Short Term Alternatives for Therapy Services (STATS) Task Order

Final Report on Short Term Alternatives

Prepared for:
Centers for Medicare & Medicaid Services (CMS)

Prepared by:

Computer Sciences Corporation
Daniel E. Ciolek, M.S.
Wenke Hwang, PhD
Federal Sector – Civil Group
Federal Healthcare Organization
3217 Lord Baltimore Drive
Baltimore, MD 21244

Contract Number: GS-23F-8029H
Task Order Number: HHSM-500-2008-00065C

July 9, 2010

Disclaimer

American Medical Association (AMA) Notice and Disclaimer

ICD-9 Notice

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. The International Classification of Diseases, 9th Revision, published by the World Health Organization (WHO) is the foundation of the ICD-9-CM. The ICD-9-CM is completely comparable with the ICD-9. ICD-9 is published by the World Health Organization (WHO). Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. For rights of reproduction or translation of WHO publications, in part or in total, application should be made to the Office of Publications, World Health Organization, Geneva, Switzerland. The World Health Organization welcomes such applications.

Table of Contents

List of Tables

List of Figures

Short Term Alternatives Summary

Medicare outpatient therapy services, which include physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services furnished in provider facility settings and in professional offices, and are an integral and relatively low-cost part of the continuum of rehabilitation care and healthcare in general. In addition to being provided as a stand-alone service, these services often are furnished as a conservative treatment alternative to more costly and higher risk interventions (e.g. surgery), and are often furnished after inpatient admissions, or after the conclusion of home health benefits, in order to complete the restoration of lost function or to limit the negative impact of physical decline.

In 2008, Medicare outpatient therapy expenditures totaled $4.8 billion for services furnished to 4.5 million beneficiaries, or $1,057 per-patient. This represented only 2.6 percent of the total Medicare Part B spending for that year.

The Medicare Physician Fee Schedule (MPFS) is used in claims to report outpatient therapy services. Provider facilities and professional offices receive payment for procedures billed. However, there is no current mechanism for clinicians to identify the therapy need, beneficiary function or intervention outcome on the claim, which constrains the ability of Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractors (MACs) to limit payments to those that are medically necessary.

Several recent (CMS) contracted studies have demonstrated that while the number of beneficiaries receiving outpatient therapy services has increased at a rate of about 2.9 percent per-year from 1998 to 2008, Medicare expenditures have increased at a rate of about 10.1 percent per-year (fluctuating during capped and not capped years). While some of the increase can be attributed to inflationary fee schedule price increases, it is uncertain whether the remaining increases were due to necessary services or not.

The growth in outpatient therapy expenditures has surpassed the rate of growth of spending in other Medicare benefits and has been under scrutiny from organizations including the Medicare Payment Advisory Commission (MedPAC), the U.S. Government Accountability Office (GAO), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (DHHS). These organizations have conducted studies on outpatient therapy services and have provided recommendations for policy changes to better assure that Medicare only pays for medically necessary services.

In order to control the growth in outpatient therapy (and other) spending, CMS and its contractors have implemented a variety of different utilization edits in response to perceived overutilization or improper use of certain HCPCS codes. These edits include:

- CMS Medically Unlikely Edits (MUEs),
- CMS Deficit Reduction Act (DRA) edits,
- CMS Correct Coding Initiative (CCI) edits, and
- Local MAC medical necessity edits including; limits per-HCPCS, and HCPCS and ICD-9 crosswalk edits.

In the Proposed Rule for the 2011 Fee Schedule on July 13, 2010, CMS proposed additional Multiple Procedure Payment Reduction (MPPR) edits for therapy services.

The edits are implemented by CMS and contractor systems that review submitted procedure codes per claim line or date-of-service and apply the various utilization edits. Those procedure codes that pass the edits are paid while those that do not are denied payment. The edits are applied without consideration of need or outcomes as such information is currently not available on claims.

In 2008, CMS awarded the Developing Outpatient Therapy Payment Alternatives (DOTPA) contract to Research Triangle Institute (RTI) to: collect a broad range of beneficiary data relevant to a beneficiary's need for outpatient therapy services, analyze the collected data in terms of predictive power and cost, and develop long-term payment alternative options. The DOTPA project is planned as a five-year study.

Also in 2008, CMS awarded the two-year Short Term Alternatives for Therapy Services (STATS) project to: conduct follow-on utilization analysis, develop new systems capabilities to provide CMS with near real-time utilization trends, and to conduct research and confer with outpatient therapy stakeholders and subject matter experts to develop specific payment policy applications as an alternative to the current outpatient therapy caps that can be used in the short-term to limit payments to medically necessary outpatient therapy services.

The recommendations in this report complete the development of preliminary recommendations submitted in a draft report to CMS in June 2009 and reflect new information as well as feedback received from CMS and stakeholder representatives since then. The options included in these recommendations represent concepts that have the general support of stakeholder workgroups, meet the project objectives, and are technically feasible within the time constraints. Based on stakeholder feedback, we believe these recommendations represent those most likely to be acceptable to the broadest range of provider and beneficiary stakeholders.

We have concluded that, in the long-term, the most feasible payment model for outpatient therapy services is one that is based on the episode of care. Provider payments should be influenced by underlying beneficiary characteristics, as Congress has requested. To assure appropriate payment for needed services, the outcomes resulting from provider interventions must be incorporated in payment models. Also, a well-designed long-term payment policy will maintain the clinician's ability to use clinical judgment to provide medically necessary services.

However, clinicians will need to communicate standardized information using a function and/or outcomes reporting tool that could be used for quality and/or risk-adjustment payment policy purposes. The tool should align with the International Classification of Diseases, 10th revision (ICD-10) and International Classification of Function (ICF) systems to improve standardization of reporting and documentation. The transition to an episode-based payment policy will mean that many of the burdensome granular policies that serve to control utilization without regard to the patient's clinical presentation (e.g. edits) may (and should) be eliminated since the emphasis of payment policy will have shifted from managing procedures billed to the management of

patient progress or outcomes. Efficiencies will be obtained for both clinical work and contractor review when the emphasis is on paying appropriately for objectively recorded outcomes.

The following short-term outpatient therapy payment policy options are recommended in this report as the most promising concepts to revising the current therapy caps policy. These options can be developed and implemented within a 2-3 year time frame, and facilitate the transition towards a long-term episode payment model that is based upon beneficiary function and/or outcomes. Since they are focused on the short-term, none of the recommended options would require changes in statute, other than the extension for the outpatient therapy caps exceptions process. However, some options would require additional systems, Medicare manual, and provider education updates, as well as possible pilot study before a national rollout. These recommended options are not necessarily exclusive of each other but could be implemented concurrently while a long-term solution is developed.

Option #1 – Revise therapy caps exceptions process by requiring the reporting of new patient function-related Level II HCPCS codes and severity modifiers

This option would modify the therapy cap exceptions process by introducing new nonpayable HCPCS codes to be submitted at episode onset and at periodic intervals that reflect current and prospective (treatment goal) function. The new codes would replace the KX modifier and would provide more clinically relevant information for medical review than the KX modifier does now.

These new codes would be new codes, separate from the existing 76 outpatient therapy HCPCS procedure codes. The new codes would not change the reporting requirements for the existing codes. We are proposing that the new codes be submitted at episode onset and at periodic intervals. The intervals would be no longer than every 12 treatment sessions or 30 calendar days, whichever is less. Unlike the KX modifier which is submitted on outpatient therapy claim lines only when nearing or surpassing the therapy cap, the new codes would be submitted for all patient episodes and not only for those claims approaching or surpassing the therapy cap limits.

Option #2 – Enhance existing therapy caps exceptions process by applying edits when per-beneficiary expenditures reach a predetermined value

The current automatic process for outpatient therapy cap exceptions, and the proposed revised exceptions process described in Option #1 above pay clinicians for an indefinite amount of services per-session or per-episode if the clinician attests on the claim, by using specified codes, that the services being billed for are medically necessary, and that supporting documentation is included the beneficiary's patient record. Recently, CMS has implemented national DRA edits to outpatient therapy evaluation codes and MUE edits to several outpatient therapy treatment intervention codes to limit the amount of units of each code to be billed per-date of service. There are no national edits that limit unusual per-episode or annual per-beneficiary utilization. Unless the Medicare contractor applies local claim medical necessity edits or conducts post-payment medical review, unusually high utilization that may not be necessary is difficult to identify and limit while exceptions are in use.

We are proposing that in the short-term, CMS consider;

- Option #2a. Refining the existing national MUE edits for outpatient therapy timed intervention HCPCS codes, and
- Option #2b. Implementing new, national, per-beneficiary per-year payment edits. These edits would be based upon existing utilization data. CMS would establish benchmark payment levels for these edits that would only affect a very small percentage of beneficiaries with extraordinary utilization patterns. Even with the exception process, once these high utilization outlier threshold levels were reached, additional services would be denied and clinicians would need to appeal these denials if they wished to challenge Medicare's nonpayment above the edit limits.

Option #3 - Introduce new outpatient therapy 'Evaluation/Assessment and Intervention' (E&I) codes to package groups of current therapy HCPCS codes into a single per-session payment.

This option would change how clinicians report and are paid for outpatient therapy services from payment per service to payment per therapy session. It lays the groundwork for the transition towards an episode-based payment model. Professionals would be required to submit new Level II HCPCS outpatient therapy E&I codes for each therapy session to replace all individual therapy procedure codes currently paid separately. Payment for the new outpatient therapy E&I codes would be based on the beneficiary characteristics reflected by a combination of the evaluation or assessment complexity and/or the intervention complexity for that particular session. Fewer codes will reduce the variation in per-session payments. We are proposing that twelve new Level II HCPCS codes would be sufficient to describe all outpatient therapy sessions. However, since the practice patterns of PT, OT, and SLP services differ, each discipline would require twelve unique codes so that appropriate pricing could be established for each discipline.

1 - Introduction

On September 23, 2008 the Centers for Medicare and Medicaid Services (CMS) awarded a two-year contract to Computer Sciences Corporation (CSC) to perform professional services that build upon prior outpatient therapy studies. The project name is Short Term Alternatives for Therapy Services, or STATS[1]. The STATS Statement of Work (SOW) indicates that additional study is needed to develop short-term alternatives to outpatient therapy caps, which may include both systems changes and Medicare Manual guidance, which encourages payment for only those therapy services that are medically necessary.

Appendix A 'Acronyms' provides definitions of acronyms used throughout this report.

1.1 The Medicare outpatient therapy benefit

Outpatient therapy services are a covered Medicare benefit in §§1861(g), 1861(p), and 1861(ll) of Title XVIII of the Social Security Act (*the Act*). Outpatient therapy services may also be provided incident to the services of a physician or non-physician practitioner (NPP) under §§1861(s)(2) and 1862(a)(20) of *the Act*.

Medicare outpatient therapy includes; physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. Covered services for all three disciplines involve evaluations and interventions provided within the applicable PT, OT or SLP scope of practice and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities, or changes in physical function and health status.

Funding for the outpatient therapy services benefit is through the Supplementary Medical Insurance Program for the Aged and Disabled (Medicare Part B). Medicare outpatient therapy services are an integral part of the continuum of rehabilitation care and may be provided on an ambulatory outpatient basis as well as to inpatients and homebound individuals who do not have Medicare Part A benefits, who not qualify for Part A services, or whose Part A benefits have expired. Medicare outpatient therapy services are a relatively low-cost alternative to comprehensive inpatient and home health services. They are often furnished as a conservative treatment alternative to more costly and higher risk interventions (e.g. surgery). They are also often furnished after inpatient admissions, or after the conclusion of home health benefits, in order to complete the restoration of function or to limit the negative impact of physical decline using the lower cost outpatient therapy benefit.

Medicare outpatient PT services are directed at restoring or compensating for movement losses due to impairments of the musculoskeletal, neurologic, cardiac, pulmonary and other body functions and structures as well as activity limitations and/or participation restrictions related to the impairments. Specific PT outcomes may include a restoration of the ability to sit, stand, or walk independently or to perform activities pain-free. This may be accomplished with or without the use of assistive technology or environmental modification. In addition, Medicare outpatient PT services can serve goals of promoting the healing of damaged body structures such as burns and decubiti of the integumentary system.

[1] Contract Number: GS-23F-8029H, Task Order Number: *HHSM-500-2008-00065C*

Medicare outpatient OT services are directed at assisting patients in restoring and/or compensating for activity limitations and/or participation restrictions as well as impairments to body functions and structures. OT services address problems related to the patient's ability to conduct activities of daily living (ADL) and instrumental activities of daily living (IADL). Specific OT outcomes may include a restoration of a person's ability to bathe oneself, dress oneself, manage a household, or prepare meals, with or without assistive technology or environmental modification.

Medicare outpatient SLP services are directed at assisting patients in restoring and/or compensating for impaired abilities in cognition, communication and swallowing. Interventions may be directed at impairments to specific body functions or structures, activity limitations, or participation restrictions related to cognition, communication and swallowing. Specific SLP outcomes may include the restoration of the ability to process information, communicate effectively, or to swallow food and beverages safely, with or without adaptive technology or environmental modification.

