included in the analyses presented in this report.

---

1 For physician office and NPP claims the discipline (OT, PT, or SLP) was established using modifier codes. The value of the first modifier code that identified a therapy discipline was the one used. If neither modifier identified a therapy discipline, but the HCPCS code was an "always therapy" code, then the default was to assign PT as the discipline.

2 The current version of the CMS Therapy Code List can be found on the CMS Web site at http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

3 SLP specialty codes were not part of claims extraction specification. SLPs were not able to bill independently until 7/1/09. We do not believe the amount of missing data is large based on growth rates from settings where SLP services are captured in our data, such as physician offices.

Table A1
Therapy codes, CY2009

HCPCS Code	Description	Always therapy	Carrier-priced	Bundled with other therapy codes	Paid under HOPPS if billed by HOPD
0019T	extracorp shock wv tx,ms nos	No	Yes	No	No
64550	apply neurostimulator	No	No	No	No
0183T	Low frequency, non-contact, non-thermal ultrasound	Yes	Yes	No	Yes
90901	biofeedback train, any meth	No	No	No	No
92506	speech/hearing evaluation	Yes	No	No	No
92507	speech/hearing therapy	Yes	No	No	No
92508	speech/hearing therapy	Yes	No	No	No
92526	oral function therapy	Yes	No	No	No
92597	oral speech device eval	Yes	No	No	No
92605	eval for nonspeech device rx	Yes	No	Yes	No
92606	non-speech device service	Yes	No	Yes	No
92607	ex for speech device rx, 1hr	Yes	No	No	No
92608	ex for speech device rx addl	Yes	No	No	No
92609	use of speech device service	Yes	No	No	No
92610	evaluate swallowing function	No	No	No	No
92611	motion fluoroscopy/swallow	No	No	No	No
92612	endoscopy swallow tst (fees)	No	No	No	No
92614	laryngoscopic sensory test	No	No	No	No
92616	fees w/laryngeal sense test	No	No	No	No
95831	limb muscle testing, manual	No	No	No	No
95832	hand muscle testing, manual	No	No	No	No
95833	body muscle testing, manual	No	No	No	No
95834	body muscle testing, manual	No	No	No	No
95851	range of motion measurements	No	No	No	No
95852	range of motion measurements	No	No	No	No
95992	Canalith repositioning proc	No	No	Yes	No
96105	assessment of aphasia	No	No	No	No
96110	developmental test, lim	No	No	No	Yes
96111	developmental test, extend	No	No	No	Yes
96125	cognitive test by hc pro	Yes	No	No	No
97001	pt evaluation	Yes	No	No	No
97002	pt re-evaluation	Yes	No	No	No
97003	ot evaluation	Yes	No	No	No
97004	ot re-evaluation	Yes	No	No	No
97010	hot or cold packs therapy	Yes	No	Yes	No
97012	mechanical traction therapy	Yes	No	No	No
97016	vasopneumatic device therapy	Yes	No	No	No
97018	paraffin bath therapy	Yes	No	No	No
97022	whirlpool therapy	Yes	No	No	No
97024	diathermy e.g., microwave	Yes	No	No	No

(continued)

Table A1 (continued)
Therapy codes, CY2009

HCPCS Code	Description	Always therapy	Carrier-priced	Bundled with other therapy codes	Paid under HOPPS if billed by HOPD
97026	infrared therapy	Yes	No	No	No
97028	ultraviolet therapy	Yes	No	No	No
97032	electrical stimulation	Yes	No	No	No
97033	electric current therapy	Yes	No	No	No
97034	contrast bath therapy	Yes	No	No	No
97035	ultrasound therapy	Yes	No	No	No
97036	hydrotherapy	Yes	No	No	No
97039	physical therapy treatment	Yes	Yes	No	No
97110	therapeutic exercises	Yes	No	No	No
97112	neuromuscular reeducation	Yes	No	No	No
97113	aquatic therapy/exercises	Yes	No	No	No
97116	gait training therapy	Yes	No	No	No
97124	massage therapy	Yes	No	No	No
97139	physical medicine procedure	Yes	Yes	No	No
97140	manual therapy	Yes	No	No	No
97150	group therapeutic procedures	Yes	No	No	No
97530	therapeutic activities	Yes	No	No	No
97532	cognitive skills development	No	No	No	No
97533	sensory integration	Yes	No	No	No
97535	self care mngment training	Yes	No	No	No
97537	community/work reintegration	Yes	No	No	No
97542	wheelchair mngment training	Yes	No	No	No
97597	active wound care/20 cm or <	No	No	No	No
97598	active wound care > 20 cm	No	No	No	If not appropriate under therapy plan of care
97602	wound(s) care non-selective	No	No	Yes	If not appropriate under therapy plan of care
97605	neg press wound tx, < 50 cm	No	No	No	If not appropriate under therapy plan of care
97606	neg press wound tx, > 50 cm	No	No	No	If not appropriate under therapy plan of care
97750	physical performance test	Yes	No	No	No

(continued)

Table A1 (continued)
Therapy codes, CY2009

HCPCS Code	Description	Always therapy	Carrier-priced	Bundled with other therapy codes	Paid under HOPPS if billed by HOPD
97755	assistive technology assess	Yes	No	No	No
97760	orthotic mgmt and training	Yes	No	No	No
97761	prosthetic training	Yes	No	No	No
97762	c/o for orthotic/prosth use	Yes	No	No	No
97799	physical medicine procedure	Yes	Yes	No	No
G0281	elec stim unattend for press	Yes	No	No	No
G0283	elec stim other than wound	Yes	No	No	No
G0329	electromagntic tx for ulcers	Yes	No	No	No

NOTES: "Always therapy" codes are codes for services requiring provision by a licensed therapist; the appropriate therapy modifier (GN for speech/language pathology, GO for occupational therapy, or GP for physical therapy) is not required for Medicare billing. "Carrier-priced" services are not priced under the Medicare Physician Fee Schedule (MPFS) but rather are priced by individual Carriers or Medicare Administrative Contractors (MACs). Services "bundled under other therapy codes" are services for which no separate payment is made but instead are paid for in the payment for other therapy services provided along with the indicated service. Services indicated as "billed under the HOPPS if billed by HOPD" are paid using the Hospital Outpatient PPS (HOPPS) if billed and provided by a hospital outpatient department (HOPD).

SOURCE: Annual Therapy Update: 2009 Therapy Code List and Dispositions.
http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage

A.2 Dataset Description

Paid amounts and allowed charges are taken from the claims data. From the Medicare Non-Institutional Data, the Line NCH (National Claims History) Payment Amount is used to calculate the paid amounts for the physician office settings (PTPP, OTPP, Physician, and NPP), and the Line Allowed Charge Amount is used for the allowed charges. In most cases, the difference between the allowed charges and the paid amounts includes both the 20 percent coinsurance and the deductible (where applicable) paid by the Medicare beneficiary. For claims from institutional settings, the Revenue Center Payment Amount is used to calculate paid amounts for the facility settings (hospital, S/NF, CORF, ORF, and HHA), and the allowed charges are the product of the Revenue Center Rate Amount and the Revenue Center Unit Amount. In general, the difference between these values also takes into account both the 20 percent coinsurance and the deductible paid by the beneficiary.

APPENDIX B
LIST OF TABLES IN ACCOMPANYING WORKBOOK