

REPORT TO CONGRESS

STANDARDS FOR SUPERVISION OF PHYSICAL THERAPIST ASSISTANTS (PTAs) AND THE EFFECTS OF ELIMINATING THE “PERSONAL” PTA SUPERVISION REQUIREMENT ON THE FINANCIAL CAPS FOR MEDICARE THERAPY SERVICES

Introduction

As part of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress mandated that the Secretary of Health and Human Services conduct a study of standards of supervision for physical therapist assistants (PTAs). This report was to investigate the implications of eliminating the “in the room” supervision requirement for Medicare payment for services provided by PTAs who are supervised by physical therapists (PTs) in private practice settings. In addition, Congress requested that this report analyze the effect of such a requirement on the Medicare limitation on reimbursements for PT services then in effect. The Balanced Budget Act of 1997 (BBA) imposed a \$1,500 per beneficiary annual cap (adjusted for inflation) for physical therapy services (including speech-language pathology services). Medicare Part B spending for outpatient therapy services, including physical and occupational therapy and speech-language pathology services reached nearly \$2.1 billion in CY 2000. Spending for the services of PTs in private practice (PTPP) represented 15 percent of this total.

PTAs are skilled health care workers who provide services under the direction and supervision of PTs and implement certain aspects of treatment plans that are outlined by PTs. PTAs are not permitted to perform evaluations, assessment procedures, or certain complex procedures; nor do they design plans of care or develop treatment plans. Accordingly, PTAs do not possess an independent “scope of practice” as do PTs. Each State’s PT practice act defines the physical therapy “scope of practice” as belonging solely to the PT, who is legally responsible for all of the services, including the services of PTAs, provided under his or her supervision.

Under Medicare Part B, outpatient therapy services are generally defined as covered when reasonable and necessary and when provided by therapists and pathologists meeting the qualifications set forth at 42 CFR § 484.4, including physical therapists, occupational therapists, and speech-language pathologists. Services provided by qualified therapy assistants (also defined at 42 CFR § 484.4), including PTAs, may also be covered by Medicare when furnished under the specified level of supervision that is required for each setting.

Under current regulations, outpatient physical therapy services are covered as a separately and independently listed service when provided by a physical therapist in private practice (PTPP). However, PTPPs must provide “personal” supervision of the PTA providing services, meaning that the PT must be in the room when the PTA performs the service. See 42 C.F.R. §§ 410.32(b)(3)(iii), 410.60(c)(2).

Prior to 2003, all PT services provided in physician offices were considered “incident to” a physician’s professional service in accordance with section 1861(s)(2)(a) of the Social Security Act. In order for services to be covered as “incident to” a physician’s services, the physician must provide “direct” supervision of auxiliary personnel, including PTs, PTAs, and aides. (CMS is proposing to include in the regulations the statutory requirements at 1862(a)(20) of the Act regarding qualifications for therapists providing incident-to services. If adopted, this clarification would become effective January 1, 2005.) This means that the physician must be present in the office suite for the services to be covered. In 2003, CMS began permitting physicians to employ physical therapists who are enrolled as PTPPs. In these instances, the PTPP rules apply, which require the PT to provide “personal” (in-the-room) supervision of the PTA. This change occurred after completion of the Urban Institute’s report: “**Supervision of Physical Therapist Assistants: Analysis of State Regulations**” (Attachment A). Therefore, this type of arrangement is not addressed in the Urban Institute report.

In institutional settings, covered physical therapy services may be provided by PTAs under a “general” level of supervision, meaning that a PT need not be on the premises when the PTA services are provided. These institutional settings include: outpatient hospital departments (OPDs), skilled nursing facilities (SNFs), comprehensive outpatient rehab facilities (CORFs), outpatient rehabilitation facilities (ORFs), and home health agencies (HHAs).

The following table lists the various PTA supervision requirements as discussed above:

Table A

<u>Medicare Therapy Provider Setting</u>	<u>PTA Supervision Level</u>	<u>Supervisory Requirement</u>
Outpatient Hospital	General	PT Presence not required on premises
Nursing Facility	General	PT Presence not required on premises
CORFs	General	PT Presence not required on premises
ORFs	General	PT Presence not required on premises
HHAs	General	PT Presence not required on premises
PT in Private Practice (PTPP)	Personal	PT Present in-the-same room
Physician Office (Incident to)	Direct	Physician Present in the Office Suite
Physician Office (PTPP)	Personal	PT Present in-the-same room

Industry representatives have requested that the “personal” supervision requirement for PTPPs be changed to a “direct” supervision requirement. Such a change would make the supervision requirements in the private practice setting more uniform, because only direct supervision would be required, regardless of whether PT services were provided by a PT private practice or incident to in a physician’s office. In practical terms, a change from personal to direct supervision would enable PTs to supervise PTA services provided

within the PTPP office suite, including services provided in the same room, in separate treatment areas, or behind closed doors.