Medicare outpatient therapy services are furnished by clinicians in professional offices and in a variety of outpatient therapy provider facilities including:

- Hospital,
- Skilled nursing facility (SNF),
- Comprehensive outpatient therapy facility (CORF),
- Outpatient rehabilitation facility (ORF), and
- Home health agency (HHA).

Beginning in 2003, CMS revised 42 C.F.R. §§ 410.59 and 410.60 and began issuing PTPP and OTPP provider numbers to physical and occupational therapists employed by or under contract with physicians and NPPs. Enrollment was extended to speech-language pathologists in 2009 when SLPPs were permitted to bill Medicare[2]. Previously, all PT, OT, and SLP services of employees or contractors were required to be billed by physician and NPP offices under the business owner's provider number. Therefore, the data reflected the services of PTs, OTs and SLPs as physician or NPP services. This new 2003 policy (and subsequent 2009 policy) permitted physician and NPP business owners the option to bill PT, OT, and SLP services of their employees using the employee's PTPP, OTPP, or SLPP provider number. As a result, we can no longer identify PTPP, OTPP, physician, or NPP as unique 'settings' and are thus referring them as 'professional office specialties' in this report. In CY2008, those services furnished by PTPPs and OTPPs in physician or NPP offices are reflected in the data for PTPP and OTPP.

Outpatient therapy professional office specialties include:

- Physical therapist in private practice (PTPP),
- Occupational therapist in private practice (OTPP),

[2] Section 143 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPA) authorized CMS to enroll speech-language pathologists as SLPPs so that they may bill Medicare directly for SLP services, beginning in 2009. Previously SLP services could only be billed by facility providers, physicians and NPPs. See 42CFR410.62(c) for regulations related to speech-language pathologists' enrollment and 73FR69874 for the final rule describing section 143 of the MIPPA that authorized enrollment. CMS issued instructions in Transmittal 106. *Speech-Language Pathology Private Practice Payment Policy* on April 24, 2009.

- Speech-language pathologist in private practice (SLPP),
- Physician, and
- Non-physician practitioner (NPP).

Medicare covers outpatient therapy services when they are furnished by a qualified professional[3] within the scope of practice allowed by state law, when:

- Such services were required because the individual needed therapy services, and
- A plan for furnishing such services (containing at a minimum: diagnosis(es); long term treatment goals; and type, amount, duration, and frequency of therapy services) was established by a clinician[4] which was also periodically reviewed by a physician or NPP, and
- Such services were furnished while the beneficiary was under the care of a physician, and
- Such services were furnished on an outpatient basis, and
- The physician or NPP certified the plan of care for the applicable payment period[5].

The Medicare requirements for coverage, claims processing and medical necessity documentation for outpatient therapy services are described in the following web-based manuals:

- Medicare Benefit Policy Manual,
- Medicare Claims Processing Manual,
- Medicare National Coverage Determinations Manual, and
- Medicare Program Integrity Manual.

Outpatient therapy provider facilities and professional offices receive coverage and payment policy instructions and billing guidance from their regional contractors, generally a Medicare Administrative Contractor (MAC), who may also establish local coverage decision (LCD) policies to clarify rules when there is no conflicting national directive from CMS.

Once outpatient therapy services are furnished, Medicare claims are submitted by outpatient therapy provider facilities and professional offices to their regional Medicare Administrative Contractors (MACs) who process the claims. There are two types of claim forms used for outpatient therapy services. Facilities such as hospitals, SNF, CORF, ORF, and HHA are classified in Medicare data as 'Providers'. Providers submit the CMS-1450 (UB-04) form, or the 837P electronic equivalent to be reimbursed for outpatient therapy services. Professional offices composed of individuals, or groups of individuals are classified in Medicare data as 'Professionals'. Professionals such as PTPPs, OTPPs, SLPPs, physicians, or NPPs submit the CMS 1500 form, or the 837I electronic equivalent to be reimbursed for outpatient therapy services.

[3] The Medicare Benefit Policy Manual, Chapter 15, Section 220(A) defines an outpatient therapy 'qualified professional' as "…a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant…Qualified professionals may also include physical therapist assistants and occupational therapy assistants when working under the supervision of a qualified therapist…"

[4] The Medicare Benefit Policy Manual, Chapter 5, Section 220(A) definition of outpatient therapy 'clinician' refers to only "…a physician, nonphysician practitioner, or a therapist (but not to an assistant, aide or other personnel)…"

[5] The Medicare Benefit Policy Manual, Chapter 15, Section 220.1

Outpatient therapy claims contain various items relevant or potentially relevant to current payment policy or potential payment policy options. These items include those that: 1) describe beneficiary demographics, 2) describe beneficiary diagnoses, and 3) describe services furnished. However, there are inconsistencies in the type of information contained on these two claim formats that limit the ability to compare data across outpatient therapy provider settings/professional specialties.

Table 1 identifies variations in key data elements submitted on either the CMS-1450 or CMS-1500 forms. With regards to diagnoses, the CMS-1450 form permits up to eight secondary claim diagnoses while the CMS-1500 form only permits four. However, the CMS-1500 form does permit claim line diagnoses while the CMS-1450 form does not. Another notable difference between the claim forms is that only the CMS-1500 form includes prior episode date and prior hospitalization date information. Of particular importance is that the CMS-1500 form claim line National Provider Identifier (NPI) information permits the identification of the individual clinician (and their specialty) responsible for the submitted outpatient therapy charges on each claim line while the CMS-1450 does not have such information.

Table 1. Variations in key data elements available on outpatient therapy claims

Claim Data Element	CMS 1450 (UB-04)	CMS-1500
Beneficiary age	Available	Available
Beneficiary gender	Available	Available
Principal claim diagnosis	Available	Available
Secondary claim diagnosis	Up to 8 additional	Up to 3 additional
Claim line diagnosis	Not available	Available
Date of current onset	Not available	Available
Prior episode date	Not available	Available
Prior hospitalization date	Available	Available
Procedures furnished by date	Available	Available
Therapy discipline modifier	Available	Available
Other therapy related modifiers	Available	Available
Identity of clinician specialty	Not available	Available

Submitted outpatient therapy claims must contain International Classification of Diseases, 9th Revision (ICD-9) diagnosis codes, Healthcare Common Procedure Coding System (HCPCS) procedure codes[6], and code modifiers that describe the patient condition and the services furnished per each date of service. Supporting documentation from qualified professionals in the patient's record must support the codes submitted on the claim and must describe medically necessary services. This supporting documentation must be submitted if/when requested by Medicare contractors for medical review. Provider facilities and professional offices are permitted an appeals process to challenge claim payment denials based upon contractor decisions, for example, that the services were not medically necessary.

[6] In this report, HCPCS refers to all Level I HCPCS, which are numeric CPT codes developed by the American Medical Association, and Level II HCPCS codes, which are alphanumeric codes developed by CMS.

1.2 Recent history of Medicare outpatient therapy payment policy

The Balanced Budget Act of 1997 enacted financial limitations (caps) on outpatient PT and SLP combined, and outpatient OT separately. The therapy caps limited the annual amount of outpatient therapy services a beneficiary could receive regardless of condition or need. The caps applied to all outpatient therapy services in all settings except outpatient hospital. The therapy caps were implemented in a modified per-provider format throughout calendar year (CY) 1999. However, they were subsequently under various Congressional moratoria from CY 2000-2005 (with the exception of implementation from September 1 – December 7, 2003). Although the moratoria expired, exceptions to the caps were enacted by the Deficit Reduction Act of 2005 and were effective beginning January 1, 2006. Since then, the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, the Temporary Extension Act of 2010, and the Patient Protection and Affordable Care Act of 2010 have extended the cap exceptions process through December 31, 2010. Without new Congressional action, full implementation of the outpatient therapy caps (with the hospital exception) will be enforced by CMS beginning on January 1, 2011.

Under task orders from 2000-current, CSC (formerly AdvanceMed/DynCorp) performed analytic activities using a 100% file of outpatient therapy claims to describe utilization patterns. These analyses addressed the impact of policy changes on utilization, such as the therapy caps. Additional activities preformed in these prior projects included; identifying potential claim edits, identifying the feasibility of using claims data as the foundation for a condition-based alternative payment system and/or pilot, identifying beneficiary characteristics and clinical factors for CMS to consider collecting in order to identify therapy need and outcomes, and short-term policy support activities such as the development of the therapy cap exceptions process by CMS. The analysis activities are described in numerous reports at: http://www.cms.gov/TherapyServices/.

These studies are referred to on the CMS website as:

- CY 2008 Outpatient Therapy Utilization Report[7]
- CSC – CY2006 Therapy Utilization[8],
- CSC – 2006 Therapy Cap Report[9],
- CSC – CY2006 Therapy Edit Tables[10],
- CSC – Utilization and Edit [11],
- CSC – Pilot Report[12],
- AdvanceMed – Edit Report[13],

[7] Ciolek, D. E. and Hwang. W. *CY 2008 Outpatient Therapy Utilization Report*, June 4, 2010. Contract Number *GS-23F-8029H*, Task Order Number *HHSM-500-2008-00065C*.
[8] Ciolek, D. E. and Hwang, W. CY 2006 *Outpatient Therapy Services Utilization Report*, February 1, 2008. Contract Number *GS-23F-8029H*, Task Order Number *HHSM-500-2007-00322G*.
[9] Ciolek, D. E. and Hwang, W. *CY 2006 Outpatient Therapy Cap Report*, March 21, 2008. Contract Number *GS-35F-802H*, Task Order Number *HHSM-500-2007-00322G*.
[10] Ciolek, D. E. and Hwang, W. *CY 2006 Outpatient Therapy Edit Tables*, April 14, 2008. Contract Number *GS-35F-802H*, Task Order Number *HHSM-500-2007-00322G*.
[11] Ciolek, D. E. and Hwang, W. *Outpatient Therapy Services Utilization and Edit Report*, May 17, 2006. Contract Number *GS-35F-4694G*, Task Order Number *HHSM-500-2005-00192G*.
[12] Ciolek, D.E., Carter, S, MacIsaac, J, and Hwang, W. *Outpatient Therapy Services Pilot Report 2006*. July 28, 2006. Contract Number *GS-35F-4694G*, Task Order Number *HHSM-500-2005-00192G*.

- AdvanceMed – Costliest Report[14],
- AdvanceMed – Model Report[15],
- AdvanceMed – Final Report[16], and
- DynCorp Report – Outpatient Therapy Utilization[17].

Other analytic reports available at http://www.cms.gov/TherapyServices/ include the Urban Institute's 2001 analysis of the impact of the therapy caps[18] and 2002 report on standards of outpatient therapy supervision of therapy/therapist assistants[19], and the 2006 Focus on Therapeutic Outcomes, Inc. (FOTO) demonstration of pay-for-performance concepts for outpatient physical and occupational therapy services[20].

In addition, the Medicare Payment Advisory Commission (MedPAC)[21], the U.S. Government Accountability Office (GAO)[22], and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (DHHS)[23] have conducted numerous studies on outpatient therapy services and have provided recommendations for policy changes to better assure that Medicare only pays for medically necessary services.

Over the past ten years, several potential administrative alternatives have been proposed for revising outpatient therapy coverage policy while maintaining the integrity of the Medicare Physician Fee Schedule (MPFS) payment methodology. They include the following:

- Impose volume controls,
- Refine/expand claim line procedure edits,
- Create alternative applications of the original payment caps (e.g., separate into three caps, merge into a single cap, create facility or condition-specific caps),
- Track and limit therapy expenditures on a different basis than the current annual per-beneficiary basis (e.g., per-episode),
- Develop a tiered cap that allows for higher limits for targeted patients with greater needs,
- Intensify and expand medical review efforts,

---

[13] Ciolek, D.E. and Hwang, W. *Feasibility and Impact Analysis: Application of Various Outpatient Therapy Service Claim HCPCS Edits*, November 15, 2004. Contract Number PSC 500-99-0009/0009.
[14] Ciolek, D.E. and Hwang, W. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002*. November 22, 2004. Contract Number 500-99-0009/0009.
[15] Ciolek, D.E. and Hwang, W. *Development of a Model Episode-Based Payment System for Outpatient Therapy Services: Feasibility Analysis Using Existing CY 2002 Claims Data.* November 3, 2004. Contract Number 500-99-0009/0009.
[16] Ciolek, D.E. and Hwang W. *Final Project Report.* November 15, 2004. Contract Number 500-99-0009/0009.
[17] Olshin, J, Ciolek, D.E., and Hwang, W. *Study and Report on Outpatient Therapy Utilization: Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services Billed to Medicare Part B in all Settings in 1998, 1999, and 2000.* September 16, 2002. Contract Number 500-99-0009/0002.
[18] Maxwell, S., Baseggio, C., and Storeygard, M. Part B Therapy Services under Medicare in 1998-2000: Impact of Extending Fee Schedule Payments and Coverage Limits. September 2001. Contract Number 500-95-0055.
[19] Maxwell, S., Boccuti., and Tong, K. Supervision of Physical Therapist Assistants: Analysis of State Regulations. August 2002. Contract Number 500-95-0055.
[20] Hart, D.L. and Connolly, J.B. *Pay-for-Performance for Physical therapy and Occupational Therapy: Medicare Part B Services.* June 1, 2006. Grant Number 18-P-93066/9-01
[21] MedPAC web address: http://www.medpac.gov
[22] GAO web address: http://www.gao.gov
[23] OIG web address: http://www.oig.hhs.gov

- Eliminate the outpatient therapy caps altogether to allow other alternatives to function,
- Continue the caps with exceptions for services identified as medically necessary, and
- Continue the caps but reinstate a form of the 'Manual Process Exceptions' procedures applied during CY 2006 which required pre-authorization from the contractor beyond predetermined benchmark threshold limits.

In the June 2010 *Report to Congress – Aligning Incentives in Medicare*, MedPAC indicated that, until long-term outpatient therapy payment policies can be developed to assure more appropriate payments and improve quality, interim policies could include options such as:

- "excluding therapeutic services such as physical therapy…from the in-office ancillary services (IOAS) exception, and
- "improving payment accuracy and expanding payment rates to include multiple related services[24]"

An inherent limitation of all these approaches is they lack an effective and efficient method to appropriately pay for outpatient therapy based on the needs of the individual. In the prior CSC *Outpatient Therapy Services Pilot Report 2006*[11] and in reports by MedPAC [25] and the GAO[26], the authors indicate that Medicare needs more information about therapy users and their outcomes than is available solely through currently available administrative claims data, in order to consider additional payment policy approaches that are patient-centered.

In the absence of this information, Congress, CMS and the various MACs have implemented policies to control the growth of utilization based on the limited information that is available on the claim. These policies include: Deficit Reduction Act (DRA) edits that limit outpatient therapy evaluation codes, LCD edits that match claim diagnosis with procedures; Medically Unlikely Edits (MUE) that limit the number of units an individual procedure may be paid per claim line; and the outpatient therapy caps that limit the total payments permitted per-beneficiary per-year, regardless of need. In addition, Correct Coding initiative (CCI) edits were introduced to prevent the unbundling of procedures. None of these approaches addresses the medical necessity of the individual patient, but instead each restricts payments due to outlier billing patterns or presumed overbilling. CMS is also considering expanding the multiple procedure payment reductions (MPPR) adjustment policy to outpatient therapy services due to agency analysis that revealed MPFS practice expense duplication when multiple outpatient therapy procedures are furnished on the same date of service[27].

The majority of the short-term administrative alternative policies implemented over the past ten years do not adequately provide an approach that transitions fee-for-service policy towards a long-term solution where outpatient therapy is measured and paid for based upon an individual

[24] MedPAC. *Report To Congress – Aligning Incentives in Medicare. Chapter 8. Addressing the growth of ancillary services in physician's offices.* June 2010.
[25] Medicare Payment Advisory Commission. Report to Congress: Increasing the Value of Medicare. *Chapter 6 – Toward better value in purchasing outpatient therapy services.* June 2006.
[26] United States Government Accountability Office. Report to Congressional Committees. *Medicare: Little progress made in targeting outpatient therapy payments to beneficiary needs.* November 2005. GAO-06-59.
[27] Federal Register. *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011 - Proposed rule.* July 13, 2010.

patient's functional evaluation and progress towards expected clinical outcomes. Under the current MPFS fee-for-service payment model, outpatient therapy providers are financially rewarded for the quantity of services furnished rather than quality of care and outcomes. Current outpatient therapy coverage and documentation requirements describe the type of information that supports the delivery of medically necessary services. However, such no information is submitted with the claim that CMS could use to help assure that medically necessary services are being furnished. The only way CMS can currently identify the severity of the beneficiary's condition, the clinician's plan of care, and indicators of functional progress is to perform costly manual medical review. With nearly 30 million outpatient therapy claims per-year, manual review alone is a cost-prohibitive option.

To address these limitations, CMS awarded the Developing Outpatient Therapy Payment Alternatives (DOTPA) contract to Research Triangle Institute (RTI) in January 2008 to; collect a broad range of beneficiary data relevant to a beneficiary's need for outpatient therapy services, analyze the collected data in terms of predictive power and cost, and develop long-term payment alternative options. The DOTPA project is a five-year study.

In addition, this STATS study was awarded for two years starting in September 2008 to address short-term payment policy opportunities. The specific listed purposes of the STATS project are:

1. To update data on the utilization of outpatient therapy services,
2. To develop a method for CMS to update the utilization data quarterly (to evaluate the impact of policy changes on utilization), and
3. To use data from these sources and clinical expertise to;
    a. Identify characteristics of patients who need therapy services, and
    b. Develop specific payment policy applications that can be used in the short-term with the MPFS to limit payments for covered outpatient therapy services to medically necessary services.

The STATS project will not develop a new measurement tool, but will explore existing information and perform analyses that will result in recommendations for operational and efficient methods that can be implemented in the short-term to pay for appropriately provided outpatient therapy services that are needed by beneficiaries.

To better assure that medically necessary services are being provided requires a significant conceptual shift in the management of outpatient therapy payment policy. This report is directed at bridging this gap and facilitating the transition from a procedure-driven payment policy to a need and outcomes based model.

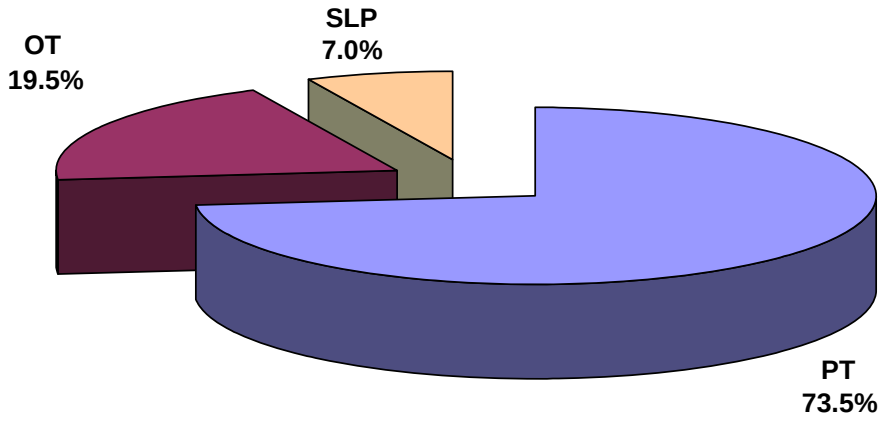
1.3 Medicare outpatient therapy utilization

Medicare outpatient therapy payments for over 4.5 million beneficiaries totaled nearly $4.8 billion in calendar year (CY) 2008 (Table 2). PT services accounted for 73.5% of the expenditures, followed by OT services at 19.5% and SLP services at 7.0% (Figure 1). In CY 2008, outpatient therapy patients represented 10.5% of all Part B beneficiaries enrolled in fee-for-service Medicare Part B and 2.6% of all Part B expenditures.

Table 2. Summary of outpatient therapy utilization by therapy type in CY 2008

CY 2008	Users	Total Paid	Mean Paid per User
All	4,503,178	$4,760,051,098	$1,057
PT	3,955,285	$3,496,865,018	$884
OT	973,222	$927,619,507	$953
SLP	477,988	$335,566,573	$702

Figure 1. Distribution of outpatient therapy payments by therapy type in CY 2008



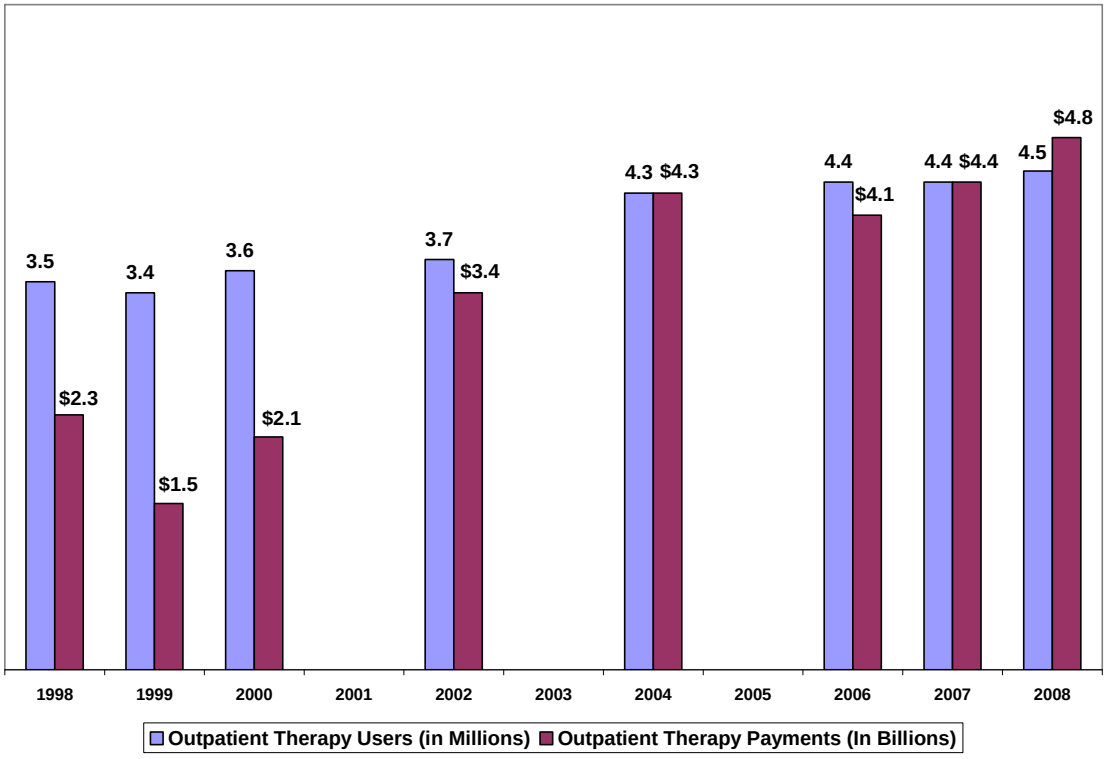
During CY 2008, Medicare contractors processed and paid for over 92 million claim lines on 7,649,807 outpatient therapy claims from provider settings, and nearly 58 million claim lines on 20,139,632 outpatient therapy claims from professional offices. The mean outpatient therapy paid amount was $398 per provider setting claim and $85 per professional office claim[28].

As demonstrated in Figure 2, the number of beneficiaries who received outpatient therapy services increased from 3.5 million in CY 1998 to 4.5 million in CY 2008 (about 2.9% per-year increase in the aggregate), and total outpatient therapy payments increased from $2.3 billion to $4.8 billion (about 10.1% per-year increase, although there were large variations across capped and uncapped years). During the same period, the mean annual payment per outpatient therapy user increased from $662 to $1,057, or an increase of about 6.0% per-year (again, varying in capped and uncapped years). While some of the increase per outpatient therapy user can be attributed to inflationary fee schedule price increases, it is uncertain whether the remaining increases were due to increases in necessary services or not.

[28] The differences in mean claim paid amount by claim type primarily results from the fact that provider setting claims are commonly submitted monthly, and contain multiple dates of service, while professional office claims are typically submitted on the date of service.

As Figure 2 also demonstrates, the implementation of the outpatient therapy caps in CY 1999 without exceptions resulted in a significant reduction in total payments and a slight reduction in beneficiaries treated. Beneficiaries most affected by the payment caps without exceptions were typically older, lived in states with limited hospital access, and had complex conditions that often required multidisciplinary interventions. The implementation of the outpatient therapy caps in CY 2006 initially reduced the amount of outpatient therapy services furnished to beneficiaries with certain characteristics similar to what was seen in CY 1999, however, utilization patterns have since returned to levels consistent with, and in some cases higher than, that observed in the uncapped CY 2004.

Figure 2. Total outpatient therapy users and payments from CY 1998-2008



We have estimated that elimination of the outpatient therapy caps exceptions process in CY 2008 would have limited benefits for 641 thousand (15.3%) of beneficiaries receiving PT and SLP services combined and 185 thousand (19.1%) of beneficiaries receiving OT services (Table 3). If the exceptions process was eliminated, this would have resulted in a reduction of over $1.1 billion, or 23.8 percent of all CY 2008 outpatient therapy payments. Full details of CY 2008 outpatient therapy utilization, recent utilization trends, and estimated impact of the therapy caps without exceptions are available in the *CY 2008 Outpatient Therapy Utilization Report*[29] submitted earlier in this contract.

[29] Ciolek, D. E. and Hwang, W. *CY 2008 Outpatient Therapy Services Utilization Report*, June 4, 2010. Contract Number *GS-23F-8029H*, Task Order Number *HHSM-500-2008-00065C*.