Background

The Centers for Medicare and Medicaid Services (CMS) contracted with the Urban Institute to assist in the preparation of this report. Upon its completion, CMS released the Urban Institute report to the professional associations representing physical and occupational therapists and received comments from both the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA). Some of these comments have been reflected in the text of this report.

Highlights of the Urban Institute Report:

Professional Differences

- While both PT and PTA educational programs prepare graduates to provide basic physical therapy services, PT students receive additional training in more complex therapeutic interventions and in more analytical and evaluative procedures and activities, such as: patient screening, evaluation, physical therapy diagnosis, prognosis and care plan design.
- The entry-level education requirement for PTs, as of 2002, is a master's degree in physical therapy (MPT), which generally requires 5 semesters followed by 4-6 months of clinical experience. A MPT requires nearly 3 years of full-time enrollment. PTA programs offer an associate's degree. Across the country, PTA programs are offered through 247 community or junior colleges. PT degree programs are offered through 190 colleges and universities.
- Professional distinctions between the PT and the PTA are specified at the State level. All States require PTs to graduate from accredited educational programs and to pass respective national exams; most States impose similar requirements on PTAs.
- Current issues in physical therapy practice and education include: "direct access," which in 35 States (in 2002) permits PTs to provide a range of specified services without physician referral, and whether an increase over time in the number of highly educated PTs (i.e., as the entry level PT degree transitions from a MPT to a doctoral-level degree in physical therapy (DPT)) would increase direct access to PTs.

Employment Differences

- In the Urban Institute report, PT and PTA workforces were estimated for 1999. The total PT workforce was estimated between 105,000 and 108,000, and the PTA workforce was projected to be more than 35,000.
- In 1999, the PT annual wage income was almost twice that of the PTA (\$55,936 vs. \$30,274). As a group, PTs and PTAs are similar in age distribution, but PTAs have fewer years of experience than PTs. More than 60 percent of PTAs, compared to 24 percent of PTs, have been employed for fewer than 5 years. In addition to the PTA associate degree, nearly 30 percent of PTAs have attained

other higher-level college degrees, including either a Bachelor's or Master's degree, although some PTAs are in their second careers, so their degrees may be in a different field.

- Workforce and distribution percentages of PTs and PTAs parallel each other in the following settings: (a) nearly 25 percent are employed in PTPPs; (b) 20 percent work in various outpatient facilities; (c) acute inpatient hospitals account for nearly 14 percent of each. However, they differ in that more PTAs (22 percent) than PTs (9 percent) work in SNFs, while more PTs work in HHAs and colleges/schools.

State Licensure Laws and Regulations

- All States (and Washington, DC) license PTs. For PTAs, 43 States have specific licensure-related provisions: One State requires an approval process, 32 States require licensure, 4 require registration, and 6 require certification.
- A national examination (administered to graduates of accredited PT and PTA programs and certain foreign educated physical therapists with equivalent credentials) is mandated for PTs in all jurisdictions and for PTAs in all but two jurisdictions.
- In areas of the country where PTAs do not have licensure-type regulations, many PTAs opt to take a national exam in order to improve their employment opportunities.
- All States' licensure regulations stipulate that PTs are professionally and legally responsible for all care rendered under their license, including those provided by PTAs, even in States without specific PTA regulations.

Supervision of Physical Therapist Assistants

In order to determine the kind of PTA supervision standard in place outside Medicare, as requested by Congress, the Urban Institute report analyzed State statutes and administrative codes regarding physical therapy practice. Supervision requirements vary from State to State, and terminology and definitions differ as well. The terminology used by States also varies from that used in Medicare. Four State levels of PTA supervision were identified and are outlined below:

- Full time "on-site" supervision of PTAs is required by 7 States and Washington, DC, corresponding to Medicare's "direct" supervision definition.
- Periodic "in-room" PTA supervision with telecommunication supervision at other times is required by 7 States. Three of these States specified a different minimum frequency (at 14, 30, or 60 days) for this in-room PTA supervision requirement, while 4 States require only "regular" or "periodic" in-room supervision. This State supervision level falls somewhere in between Medicare's "general" and "personal" supervision levels.
- Periodic "on-site" supervision of PTAs with telecommunication supervision at other times is required in 16 States. Most states require "regular" or "periodic" supervisory visits and specify either: (a) a number of patient visits (4 to 6 visits is most common), (b) a time frame (30 days is common), or (c) a percentage of time

- (up to 50 percent). This State supervision level falls somewhere between Medicare’s “general” and “direct” supervision levels.
- Sixteen States require telecommunication supervision at all times. This supervision level is somewhat similar to Medicare’s “general” supervision requirement because the PT’s presence is not required when PTA services are provided.