Table 3. Estimated cap impact by therapy type

Therapy Type	Total Users	Users Over Cap	Percent of Users in Therapy Type Over Cap	Mean Paid for Users That Surpassed Cap	Net Paid Above Cap Limits for Users That Surpassed Cap	Total Payments for Users That Surpassed Caps	Net Paid Above Cap Limits
PT	3,955,285	578,244	14.6%	$2,704	$1,256	$1,563,684,359	$726,384,330
OT	973,222	185,428	19.1%	$2,843	$1,395	$527,209,067	$258,709,146
SLP	477,988	55,765	11.7%	$2,633	$1,185	$146,846,657	$66,098,812
PT/SLP	4,194,265	640,937	15.3%	$2,811	$1,363	$1,801,634,899	$873,558,675

1.4 Report purpose

This report represents the culmination of a broad range of activities under the STATS *Development of Recommended Methods to Operationalize Alternative Policies* task. Under this task, CSC was asked to develop recommendations utilizing data from prior CSC studies, information gathered during this study, and other pertinent information.

Under the SOW, "There may be several forms of alternatives such as edits and policy recommendations." The short term alternatives recommendations in this report, therefore, may encompass a variety of CMS administrative activities, for example:

- Development of new or revised system edits (e.g. to claim lines, to claim dates of service or to episodes),
- Modifications in Medicare manual guidance,
- Modifications in the therapy cap exceptions process, or
- Recommendations for pilot testing alternatives.

This report completes the further development of preliminary recommendations submitted in a draft report to CMS on June 30, 2009[30], and reflects new information as well as feedback received from CMS and stakeholder representatives during the past year. Although stakeholder consensus was not required of the task, the options included in the recommendations represent ideas that meet the project objectives, are technically feasible within the time constraints, and, based upon the range of stakeholder feedback, are the most likely options to be acceptable to the broadest range of provider and beneficiary stakeholders.

The three specific recommendations in this report are intended to be clinically appropriate, enhance the process of making appropriate medical necessity determinations, provide mechanisms to limit unnecessary payments, and to facilitate the transition towards an episode-based payment model. The proposed short term alternatives are not intended to direct clinical decision making.

[30] Ciolek, D. E. and Hwang, W. *CY 2006 STATS Outpatient Therapy Practice Guidelines - Draft*, June 30, 2009. Contract Number *GS-23F-8029H*, Task Order Number *HHSM-500-2008-00065C*.

1.5 Assumptions

The first assumption for this report is that implementation of therapy caps without exceptions would create a significant negative impact on beneficiary ongoing access to medically necessary services and a significant reduction in overall payments to outpatient therapy providers. The assumption is based upon prior experience with full implementation of the outpatient therapy caps in 1999, and in the projected cap impact analysis described in prior outpatient therapy utilization reports[5,10,13] as well at the CY 2008 utilization report submitted earlier in this contract[27].

A primary purpose of this project is to develop short-term payment policy application options that are alternatives to the current outpatient therapy annual per-beneficiary payment limits (caps). Therefore, the policy recommendations in this report were developed on the second assumption that in the short-term, Congress will enact legislation that will permit beneficiaries to access medically outpatient therapy services from a qualified outpatient therapy provider without fixed annual benefit limits, or permit some form of exceptions process to continue.

This is an important assumption as the cap policy imposes significant administrative burdens upon CMS, the MACs, and providers/professionals. Elimination or reduction of these administrative burdens would free up time and resources that could be applied towards alternative activities such as function and outcomes reporting that would serve to give better confidence to CMS and Congress that medically necessary services are being furnished in the appropriate amount.

For example, a continuation of the outpatient therapy caps, even with the current exceptions process requires administrative efforts for CMS regarding maintaining the cap policies, maintaining the Medicare Common Working File (CWF) cap edit programming, developing provider and beneficiary notifications and education, and maintaining a mechanism for clinicians to check on the current debits against the cap limits. For providers and professionals, administrative efforts related to the caps involve checking with the CMS systems or the MAC to determine remaining cap limit available, tracking cap limits internally during every treatment, keeping up to date with CMS cap (and exceptions process) policies, and identifying the appropriate time to begin utilizing the KX modifier to override the cap limits.

There is also the additional administrative burden of identifying whether the patient is currently identified as under a home health plan of care, or a beneficiary is in a certified part of a SNF, as consolidated billing rules prohibit payment for outpatient therapy until the home health agency has submitted the appropriate discharge code, or the beneficiary is discharged from the distinct part of the SNF.

In addition, if caps remain in place without some exceptions process, new information collected through claims data regarding the beneficiaries that require the most extensive outpatient therapy services would not be available once the benefit limit was surpassed.

The third assumption of this report is that any new administrative burden generated by the proposed new policies would be more than offset by the elimination or reduction of cap related requirements, and not be implemented in addition to existing cap policies.

Finally, the recommendations in this report require a fourth assumption that payment rates for currently available outpatient therapy HCPCS codes will remain stable. Any significant re-pricing of individual procedure codes would significantly impact the estimated cost/savings impact of the proposed policy options presented in this report.

1.6 Constraints

In the current climate of the national healthcare debate, there is much uncertainty regarding what the Medicare payment system will look like and how outpatient therapy services will fit into the big picture. However, several technical considerations within the SOW provide the underlying framework regarding the scope of the proposed recommendations:

- Continuous medical review of outpatient therapy claims by CMS contractors is impractical, labor intensive, and burdensome to providers, and is therefore not an administratively feasible option. Particularly if significant numbers of claims are involved.
- Proposed changes in a short term policy recommendation that would require significant changes to CMS claims processing systems (e.g. CWF) would be impractical. However, minor systems change recommendation may be considered feasible.
- Proposed recommendations should be based on payments using the MPFS rather than the creation of a new payment model (e.g. fixed episode payments) to facilitate short-term implementation.
- Proposed policy changes shall be clinically appropriate, operationally feasible, and potentially effective in limiting unnecessary expenditures while maintaining appropriate access to medically necessary services.

Following the guidance of these SOW constraints, CSC developed a list seven specific items to be considered for any policy option proposed. These questions were also presented to stakeholder representatives to consider when they submitted suggestions and/or feedback. The seven considerations were:

- Is the option clinically appropriate?
- Is the option administratively appropriate?
- What level of policy change would be required?
- What level of systems change would be required?
- Would standard forms need modification or creation?
- What type of education would need to be developed? and
- What time frame would be needed for implementation?

The answers to these questions helped guide decisions regarding which potential options were further developed versus those that were ruled out of consideration as potential short-term options.

2 – Alternative Policy Options Development Methodology

As required in the SOW, CSC has consulted with Medicare contractors, CMS data systems experts, and others to explore the feasibility of rapid implementation of potential recommendations for short term alternatives to the therapy caps. Secondly, CSC reviewed a variety if existing outpatient therapy patient assessment tools for their potential applicability in short term payment policy recommendations. Third, CSC evaluated outpatient therapy utilizations patterns to identify trends, vulnerabilities, and opportunities for policy changes. Most importantly, CSC conducted extensive outreach activities with outpatient therapy stakeholders to identify opportunities for innovative policy recommendations and potential barriers that could inhibit the potential success of any proposed solution. By conducting these four activities, we believe that the proposed short-term outpatient therapy payment policy recommendations presented in this report represent the most practical and realistic options available that could serve as alternatives to the therapy caps until a long-term solution can be developed.

2.1 Consultation with systems experts

The rapid development of technically feasible policy options may require: changes in current claims processing system edits; the development of new or revised coding; the development of innovative mechanisms of gathering additional clinically relevant information; and the mechanism for measuring the impact of potential policy changes. Throughout the STATS project, CSC has consulted with officials within: the CMS Center for Medicare Management (CMM); CMS Office of Information Services (OIS); CMS Office of Research, Development and Information (ORDI), therapy researchers, tool instrument developers, and internal CSC systems experts to identify current opportunities and potential barriers to implementing meaningful policy changes in the short term. As the project progressed, CSC expanded the consultation to include the CMS Program Integrity (PI) Group and to Medicare Administrative Contractor (MACs) medical directors and medical review staff to address the potential impact on local claims processing and medical review activities of proposed policy changes.

2.2 Review of existing outpatient therapy patient assessment tools

CSC reviewed several patient assessment tools that are currently available to outpatient therapy clinicians, and are applicable for describing beneficiaries who require outpatient therapy services and their functional progress[31]. The outpatient therapy assessment tools examined included those identified in prior reports or that were suggested by various stakeholders during the STATS workgroup process. While some tools have pencil and paper versions that are in the public domain, all tools that provide benchmark data to clinicians are proprietary. Components of the assessment tools reviewed included:

- Applicable therapy disciplines (e.g. PT, OT and SLP),
- Time window of measurement (e.g. episode of care),
- Data collection methodology (e.g. patient survey or clinician entered and paper or web-based),
- Tool use published in per-reviewed journals,
- Tool listed in 2010 PQRI data registry,

[31] A list of assessment tools examined is provided in Appendix B

- Tool listed in National Quality Forum (NQF) Endorsed Standards,
- Tool listed in National Quality Measures Clearinghouse (NQMC),
- Tool provides benchmark outcomes data feedback to clinician, and
- Tool items can be mapped to the ICF.

These tools were reviewed to determine whether they may be useful to CMS in any short-term payment policy, particularly regarding whether they could help clinicians support that medically necessary services are being furnished to individual beneficiaries. The STATS project was not tasked to validate the tools themselves.

In general, all of these tools captured clinically relevant information using scales that represent key body functions, which could help support medical necessity determinations. Many of these tools use similar, if not identical core items. All tools reviewed also described functions that could be mapped in large part to the ICF classification, which could be useful for comparing tools.

Similar to the findings in the prior *Outpatient Therapy Alternative Payment Study Pilot Report 2006*,[12] we observed that there continues to be no single currently available tool that is applicable across all outpatient therapy treatment settings, to all three therapy disciplines, and to all conditions addressed by outpatient therapy services. None have been specifically tested across the entire spectrum of outpatient therapy users. Even the CARE tool being developed and tested under the CMS DOTPA study has separate (but similarly constructed) tools for assessing ambulatory outpatients (CARE-C) and residents of inpatient facilities (CARE-F). In addition, while some of the therapy assessment/outcomes tools (e.g. Patient Inquiry © from FOTO, Inc.) have undergone the rigors of scientific publication and/or outcomes and quality measures registry credentialing, others have not.

In the Proposed Rule for the 2011 Fee Schedule on July 13, 2010 (p. 40096), CMS indicated that "proprietary tools do not serve CMS' purposes because modifications of proprietary tools may only be done by the tool sponsor." However, we believe that there is a place in short-term policy, and possibly even long-term policy approaches for such tools. As we indicated in the prior 2006 Pilot Report, many existing outpatient therapy patient assessment tools were developed for clinical quality and outcomes measurement purposes and are integrated into HIPAA compliant documentation and billing software packages. These software applications could be used as a vehicle to transmit core function related information to CMS. Although collecting information universally through such tools could not realistically be completed in the short-term, we still believe that pilot studies or demonstrations should still be considered that permit outpatient therapy proprietary assessment tools to submit clinical information to CMS for long-term quality and risk-adjustment (payment policy) study. In the short-term, we believe that the recommended options proposed in this report would permit clinicians to use existing proprietary and public domain assessment tools to better support the medically necessity of furnished services, and to support the use of new codes that would result from adoption of the recommendations of this report.

2.3 Evaluation of outpatient therapy utilization patterns

In prior studies, and in this contract, CSC was able to analyze outpatient therapy service utilization patterns at multiple levels to identify changes in provider billing patterns in response to previously implemented outpatient therapy policy, and to predict the impact of policy options on future utilization. These utilization analyses included:

- Overall expenditure patterns,
- Expenditures by therapy discipline (PT, OT, or SLP),
- Expenditures by outpatient therapy provider setting (hospital, SNF, CORF, ORF, HHA, or professional specialty (PTPP, OTPP, SLPP, physician, and NPP),
- Expenditures per claim ICD-9 code,
- Expenditures per clinical classification group,
- Expenditures per individual HCPCS procedure,
- Expenditures per date of service,
- Expenditures per episode of care, and
- Impact of the outpatient therapy caps (e.g. number of beneficiaries, settings/specialists affected, and dollar impact).

During STATS, we reviewed the previously reported utilization trends spanning calendar year (CY) 1998 through CY 2006 and have supplemented that with analysis of CY 2008. The findings and recommendations from these prior analyses directly contributed to the recent CMS introduction new procedure code edits that were discipline specific and have stakeholder support.

In addition, we have developed a method to analyze CY 2006-current claims on at least a quarterly basis in near real-time using the new CMS Integrated Data Repository (IDR) and Microstrategy business intelligence reporting tools. This will allow CMS to better monitor utilization changes resulting from implementation of any recent and future policy changes to permit rapid response to any unintended consequences of new policies.

2.4 Conducting provider outreach

Stakeholder feedback is a critical factor in developing new short-term policy options and supporting educational materials that are administratively feasible, clinically relevant, and acceptable to outpatient therapy stakeholders. Provider outreach was directed at treating clinicians, practice managers/owners, compliance personnel, professional association representatives, researchers, and assessment/outcomes tool developers. Efforts were made to obtain input from representatives from all outpatient therapy practice settings, as many states as possible, and from clinicians that treat a variety of patient conditions.

Specific STATS outreach activities included:

- On-site project 2-hour kickoff meeting for general information exchange at CMS on November 6, 2008 that had 44 participants,
- Web-based 2-hour conference call project kickoff meeting for general information exchange on November 17, 2008 that had 68 attendees,
- Various conference calls, face-to-face meetings, and e-mail exchange with stakeholder national organizations and individual stakeholders regarding specific detailed issues

not appropriate for workgroup discussions (e.g. proprietary issues or follow-up questions), and

- Three separate workgroups of stakeholder plus CSC and CMS representatives were created. Most STATS workgroup members were selected from a list of individuals nominated by stakeholder organizations or by individuals. A small number of additional 'at-large' workgroup participants were requested by CSC based upon the specific expertise of the individuals. All STATS workgroup members were selected to represent a diversity of practice settings, patient populations, and clinical, research, and policy expertise throughout the country[32]. To facilitate additional participation, workgroup discussion documents were disseminated prior to each meeting to permit workgroup members to collaborate and receive feedback from colleagues and members of their respective organizations in advance so that the workgroup member could better represent the views of a broad group of stakeholders. To obtain insights and feedback, we conducted 24 interactive 2-hour web based conference calls held every 1-2 months from December 2008 through February 2010 where workgroup members discussed specific focused issues contained in the discussion documents. The composition of the three workgroups was as follows:
    - STATS Clinical Workgroup – 22 stakeholder participants (15 PTs, 4 OTs, and 3 SLPs), 16 states, and 16 nominating organizations,
    - STATS Assessment Workgroup – 20 stakeholder participants (9 PTs, 4 OTs, 4 SLPs, and 3 Other), 16 states, and 17 nominating organizations, and
    - STATS Policy Workgroup – 21 stakeholder participants (7 PTs, 2 OTs, 3 SLPs, and 9 'Other'), 14 states, 14 nominating organizations, and 2 self-nominations.

[32] Appendix C identifies the individuals that participated in the STATS workgroup meetings and the organizations they represented.

3.0 Recommended Short Term Alternatives

Recent CMS studies, MedPAC reports, GAO reports, and the current national healthcare debate indicate a trend towards an emphasis on the measurement and reporting of key clinical indicators that represent measures of quality and/or outcomes. Frequently these indicators are reported within the context of a patient episode, and in some cases, these indicators have been incorporated into various payment models. There is no single current patient reporting tool for outpatient therapy services that has been identified that could serve these purposes. One of the objectives of the CMS DOTPA project is to develop such a tool, but the study results will not be available in time to address short-term policy needs.

The SOW has requested that CSC provide recommendations to CMS for outpatient therapy policy changes that could be implemented in the short-term to better assure that medically necessary services are being furnished, and to serve as an alternative to the caps.
During various activities to date, including numerous stakeholder workgroup meetings, CSC has identified several consistent themes. In general, outpatient therapy provider stakeholders believe that clinicians and Medicare contractors could better focus on needed services if policy placed more emphasis on:

- The episode of care,
- The patient's evaluation and periodic reevaluation,
- The clinician's clinical judgment,
- Use of evidence-based-practice, and
- Progress towards expected outcomes.

These common stakeholder themes are consistent with current payment policy trends.

The outpatient therapy stakeholders also acknowledge that realistic cost containment measures are necessary and can be attainable through the transition towards a patient centered payment approach with consistent and reasonable documentation and coding policy. During the transition, interim administrative cost containment measures (if necessary) such as edits and utilization limits should be based on currently available medically unlikely outlier data rather than on arbitrary limits on all beneficiaries regardless of clinical need (e.g., cap policy).

In addition, stakeholders agree that if the long-term outpatient therapy payment policy moves towards an episode-based payment system that incorporates some form of patient function reporting tool, then short-term policy recommendations should facilitate such a transition.

There is no current Medicare requirement for outpatient therapy providers to collect or report standardized measurements that could help identify the need for therapy services. As a result, therapy professional associations, providers, and segments of the health care industry have developed numerous and fragmented approaches to report and measure function and/or outcomes. These vary from simple pencil and paper reports to sophisticated software packages that serve as stand-alone programs or that are integrated into commercially available provider billing software packages. Many of these tools provide important risk-adjusted feedback to clinicians regarding the patient's function and potential for restoration of function, compared to

similar patients, which could help guide clinical decision making. Properly calibrated risk-adjustment tools such as those being tested in the DOTPA project could also be useful in the long term development of episode-based payment systems. In this report, when we refer to 'reporting tool', 'functional measurement tool', or 'outcomes measurement tool' we are referring generically to any of these tools in a generic sense.

The SOW limited the short-term payment policy recommendations to those that could be accomplished while maintaining the current MPFS structure of outpatient therapy services. In particular, the recommendations offered could be realistically implemented in the immediate future but no later than 2-3 years from the conclusion of the STATS contract.

CSC approached the process of developing recommendations by first considering what outpatient therapy service policy is likely to look like in the long-term. Once that was established, we evaluated individual components of the current payment system to identify opportunities to adapt the current payment model to the likely future model. Recommendations that were favored were the least burdensome, or had burdens that could be mitigated if other burdensome, redundant or unnecessary activities could simultaneously be eliminated.

After thoughtfully reviewing current payment policy, reviewing outpatient therapy utilization trends, and conducting extensive information gathering outreach with affected outpatient therapy stakeholders and stakeholder organizations, CSC has established a number of assumptions that serve to guide the recommendations offered in this report. These assumptions are consistent with recent CMS efforts at packaging or bundling payments into models based upon the care needs of beneficiaries and outcomes, not service provision. They also are consistent with recommendations from the Institute of Medicine (IOM)[33] and the Medicare Payment Advisory Commission (MedPAC)[34].

- In the long-term the most likely payment model for outpatient therapy services will be one that is based upon the episode of care. Provider payments will be influenced by beneficiary condition characteristics, and the outcomes, or value, resulting from provider interventions.
    - Short-term policy changes to support this direction should increase information on the claim regarding beneficiary characteristics, expected outcome, and treatment progress. This information would help CMS and Medicare MACs make better medical necessity determinations and would also help target education and medical review efforts. It could provide a bridge towards a long-term policy that requires more risk-adjustment analysis.
- In the long-term, outpatient therapy payment policy will maintain the clinicians' ability to use their clinical judgment to provide medically necessary services.
    - Short-term policy changes to support this direction should avoid placing real or perceived restrictions on the clinician's ability to use the best available information in his/her clinical decision making process. However, the same

[33] Institute of Medicine. *Crossing the Quality Chasm. A New health System for the 21st Century*. Washington, DC: National Academy Press 2001.
[34] MedPAC, *Report to Congress: Increasing the value of Medicare*. Chapter 6. Toward better value in purchasing outpatient therapy services. June, 2006.

short-term changes should serve to promote the use of modern evidence based practice, use of clinical practice guidelines, and to facilitate the public and private research necessary to identify and/or develop standardized tools to measure meaningful clinical change and reduce practice variation.

- In the long-term, a single outpatient therapy function and/or outcomes reporting tool (or a core tool with multiple modules specific to discipline or conditions) may be available to measure outpatient therapy quality and/or to adequately perform risk-adjustment for episode-based payment purposes.
    - Short-term policy changes should encourage the use of currently available function and/or outcomes reporting tools that could provide useful information while a long-term solution is developed.
- In the long-term, the currently burdensome granular policies that serve to control utilization without regard to the patient's clinical presentation such as HCPCS edits and ICD-9 CM and HCPCS crosswalk edits can be eliminated since the emphasis of payment policy will have shifted from managing procedures billed to managing patient functional progress and/or outcomes.
    - Short-term coding policy changes should not add to beneficiary, provider, CMS systems, and CMS contractor burden unless there is a clear long-term benefit (including savings). In the short-term it is preferable to identify coding policies that can be streamlined or eliminated if they are redundant or when they create barriers to the effective implementation of policies necessary to move towards the long-term payment policy model.
- In the long-term, diagnosis code reporting will transition from the current use of ICD-9 to the use of the more robust and precise ICD-10 coding system and may also include components of the related ICF coding system.
    - Short-term policy changes should facilitate the transition to ICD-10 coding due to be implemented in late 2013. In addition, short-term policy changes and provider education should incorporate ICF concepts to facilitate the standardization of documentation and reporting of function. The ICF was designed to be complimentary to ICD-10.

The *STATS Outpatient Therapy Practice Guidelines Draft Report*[30] submitted to CMS in June 2009 represented the preliminary recommendations of CSC. That report was organized into five separate conceptual areas of recommendations, including:

- Potential payment model variations (4 options),
- Potential introduction of new HCPCS codes to support medical necessity decisions (4 code groups),
- Potential revisions to Medicare manual guidance (Benefit Policy and Claims Processing),
- Potential refinements to the therapy caps exceptions process,
- Potential pilot studies to develop new policy concepts (4 options), and
- Other miscellaneous concepts (2 options).

Although specific direction was not provided by CMS regarding the options presented, CMS has recently published a proposed rule in the Federal Register that states:

> Based on the draft *[CSC]* report, additional stakeholder input, and subsequent communications with the contractor *[CSC]*, in this proposed rule we are discussing several potential alternatives to the therapy caps that could lead to more appropriate payment for medically necessary and effective therapy services that are furnished efficiently. We are soliciting public comments on this proposed rule regarding all aspects of these alternatives, including the potential associated benefits or problems, clinical concerns, practitioner administrative burden, consistency with other Medicare and private payer payment policies, and claims processing considerations. We are not proposing either short-term or long-term alternatives to the therapy caps at this time[35]"

Three specific short-term options were presented by CMS for discussion in the proposed rule. They were:

- Modify the current therapy caps exceptions process to capture additional clinical information regarding patient severity and complexity in order to facilitate medical review.
- Introduce additional medical necessity claim edits in order to reduce overutilization, and
- Adopt a per-session bundled payment that would vary based on patient clinical presentation and the complexity of evaluation and intervention services furnished in the session.

We agree that these three short-term policy options present the most promising concepts that can be developed and implemented within a 2-3 year timeframe, and that can facilitate the transition towards a long-term episode payment model that is based upon beneficiary function and/or outcomes. The following sections provide further detail of the recommended policy options.

3.1 Option #1 – Revise therapy caps exceptions process by requiring the reporting of new patient function-related Level II HCPCS codes and severity modifiers

Description

This option would modify therapy cap exceptions process by introducing new nonpayable HCPCS codes to be submitted at episode onset and at periodic intervals that reflect current and treatment goal function. The new codes would replace the KX modifier and would provide more clinically relevant information than the KX modifier for medical review.

These new codes would be separate codes from the existing 76 outpatient therapy HCPCS procedure codes and would not change the reporting requirements for these codes. We are proposing that the new codes be submitted at episode onset and at periodic intervals. The intervals to submit these codes should not be longer than every 12 treatment sessions, or 30 calendar days, whichever is less. Unlike the KX modifier which is submitted on every outpatient therapy claim line only when nearing or surpassing the therapy cap, the new codes would be submitted for all patient episodes and not only for those claims approaching or surpassing the therapy cap limits.

[35] Federal Register, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011,* July 13, 2010, Section III.A.2.

Current claims processing under the exceptions process
System edits in the CMS common working file (CWF) track beneficiary year-to-date outpatient therapy utilization for PT/SLP services combined cap and for OT services separate cap. Once a beneficiary's annual allowed amount for the respective cap has been reached, the CWF would check the outpatient therapy claim line to identify the presence of the KX modifier.

- For outpatient therapy claim lines representing services beyond the cap limit for that year that do not have the KX modifier (except outpatient hospital services), the CWF would issue instructions to contractors to deny payment.
- If the clinician had appended the KX modifier to an outpatient therapy claim line that surpassed the respective cap limit for that year, the CWF would override the cap payment denial instructions for that claim line and instructs contractors to issue payment.

The KX modifier is a signal from the clinician that attests to the contractor that documentation is present in the medical record that supports medical necessity for the services billed on the claim line. The KX modifier can not be used for identifying claims exceeding the caps because, due to CMS systems limitations, clinicians have been instructed to use the code for services both before and after the cap limits have been exceeded.

Proposed new claims processing under the exceptions process
System edits in the CMS common working file (CWF) would continue to track beneficiary year-to-date outpatient therapy utilization for PT/SLP services combined cap and for OT services separate cap. Once a beneficiary's annual allowed amount for the respective cap has been reached, the CWF would check the outpatient therapy claim history for the claim provider number to identify the presence of the new patient function-related Level II HCPCS codes and severity modifiers within the prior 30 calendar days.