A total of 37 States have specified other PTA supervision criteria. These include: (a) setting a maximum number of PTAs that a PT can supervise at one time (33 States), and (b) establishing supervisory or reevaluation visits by PTs supervising PTAs (37 States).

The APTA has adopted a position statement with provisions relating to the supervision of the PTA. The APTA’s position statement specifically supports “at least general” supervision of the PTA (meaning that the supervising PT is available at least by telecommunications) and specifies at least monthly supervisory visits when the PTA is working off-site.

The model practice act developed by the Federation of State Boards of Physical Therapy (FSBPT) supports general supervision when working off-site. The FSBPT also notes that States should further specify “restrictions or limitations based on the practice setting, the acuity of patient populations, and the types of diagnoses.”

In a manner similar to Medicare, State supervision levels typically vary across settings. Most States permit a supervision level similar to the Medicare “general” supervision requirement for physical therapy services delivered in HHAs, SNFs, OPDs and school settings. No State has the strict, full-time “personal” supervision requirement, for any setting, that Medicare places on PTAs providing services in PTPPs.

Findings of the Urban Institute Report

The Urban Institute report discusses comments and concerns reported by clinicians and provider representatives (referred to in the Report as “stakeholders”) regarding to the Medicare personal supervision requirement in PTPPs. Some stakeholders believed the Medicare requirement was motivated by patient safety and quality assurance concerns for PTPPs, leaving the less restrictive “general” supervision requirement for other Part B providers because of: (a) the presence of other clinical personnel, (b) the requirement of patient assessment instruments, and (c) the State survey and certification processes.

Countering the patient safety argument, some stakeholders believe the PTA supervision is only indirectly related, if at all, to quality assurance. Others believe that Medicare’s PTA supervision requirements should be applied consistently across similar ambulatory settings. ORFs, CORFs, physician practices, and PTPPs all deliver outpatient physical therapy services to community dwelling beneficiaries, and these settings span the three different Medicare supervision levels: general, direct and personal.

According to the Urban Institute report, some stakeholders assert State requirements regarding reevaluations, supervisory visits, and maximum PTA to PT ratios, rather than the State-stipulated supervision level, affect their PTA hiring decisions. Non-regulatory factors affecting PTA use include the patient's episode length, volume of patients, and PTA supply. PTAs would more likely be employed in settings where the patient's episode of care is longer, the practice has a higher volume of patients, and where the PTA supply is available. The Urban Institute report noted that about 25 percent of the PTA workforce is employed in the PTPP setting.

With the personal supervision requirement in place, some PTs in PTPP settings have commented that they have either eliminated or decreased their use of PTAs to treat Medicare patients. They cite the following reasons: (a) privacy issues where both the PTA and PT are required to be in the same room to treat one patient, (b) physical layouts that are unable to accommodate the in-room or line-of-sight supervision requirements, and (c) cost-ineffectiveness of needing two health care professionals to treat one Medicare patient. Some PTPP practices commented that the personal supervision requirement is not cost-effective in practices that have large Medicare caseloads and a physical layout without an open floor plan and that some of these practices had reduced the number of PTA employees. Others voiced concerns that the practices with small Medicare caseloads might stop accepting Medicare patients completely. Alternatively, PTPPs with larger Medicare populations that have open treatment areas or gym-type settings where PTs can view multiple PTAs and patients simultaneously have commented their use of PTAs remains cost-efficient.

The review of State PTA supervision regulations indicates that the Medicare personal supervision requirement for PTPPs is stricter than supervision levels applied by any State (or Washington, DC) in any setting. Further, the study found that full-time direct supervision of PTAs - required when therapy services are provided incident to in Medicare physician practice settings - is mandated in only 7 States.

The Urban Institute Report did not specifically explore the effects of eliminating the personal supervision requirement on the supply of PTAs, and did not identify any prior research analyzing the effect of PTA utilization relative to PT utilization on the amount of therapy provided per patient. The report did cite anecdotal evidence indicating that PTs can obtain a given patient outcome earlier than PTAs because of PTs' additional analytic and evaluative training. The following discussions directly discuss the potential implications of changing the personal supervision requirement for PTPPs.

Implications of Eliminating the In-the Room PTA Supervision Policies

As part of the PTA study mandated in BIPA, Congress requested the Secretary to investigate implications of changing the personal PTA supervision requirement on payment policies regarding physical therapy Medicare expenditures, in particular on the therapy cap. Since 1992, PTPPs - along with physicians, non-physician practitioners (physician assistants, nurse practitioners, and certified nurse specialists (NPPs)), and occupational therapists in private practice (OTPPs) - have been paid under the physician

fee schedule. In 1999, other Part B institutional therapy providers were transitioned from Medicare's cost-based reimbursement mechanism to the physician fee schedule.

Medicare imposed annual per beneficiary expenditure limits for physical therapy provided in PTPPs from 1974 through 1998. Later, as OTs gained private practice enrollment status, the OTPP services were also capped. Originally, this cap was \$100 in 1974 and gradually rose to \$900 in 1994 for these two classes of therapy providers.

In 1999, Congress imposed two separate per-beneficiary Medicare payment limits of \$1500 for therapy services provided by all Part B therapy providers except for hospital outpatient departments (OPDs) - one for physical therapy and speech-language pathology services combined, and the other for occupational therapy services. These across-the-board therapy caps were implemented because annual Medicare expenditures on therapy services escalated rapidly over the prior decade. However, Congress instituted several moratoria on the therapy caps effective after 1999.

With the expiration of the most recent moratorium in 2003, CMS implemented the therapy caps beginning September 1, 2003, until the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted. The MMA imposed a new moratorium on the therapy caps from December 8, 2003 through December 31, 2005. The annual therapy caps will again be effective on January 1, 2006.

Discussion

Under the Medicare physician fee schedule, the elimination of the "personal" PTA supervision requirement in PTPPs could affect Medicare spending where there is an increase in the overall volume of services. Although the authors of the Urban Institute report were unable to substantiate a direct effect on the total number of services rendered per patient with use of PTAs versus PTs, a change of the PTPP personal supervision requirement could provide incentives for PTs to provide an increased volume of therapy services to Medicare beneficiaries. If the PT is not required to be in the same room where PTA services are provided, an increase in the volume of PTA services could occur where the PT employs additional PTAs and supervises all their services at the same time. These potential incentives must be considered in light of recent data analyzed in our separate report to Congress on part B therapy caps, which showed that between 1998 and 2000, billings for PT services by physician offices grew rapidly, resulting in physicians' offices representing a larger share of total PT services provided. Until we understand the reasons behind that trend, and can examine more recent data to see whether this trend has persisted, we can not be sure that the factors we identified as limiting PTA utilization (see below) will not change the patterns of use of PTAs in physician practice settings. On the other hand, the workforce estimates from the Urban Institute report set the current PT:PTA ratio in the PTPP setting at 3.5 PTs to one PTA. This PT:PTA ratio suggests that a significant increase in the volume of PTA services is not likely to occur in the immediate future.

To the extent that a supervision requirement affects staff mix, the physician fee schedule provides an incentive for providers to utilize the lowest-cost staff that can provide a service. Cost-savings would occur to the PTPP provider if lower-cost PTAs could be used to deliver some of the services that, under the personal PTA supervision requirement, needed to be directly furnished or personally supervised by PTs. Medicare expenditures would increase if the therapist had the capacity to increase the volume of services provided if the PT did not need to be in the same room where PTA services are provided. A less stringent PTA supervision requirement might free the therapist to better market his or her practice in order to increase the number of therapy referrals, including some for Medicare beneficiaries. While providing access to medically necessary therapy services, under physician-certified plans of care, at least some of the increased volume of services could be provided by lower-cost PTAs in PTPP settings where they are utilized.

The extent to which Medicare outlays under the physician fee schedule would be increased with the elimination of the personal in-the-room PTA supervision requirement in the PTPP is unclear. Increased utilization of PTAs in the PTPP setting could occur under less restrictive supervision requirements. However, the following factors would serve to limit any resulting increase in utilization and costs should the personal PTA supervision requirement in PTPPs be removed: (1) only a portion of physical therapists will use PTAs regardless of the supervision requirements, (2) many States mandate PTs to provide periodic reevaluations or in-room supervisory visits of PTAs, (3) PTAs perform only a subset of therapy services as certain complex therapeutic, and evaluative procedures are reserved for PTs, and (4) all therapy services are certified by physicians as medically necessary. Any change in the PTPP personal PTA supervision policy would occur through the rulemaking process and the financial impact would be projected, at that time, based on the specifics of the proposal.

Attachment