- For outpatient therapy claims containing services beyond the cap limits, the CWF would issue instructions to contractors to deny payment for dates of service after the cap limit has been surpassed only if that provider number does not have the new patient function-related Level II HCPCS codes and severity modifiers submitted for a date within the prior 30 calendar days.
- If the clinician submitted the new patient function-related Level II HCPCS codes and severity modifiers within the prior 30 calendar days, the CWF would override the cap payment denial instructions for dates of service after the cap limit has been surpassed and instruct contractors to issue payment.

Similar to the KX modifier, the new patient function-related Level II HCPCS codes and severity modifiers would be a signal from the clinician that attests to the contractor that documentation is present in the medical record that supports medical necessity for the services billed for the episode. Exceptions to the therapy caps would be based on medical necessity.

Proposed new Level II HCPCS codes and severity modifiers
Six Level II HCPCS G-codes would be utilized to report high level functional information and five (or seven) modifiers would be used to represent functional severity/complexity on the claim. The G-codes codes would identify whether certain factors are being addressed in the plan of

care, such as: 1) impairments to body functions and/or structures, 2) activity limitations and/or participation restrictions (difficulty), and 3) environmental barriers. Separate G-codes would differentiate current function from function outcome goals in the plan of care. Modifiers would rate the severity/complexity within each of the function G-codes.

Examples of six new function-related G-codes:

- GXXXU – Impairments to body functions and/or structures – current
- GXXXV – Impairments to body functions and/or structures – goal
- GXXXW – Activity limitations and/or participation restrictions – current
- GXXXX – Activity limitations and/or participation restrictions – goal
- GXXXY – Environmental barriers – current
- GXXXZ – Environmental barriers – goal

Two severity/complexity scale options are recommended that would require the adoption of five or seven new severity/complexity modifiers respectively (Table 4). Under the first option, the five modifiers are based on the ICF functional qualifier definitions. The ICF qualifier scale represents functional impairment, difficulty, or barrier percentage levels that are disproportionate. Under the second option, the seven modifiers represent proportional percentage levels for functional impairments, difficulties, or barriers.

Table 4. Examples of new 5 or 7 modifiers identifying severity of functional impairments, difficulty, and/or barriers for applicable function-related G-code:

ICF-based modifiers (5)	Proportion-based modifiers (7)
XA – NO (0-4%) XB – MILD (5-24%) XC – MODERATE (25-49%) XD – SEVERE (50-95%) XE – COMPLETE (96-100%)	XA – 0% impairment, difficulty or barrier XB – 1-19% impairment, difficulty or barrier XC – 20-39% impairment, difficulty or barrier XD – 40-59% impairment, difficulty or barrier XE – 60-79% impairment, difficulty or barrier XF – 80-99% impairment, difficulty or barrier XG – 100% impairment, difficulty or barrier

Implementation issues

This proposed option would not require a change in statute if the outpatient therapy cap exceptions process were continued, as caps would be tracked, and payments would be denied for services furnished above the cap limits, unless claims contain the necessary coding used to attest that the services billed were medically necessary were submitted properly. Implementation would require six months to two years depending on the complexity of modifying claims processing systems, disseminating educational materials, and whether CMS determines that further code refinement, development, and pilot testing is necessary before a national rollout.

There would be an initial increased burden on clinicians to learn new codes and on billers update billing systems, but clinicians would ultimately experience a reduced burden, with no further need to track cap amounts or submit a KX modifier with each claim line for beneficiaries with expenditures approaching or exceeding the caps.

These new codes and modifiers could be mapped to reliable and validated measurement tools (either proprietary, currently available in the public domain, or newly developed tools or items from the DOTPA project).

When additional statistically robust information has been collected from claims data, it may be possible to develop payment approaches for outpatient therapy services that would pay appropriately and similarly for effective and efficient services furnished to beneficiaries with similar conditions who have good potential to benefit from the services furnished.

At a minimum the new codes would allow Medicare contractors to more easily identify and limit payments for beneficiaries that show no improvement over reasonable periods of time.

Savings Impact:
We anticipate reductions in episode length, particularly with outliers, when clinicians cannot honestly support the attestation of continued medical necessity as goals are met, or reasonable progress is not supported. This option could also result in a slight reduction in outpatient therapy expenditures related to increased Medicare contractor scrutiny of episodes where functional severity/complexity scores do not change over time, or to other atypical patterns associated with new codes that suggest improper billing.

3.2 Option #2 – Enhance existing therapy caps exceptions process by applying medical necessity edits when per-beneficiary expenditures reach a predetermined value

Background
The current automatic process for outpatient therapy cap exceptions, and the proposed revised exceptions process described in Option #1 above pay clinicians (subject to review) for an indefinite amount of services per-session or per-episode if the clinician attests on the claim, by using specified codes, that the services being billed for are medically necessary and that supporting documentation is included the beneficiary's patient record. Recently, CMS has implemented national DRA edits to outpatient therapy evaluation codes and MUE edits to several outpatient therapy treatment intervention codes to limit the amount of units of each code to be billed per date of service. There are no national medical necessity edits that limit unusual per-episode or annual per-beneficiary utilization. Unless the Medicare contractor applies local claim medical necessity edits or conducts post-payment medical review, unusually high utilization that may not be necessary is difficult to identify and limit while exceptions are in use. Prior outpatient therapy utilization studies and reports from the OIG indicate that extremely high utilization (e.g. top 1-2 percent) are more likely to represent coding errors, abuse, or fraud than to represent complex cases.

In this report, we are proposing that in the short-term, CMS consider; a) refining the existing national MUE edits for outpatient therapy timed intervention HCPCS codes [Option #2a], and b) implementing new national per-beneficiary per-year medical necessity payment edits [Option #2b]. These edits would be based upon existing utilization data. CMS would establish benchmark payment levels for these edits that would only affect a small percentage of beneficiaries. With these edits, once these high utilization outlier threshold levels are reached,

additional services would be denied. Clinicians would need to appeal these denials if they wished to challenge Medicare's nonpayment above the edit limits.

Option #2a - Refining the existing national MUE edits for outpatient therapy HCPCS codes

Description

When the Balanced Budget Act (BBA) of 1997[36] was implemented, CMS chose HCPCS as the uniform coding system for the reporting and payment of outpatient therapy services. Prior to 1998, only professional offices (PTPPs, OTPPs, physicians, and NPPs) reported and were paid for services using HCPCS. Beginning in 1998, SNF, CORF, ORF, and HHA provider facilities began reporting outpatient therapy services using HCPCS. In1999, the MPFS replaced cost-based payment methodologies in these provider facility settings. Since then, all professional office and provider facility outpatient therapy payments are based upon the same fee schedule. As a result, utilization patterns of individual procedures can be analyzed across and within therapy disciplines, provider settings, and professional specialties to identify outliers.

In prior projects, CSC provided data and suggested that CMS consider implementing a 'global approach' to short term payment policy that would include the implementation of a number of administrative cost containment activities, while collecting the needed clinical information for long term alternative payment policies. These activities would include the development and implementation of various utilization limits, or edits, based upon existing utilization data patterns. The recommendations suggested establishing edits to deny payments for clinically illogical codes or outliers representing atypical utilization. Although these edits are based upon statistical analyses rather than specific clinical information, there is a higher likelihood that the outlier billing represents data entry errors or unnecessary services and a lower likelihood that medically necessary services would be denied.

Since these prior reports, CMS has responded in part by implementing two different types of edits that impact the current 76 different outpatient therapy HCPCS codes. First, section 5107 of the Deficit Reduction Act of 2005 (DRA)[37] required CMS to implement clinically appropriate code edits in order to identify and eliminate improper payments for therapy services. CMS Transmittal 1019[38], identified fifteen outpatient therapy evaluation HCPCS codes that, as of January 1, 2007, were to be limited to '0' or '1' unit billed per date of service, depending upon the discipline billing the service. For example, HCPCS code 97001 – PT evaluation would only be paid for one unit if billed as PT services and would not receive payment if billed as OT or SLP services. Per the Medicare Claims Processing Manual, Section 20.2.D, current edits limit the number of units that can be billed for evaluation procedures by discipline per-day and does not allow codes that are clinically illogical (e.g. PT evaluation billed on a claim line identified as SLP services). While the DRA edits should have prevented all occurrences of payments above the edit limits in CY 2008, utilization analysis indicates that there are opportunities for improvement.

[36] P.L. 105-33. (H.R. 2015). Enacted August 5, 1997.
[37] P.L. 109-362. (S.1932). Enacted February 8, 2006.
[38] Change Request 5253, Pub 100-04 Medicare Claims Processing, *Outpatient Therapy – Additional DRA Mandated Service Edits*. August 3, 2006

Second, beginning in 2007, CMS developed Medically Unlikely Edits (MUEs) to reduce the claims paid error rate for Part B services. An MUE for a HCPCS code is the maximum number of units of service that can be paid on a claim line for a single date of service. Most, but not all, outpatient therapy HCPCS codes have an MUE established. MUEs are updated quarterly and are posted at: http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp. While many MUE limits are publicly posted, CMS does not publish MUE values that are 4 units or higher (and some that are less) because of CMS concerns about fraud and abuse. It is notable that most of the MUEs that impact outpatient therapy service HCPCS were not established until after CY 2008 and, therefore, would not have impacted the utilization patterns reported in the *CY 2008 Outpatient Therapy Utilization Report*[28] submitted earlier in this contract.

Although CMS does not publish MUEs for all outpatient therapy HCPCS codes, it would be useful to identify those untimed and timed outpatient therapy HCPCS treatment codes that are billed at an atypically high volume per claim line. For example, an edit could be set at the 98th or 99th percentile for each individual procedure and be customized per therapy type, and/or per therapy provider setting or professional office specialty.

Proposed new outpatient therapy HCPCS claim line edits

We propose that CMS consider establishing MUE edits at the 98th percentile for most individual procedures that aren't already subject to published DRA or MUE edits. For example, if 98 percent of the claim lines for an individual HCPCS code were billed at 4 or fewer units per claim line, then the proposed edit would deny payment for 5 or more units on claim lines with that HCPCS code.

The tables in Appendix D, E and F present the estimated overall impact of the DRA, published MUE, and proposed new MUE edits on provider and professional claims if they were enforced completely in CY 2008. To do this we determined how often individual HCPCS codes were billed for 1 unit, 2 units, etc. through 10+ units per claim line. For example, for HCPCS code 97110 – Therapeutic exercise, how many claim lines were billed at 1 unit? How many at 2 units? How many at 3 units? This was repeated up to 10+ units for that HCPCS code. The results were placed into Microsoft EXCEL tables where outlier analyses could be performed[39]. Similar to the prior CSC edit analyses, the 98th and 99th percentiles were identified as baselines for identifying outliers.

In the edit analyses in prior studies, CSC applied edit thresholds that were determined by a number of factors including the 98th and 99th percentile outlier tables, and edit thresholds previously suggested by national therapy stakeholder associations. In this analysis we modified the approach and applied the DRA and published MUE edits to identify outpatient therapy HCPCS codes. Codes without an identified DRA or published MUE edit were given an edit threshold at the unit count at the 98th percentile. There were two exceptions to the 98th percentile threshold. First, if the HCPCS code was not used for at least 100 claim lines, we did not establish a proposed edit threshold for that code. Second. If a code had the 98th percentile at 9 or 10+ units, we set the maximum allowed units at 8 units for that HCPCS code.

[39] We intend to submit the complete Excel tables uses for this analyses later in this project in an *Addendum* to the previously submitted June 4, 2010 *CY 2008 Outpatient Therapy Utilization Report.*

In the prior approaches and the current approach, separate edit threshold limits were established for PT, OT, and SLP services. In addition, similar to the prior edit analyses, the estimated dollar impact of the edit thresholds were developed to determine the financial impact of the edits.

Implementation issues

The proposed new outpatient therapy MUEs can be addressed administratively without change in statute or coding. The process of developing MUEs has been established and MUEs are updated by CMS on a quarterly basis. Therefore, it is not unrealistic for CMS to implement the proposed new MUEs within six months to one year. Existing provider education materials would not need to be modified.

Estimated Savings Impact of DRA, published MUE and proposed MUE HCPCS claim line edits

Applying the DRA, MUE and proposed MUE claim line edits to CY 2008 outpatient therapy claims (as proposed in the tables in Appendix D, E and F) indicates that the edits would have reduced total payments by $42.6 million. This represents 0.9 percent of the $4.76 billion in outpatient therapy payments. Nominal improper payments were identified for bundled HCPCS codes.

For PT services, the total edit impact is estimated to be $29.1 million with $19.1 million from provider settings and $10.1 million from professional offices (Table 5). Continued enforcement of the existing DRA and published MUEs have negligible additional cost containment impact as 94.4 percent of the payment reductions would result from the proposed MUEs.

Table 5. Estimated savings impact of claim line edits for PT services

PT Service HCPCS	Provider Setting Claims	Professional Office Claims	All Claims
Proposed New MUE Edits	$18,127,125.55	$9,359,320.37	$27,486,445.92
Published MUE Edits	$893,845.90	$421,447.74	$1,315,293.64
Existing DRA Edits	$48,023.87	$272,120.39	$320,144.26
Subtotal	$19,068,995.32	$10,052,888.50	$29,121,883.82
Bundled HCPCS	$5,923.93	$140.39	$6,064.32
Total	$19,074,919.25	$10,053,028.89	$29,127,948.14

For OT services, the total edit impact is estimated to be $8.6 million with $7.8 million from provider settings and $0.7 million from professional offices (Table 6). Continued enforcement of the existing DRA and published MUEs have negligible additional cost containment impact as 94.3 percent of the payment reductions would result from the proposed MUEs.

Table 6. Estimated savings impact of claim line edits for OT services

OT Service HCPCS	Provider Setting Claims	Professional Office Claims	All Claims
Proposed New MUE Edits	$7,478,349.64	$606,377.59	$8,084,727.23
Published MUE Edits	$286,363.15	$12,728.30	$299,091.45
Existing DRA Edits	$59,487.34	$127,030.30	$186,517.64
Subtotal	$7,824,200.13	$746,136.19	$8,570,336.32
Bundled HCPCS	$133.20	$0.08	$133.28
Total	$7,824,333.33	$746,136.27	$8,570,469.60

For SLP services, the total edit impact is estimated to be $4.9 million with nearly all savings from provider settings and negligible savings from professional offices (Table 7). However, unlike the PT and OT edits, enforcing the existing published MUEs would have a significant impact on SLP services as 96.4 percent of the payment reductions would result from the published MUEs while negligible payment reductions come from the proposed MUEs and enforcing existing DRA edits.

Table 7. Estimated savings impact of claim line edits for SLP services

SLP Service HCPCS	Provider Setting Claims	Professional Office Claims	All Claims
Proposed New MUE Edits	$169,021.98	$374.77	$169,396.75
Published MUE Edits	$4,709,250.33	$493.44	$4,709,743.77
Existing DRA Edits	$4,852.54	$458.69	$5,311.23
Subtotal	$4,883,124.85	$1,326.90	$4,884,451.75
Bundled HCPCS	$1.00	$0.00	$1.00
Total	$4,883,125.85	$1,326.90	$4,884,452.75

The results presented in Tables 5-7 suggest that:

- The existing DRA edits limiting outpatient therapy evaluation HCPCS may have been effective in reducing overbilling in CY 2008, but that there are still opportunities to improve the enforcement of the edits,
- The proposed new HCPCS MUEs would have the greatest cost containment impact on the timed intervention HCPCS codes used most often for PT and OT services. Continued enforcement of the existing published MUEs have a nominal cost containment impact as these HCPCS codes are those less commonly used for PT or OT services.
- Continued enforcement of the existing published MUEs would have the greatest cost containment impact on SLP payments as most HCPCS codes used for SLP services are untimed codes covered by the published MUEs. The proposed new HCPCS MUEs would have nominal cost containment impact on SLP services as the proposed codes are less commonly used to describe SLP services.

Therefore, in the short-term, CMS should consider continuing the enforcement of the DRA edits, enforcement of the published MUE edits, and implementing the proposed MUE edits to outpatient therapy services. Overall, these edits impact no more than two percent of outpatient therapy claim lines. Although the medical necessity of these billing outliers cannot be determined solely on the submitted claims data, it is more likely that the billed HCPCS units result from data entry errors or unnecessary services. Clinicians and beneficiaries should maintain the right to appeal the denial.

Option #2b - Implementing new national per-beneficiary per-year medical necessity payment edits

Description

The concept of implementing fixed per-beneficiary payments based upon outpatient therapy episodes has been discussed in prior CSC Medicare outpatient therapy reports, and in MedPAC and GAO reports as described in Section 1 of this report. The most significant obstacle for devising such fixed payments is the current lack of information on Medicare claims that could be

used for adequate risk-adjustment. The limited information available (e.g. demographic and claim ICD-9 diagnosis codes), although useful, is too variable to predict Medicare expenditures (see section 3.6 of the *STATS CY 2008 Outpatient Therapy Utilization Report* for detailed episode analysis[28]). Until episode-based risk-adjustment can be established through the work of the DOTPA project, or other means, we do not believe that establishing fixed episode payments based on beneficiary characteristics, function, and/or outcomes is realistic in the short-term. In addition, significant systems changes would be necessary to track beneficiary utilization per-episode that is unrealistic in the short-term, which would preclude consideration of developing per-episode medical necessity edits.

However, we believe that there is sufficient and consistent information in Medicare outpatient therapy historical claims utilization data to recommend that CMS consider establishing per-beneficiary per-year medical necessity payment edits if outlier utilization patterns are considered. In other words, we are proposing, if the outpatient therapy caps exceptions process is continued, that CMS consider implementing annual per-beneficiary medical necessity utilization edits at outlier thresholds. This would mean that, although a provider is continuing outpatient therapy beyond the cap limits and is using the KX modifier, that at some point, payment may be automatically denied through instructions from a CWF edit, even if the KX modifier is being used. The dollar limit for this edit would be set at a predetermined outlier utilization level. This approach is conceptually similar to the MUE edits concept in that beneficiary utilization at extremely high outliers is more likely to include billing errors or medically unnecessary services than non-outlier utilization.

Existing utilization patterns can be useful in identifying the number of beneficiaries likely impacted by annual per-beneficiary utilization edits, and the potential impact on Medicare expenditures from the edits. Section 4 of the *STATS CY 2008 Outpatient Therapy Utilization Report* provides detailed analysis of the outpatient therapy caps if the $1,810 allowed amount limits were enforced without the exceptions process[28]. The number of beneficiaries impacted and the payment reductions were analyzed by a number of variables including; therapy discipline, beneficiary demographics (gender, age, and state), principal claim diagnosis, and provider setting/professional office specialty.

As presented in Table 8, during CY 2008, 4.2 million beneficiaries received outpatient PT and/or SLP services from all settings, including hospital. Of these PT/SLP users, 640,397 beneficiaries, or 15.3 percent, benefitted from the exceptions process and received services beyond the therapy cap threshold of $1,810 allowed amount (~$1,448 paid). The net payments beyond the PT/SLP combined cap threshold, totaling $874 million (representing 22.8 percent of all outpatient PT/SLP payments in CY 2008).

During CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital (Table 8). Of these OT users, 185,428 beneficiaries, or 19.1 percent, benefitted from the exceptions process and received services beyond the therapy cap threshold of $1,810 allowed amount (~$1,448 paid). The net payments beyond the OT cap threshold, totaling $259 million (representing 27.9 percent of all outpatient OT payments in CY 2008).

Table 8. Estimated cap impact by therapy type

Therapy Type	Total Users	Users Over Cap	Percent of Users in Therapy Type Over Cap	Mean Paid for Users That Surpassed Cap	Net Paid Above Cap Limits for Users That Surpassed Cap	Total Payments for Users That Surpassed Caps	Net Paid Above Cap Limits
PT	3,955,285	578,244	14.6%	$2,704	$1,256	$1,563,684,359	$726,384,330
OT	973,222	185,428	19.1%	$2,843	$1,395	$527,209,067	$258,709,146
SLP	477,988	55,765	11.7%	$2,633	$1,185	$146,846,657	$66,098,812
PT/SLP	4,194,265	640,937	15.3%	$2,811	$1,363	$1,801,634,899	$873,558,675

Overall, 693,248 beneficiaries benefitted from the exceptions process and received services beyond the therapy cap threshold of $1,810 allowed amount (~$1,448 paid) for either the PT/SLP combined cap or the OT separate cap during CY 2008. This represents 15.4 percent of all outpatient therapy beneficiaries. In addition, 133,117 beneficiaries received services beyond both the PT/SLP and OT cap threshold amounts in CY 2008. This represents 3.0 percent of all outpatient therapy beneficiaries. The total estimated net payments above the statutory PT/SLP combined and OT separate cap threshold limits as a result of the cap exceptions process being used was $1.1 billion. This means that 23.8 percent of all outpatient therapy payments during CY 2008 were for services furnished above the therapy cap threshold limits.

The evidence is clear that a significant number of beneficiaries would be negatively impacted by full enforcement of the outpatient therapy caps without exceptions. However, the evidence also demonstrates that without some form of utilization controls, there is increased potential for overutilization, abuse or fraud if the current exceptions process is left unchecked. The outpatient therapy cap policy as implemented in CY 2006 with both the 'Automatic Process Exceptions' and 'Manual Process Exceptions' components did appear to negatively impact the amount of outpatient therapy services furnished to beneficiaries with certain characteristics that can be identified in claims data. These effects included: a reduced number of treatment days per-episode, a reduced number of claim lines and HCPCS units billed, and a reduction in total payments per-episode and per-year for all episodes. However, the outpatient therapy cap policy as implemented in CY 2007 to the current date, which eliminated the 'Manual Process Exceptions' component did appear to negate the impact of the outpatient therapy caps exceptions process as applied in CY 2006, and utilization patterns have returned to levels consistent with, and in some cases higher than, that observed in the uncapped CY 2004 results. It is notable that Medicare contractors reported only minimal use of the "Manual Process Exceptions' in CY 2006, and when used; only a small percentage were denied. This suggests that the impact of the 'Manual Process Exceptions' was most likely behavioral as clinicians were more judicious when making decisions to continue services.

Proposed new outpatient therapy annual per-beneficiary utilization edits

If CMS were to consider establishing an annual per-beneficiary outpatient therapy cap medical necessity edit threshold to limit extreme utilization, any number of different limits could be established based upon the percentile tables presented in Sections 4.6 and 4.7 of the *CY 2008 Outpatient Therapy Utilization Report*[28]. As table 9 demonstrates, there were 4,194, 265 beneficiaries in CY 2008 that received either PT or SLP services, 640,937 (15.3%) used the exceptions process to receive services beyond the existing PT/SLP combined cap. This resulted

in nearly $873.6 million in Medicare payments beyond the PT/SLP cap limit. These amounts varied by provider setting and professional office specialty.

For administrative simplicity, we propose that while CMS continues the current cap exceptions process, a new medical necessity edit be established at a utilization outlier threshold amount that would only impact a minimal percentage of beneficiaries and providers. The threshold limit should consider the impact on each specialty and for each provider setting or professional office specialty. If the threshold allowed amount were surpassed for a beneficiary for the identified cap during the calendar year, then the CWF would issue instructions to the Medicare contractor to deny payment. Clinicians and beneficiaries should maintain the right to appeal the denial.

Tables 9-12 provide information regarding the estimated number of beneficiaries that would be impacted by various edit threshold limits and the estimated impact on Medicare outpatient therapy expenditures based upon CY 2008 utilization patterns.

For example, as demonstrated in Table 9, if CMS established a PT/SLP annual per-beneficiary outlier utilization edit at $6,000 allowed amount, then 68,708 beneficiaries would be affected and provider payments would reduce by about $151 million. This represents only 1.6 percent of PT/SLP users, 3.9 percent of PT/SLP payments, and 3.2 percent of all outpatient therapy payments.

Table 9. Estimated impact of proposed annual per-beneficiary PT/SLP utilization edits

Allowed PT/SLP Threshold	PT/SLP Users Over Threshold	Percent of PT/SLP Users Over Threshold	Mean PT/SLP Paid Above Threshold	Net PT/SLP Paid Above Threshold	Percent of Total PT/SLP Payments	Percent of Total Outpatient Therapy Payments
$1,810	640,937	15.28%	$1,363.00	$873,597,131.00	22.79%	18.35%
$4,000	179,979	4.29%	$1,845.66	$332,180,041.14	8.67%	6.98%
$4,500	139,520	3.33%	$1,930.00	$269,273,600.00	7.03%	5.66%
$5,000	109,660	2.61%	$2,006.59	$220,042,659.40	5.74%	4.62%
$5,500	86,504	2.06%	$2,096.20	$181,329,684.80	4.73%	3.81%
$6,000	68,708	1.64%	$2,193.32	$150,698,630.56	3.93%	3.17%
$6,500	55,408	1.32%	$2,277.10	$126,169,556.80	3.29%	2.65%
$7,000	44,966	1.07%	$2,364.28	$106,312,214.48	2.77%	2.23%
$7,500	36,671	0.87%	$2,458.96	$90,172,522.16	2.35%	1.89%
$8,000	29,913	0.71%	$2,574.84	$77,021,188.92	2.01%	1.62%

Similarly, as demonstrated in Table 10, if CMS established an OT annual per-beneficiary outlier utilization edit at $6,000 allowed amount, then 19,547 beneficiaries would be affected and provider payments would reduce by about $34 million. This represents only 2.0 percent of OT users, 3.7 percent of OT payments, and 0.7 percent of all outpatient therapy payments.

Although there are not separate PT and SLP caps, we believe that there is no clinically appropriate reason to combine PT and SLP services for edit purposes. Edits targeted to the specific therapy disciplines would be more effective and easier to implement than combining them. Table 11 and Table 12 present similar estimates for these separate disciplines for CMS consideration.

Table 10. Estimated impact of proposed annual per-beneficiary OT utilization edits

Allowed OT Threshold	OT Users Over Threshold	Percent of OT Users Over Threshold	Mean OT Paid Above Threshold	Net OT Paid Above Threshold	Percent of Total OT Payments	Percent of Total Outpatient Therapy Payments
$1,810	185,428	19.05%	$1,395.00	$258,672,060.00	27.89%	5.43%
$4,000	54,471	5.60%	$1,631.40	$88,863,989.40	9.58%	1.87%
$4,500	42,092	4.33%	$1,656.67	$69,732,553.64	7.52%	1.46%
$5,000	33,130	3.40%	$1,653.32	$54,774,491.60	5.90%	1.15%
$5,500	25,583	2.63%	$1,683.65	$43,072,817.95	4.64%	0.90%
$6,000	19,547	2.01%	$1,745.60	$34,121,243.20	3.68%	0.72%
$6,500	15,386	1.58%	$1,766.10	$27,173,214.60	2.93%	0.57%
$7,000	12,221	1.26%	$1,773.95	$21,679,442.95	2.34%	0.46%
$7,500	9,668	0.99%	$1,791.42	$17,319,448.56	1.87%	7.80%
$8,000	7,593	0.78%	$1,829.01	$13,887,672.93	1.50%	0.29%

Table 11. Estimated impact of proposed annual per-beneficiary PT utilization edits

Allowed PT Threshold	PT Users Over Threshold	Percent of PT Users Over Threshold	Mean PT Paid Above Threshold	Net PT Paid Above Threshold	Percent of Total PT Payments	Percent of Total Outpatient Therapy Payments
$1,810	578,244	14.62%	$1,256.00	$726,274,464.00	20.77%	15.26%
$4,000	147,719	3.73%	$1,705.90	$251,993,842.10	7.21%	5.29%
$4,500	112,395	2.84%	$1,787.89	$200,949,896.55	5.75%	4.22%
$5,000	86,863	2.20%	$1,861.44	$161,690,262.72	4.62%	3.40%
$5,500	67,223	1.70%	$1,953.94	$131,349,708.62	3.76%	2.76%
$6,000	52,172	1.32%	$2,067.37	$107,858,827.64	3.08%	2.27%
$6,500	41,327	1.04%	$2,164.29	$89,443,612.83	2.56%	1.88%
$7,000	32,998	0.83%	$2,266.32	$74,784,027.36	2.14%	1.57%
$7,500	26,496	0.67%	$2,380.19	$63,065,514.24	1.80%	1.32%
$8,000	21,262	0.54%	$2,523.77	$53,660,397.74	1.53%	1.13%

Table 12. Estimated impact of proposed annual per-beneficiary SLP utilization edits

Allowed SLP Threshold	SLP Users Over Threshold	Percent of SLP Users Over Threshold	Mean SLP Paid Above Threshold	Net SLP Paid Above Threshold	Percent of Total SLP Payments	Percent of Total Outpatient Therapy Payments
$1,810	55,765	11.67%	$1,185.00	$66,081,525.00	19.69%	1.39%
$4,000	13,187	2.76%	$1,509.83	$19,910,128.21	5.93%	0.42%
$4,500	9,784	2.05%	$1,570.36	$15,364,402.24	4.58%	0.32%
$5,000	7,366	1.54%	$1,624.33	$11,964,814.78	3.57%	0.25%
$5,500	5,526	1.16%	$1,701.97	$9,405,086.22	2.80%	0.20%
$6,000	4,250	0.89%	$1,757.07	$7,467,547.50	2.23%	0.16%
$6,500	3,314	0.69%	$1,799.14	$5,962,349.96	1.78%	0.13%
$7,000	2,569	0.54%	$1,865.23	$4,791,775.87	1.43%	0.10%
$7,500	2,033	0.43%	$1,905.89	$3,874,674.37	1.15%	0.08%
$8,000	1,609	0.34%	$1,958.16	$3,150,679.44	0.94%	0.07%

Implementation issues
The proposed new outpatient therapy annual per-beneficiary utilization edits can be addressed administratively without change in statute or coding. There would need to be some systems changes to the CWF to add the additional edits to the existing coding used to manage the outpatient therapy caps. Therefore, it is realistic for CMS to implement the proposed new annual per-beneficiary utilization edits within one year. Provider education materials may need to be modified to inform outpatient therapy professionals and billers about the new edits and how to appeal medical necessity denials that result from applying the edits.

Although the application of such an edit would deny additional services to only a very small percentage of beneficiaries, it may be problematic if it increases appeals for beneficiaries with complex conditions. CMS could consider a variation to the automatic medical necessity denial edit. This variation would be to resurrect the 'Manual Process Exceptions' that were applied in CY 2006, but to apply the Manual Process Exceptions procedure only when a beneficiary's annual expenditures reached the higher threshold level for this edit, and not at the cap threshold dollar amount. With this higher dollar threshold, and additional documentation available over the course of treatment, Medicare contractors will be able to identify more easily whether these high-utilization beneficiaries require additional services, or whether medical necessity is no longer supported.

Savings Impact:
The potential savings impact of applying the proposed new outpatient therapy annual per-beneficiary utilization edits is dependent upon the edit threshold selected by CMS. In the example tables above, the estimated reduction in provider payments from the PT/SLP and OT caps combined could range from $91 million (1.9% of total payments) if the edit threshold were set at $8,000 per-beneficiary per-year to $421 million (8.9% of total payments) if the edit threshold were set at $4,000 per-beneficiary per-year. Although these are large dollar amounts, they are significantly lower than the $1.1 billion in payment reductions (23.8% of total payments) that would occur if the cap exceptions process were eliminated.

3.3 Option #3 - Introduce new outpatient therapy 'Evaluation/Assessment and Intervention' (E&I) codes to package groups of current therapy HCPCS codes into a single per-session payment.

Description
This option would change how clinicians report and are paid for outpatient therapy services from payment per service to payment per therapy session[40]. Professionals would be required to submit a single new Level II HCPCS outpatient therapy E&I code to replace all individual therapy procedures currently reported in a session and now paid separately. Payment for the new outpatient therapy E&I codes would be based the beneficiary characteristics reflected by a

[40] The Medicare Claims Processing Manual, Chapter 15, Section 220(A) defines 'Visits or Treatment Sessions' as encounters that "…begin at the time the patient enters the treatment area and continue until all services have been completed for that session and the patient leaves the area to participate in a non-therapy activity…There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/treatment sessions in a day, plans of care indicate treatment amount of twice a day."

combination of the evaluation or assessment complexity and/or the intervention complexity for that particular session.

Current claims processing per-session
Outpatient therapy clinicians currently submit one or more of 76 available HCPCS procedure codes to describe what procedures were done to the beneficiary during the session regardless of need or complexity. While some codes are untimed and can only be billed one unit per-session, others are time-based and may be billed multiple units per-session. For more than a decade, CMS and its contractors have implemented a variety of different utilization edits in response to perceived overutilization or misuse of certain HCPCS codes. These edits include:

- CMS DRA edits,
- CMS MUE edits,
- CMS CCI edits,
- CMS proposed MPPR edits, and
- Local MAC medical necessity edits including; limits per-HCPCS, and HCPCS and ICD-9 crosswalk edits.

CMS and contractor systems review submitted procedure codes per-session and apply the various utilization edits. Those procedure codes that pass the edits are paid while those that do not are denied payment.

Proposed new claims processing per-session
This option would require that clinicians would submit a single HCPCS code to describe an outpatient therapy session instead of a list of individual procedures furnished. There are two kinds of sessions, evaluation/re-evaluation sessions and treatment intervention sessions (which may include assessment or evaluation as part of the session). Payment would be determined by the code that applies to each. Approximately 12 outpatient therapy E&I codes would be needed.

The first three proposed outpatient therapy E&I codes would be used for initial evaluation and re-evaluation sessions where no interventions were provided. These evaluation codes would be differentiated as minimal, moderate, or significant complexity (Table 13). These first three outpatient therapy E&I codes could only be billed for services performed by a "clinician" (therapist, physician, or NPP).

Table 13. Proposed per-session E&I codes for sessions that only include evaluations/re-evaluations

Evaluation/Re-Evaluation Complexity		
Minimal	Moderate	Significant
E&I Code #1	E&I Code #2	E&I Code #3

The remaining nine outpatient therapy E&I codes would be used for all sessions that include specific treatment interventions and that may or may not include assessments or evaluations. These nine E&I codes are represented by the algorithm in Table 14. Intervention levels are differentiated as minimal, moderate, or significant, and Evaluation/Assessment complexity is differentiated as observation, assessment, or evaluation. We anticipate that the definitions of outpatient therapy E&I codes 4, 7, and 10 would describe services that could be furnished by or

under the permissible supervision of all qualified outpatient therapy "professionals" (clinicians, physical therapist assistants, and occupational therapy assistants).

Because outpatient therapy E&I codes 5-6, 8-9, and 11-12 contain assessment or evaluation components, these codes can only be billed if a clinician performed at least the assessment or evaluation component of the session[41]. As only one code would be billed per session, it would be inappropriate for providers/professionals to unbundle the evaluation components of these six codes and bill outpatient therapy E&I codes 1-3 on the same day as codes 4-12 unless the services met the definition of a distinctly separate session, and the second session was indicated in the plan of care.

Table 14. Proposed per-session E&I codes for sessions that include interventions

		Evaluation/Assessment Complexity		
		Observation	Assessment	Evaluation/Re-Evaluation
Intervention Level	Minimal	E&I Code #4	E&I Code #5	E&I Code #6
	Moderate	E&I Code #7	E&I Code #8	E&I Code #9
	Significant	E&I Code #10	E&I Code #11	E&I Code #12

Proposed new outpatient therapy policy manual definitions
We believe that CMS would need to refine the existing definitions of Assessment, Evaluation, and Re-Evaluation listed in Chapter 15, Section 220.A of the Medicare Benefit Policy Manual and we propose that the definition of 'Observation' be added to support the development of these new outpatient therapy E&I HCPCS codes.

> **Observation –** Outpatient therapy observation is not separately payable from intervention. The term observation as used on Medicare outpatient therapy services to represent the routine gathering of data during treatment sessions that do not involve making clinical judgments regarding the patient's conditions. Because clinical judgments are not made regarding whether the plan of care requires adjustment, observation may be provided by qualified professionals and qualified personnel.
>
> **Assessment –** Outpatient therapy assessment is separate from evaluation, and is not separately payable from intervention. The term assessment as used in Medicare outpatient therapy services is distinguished from language in CPT codes that specify assessment, e.g. 97755 – assistive technology assessment (which is not separately payable from the outpatient therapy per-session HCPCS code). Assessments shall only be provided by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress towards goals and/or determine that a more complex evaluation

[41] For these codes, a therapy/therapist assistant could perform the intervention portion of the session, however, the assessment or evaluation components must be performed by the clinician.

or re-evaluation is indicated. Routine weekly assessments of expected progression in accordance with the plan of care are not to be reported as re-evaluations.

Evaluation – Outpatient therapy evaluation is a separately payable comprehensive service provided by a clinician, as defined above, only when no interventions are furnished during the session. Evaluation requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted, e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to the development of the plan of care, including goals and the selection of interventions.

Re-Evaluation – Outpatient therapy re-evaluation provides additional objective information not included in other intervention documentation. Re-evaluation is a separately payable comprehensive service provided by a clinician, as defined above, only when no interventions are furnished during the session. Re-evaluation is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and practice acts require re-evaluations at specific times, for Medicare payment, re-evaluations must also meet Medicare coverage guidelines. The decision to provide a re-evaluation shall be made by a clinician.

Proposed outpatient therapy E&I code definitions

The definition for each proposed outpatient therapy E&I code addresses three components; 1) clinical presentation during that session, 2) intensity of activities performed during the session, and 3) documentation resulting from the session. The proposed definitions for the 12 new E&I outpatient therapy codes are:

- **E&I Code #1 – Therapy Evaluation/Re-Evaluation, Minimal Complexity**
    - Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
    - The establishment (evaluation) or update (reevaluation) of a problem focused plan of care addressing one or more similar functional impairments or problems by a clinician, and
    - No interventions are furnished during session, and
    - Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by a clinician.

- **E&I Code #2 – Therapy Evaluation/Re-Evaluation, Moderate Complexity**
    - Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety), and/or
    - The establishment (evaluation) or update (reevaluation) of a detailed plan of care addressing 2-3 dissimilar functional impairments or problems by a clinician, and
    - No interventions are furnished during session, and

- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

- **E&I Code #3 – Therapy Evaluation/Re-Evaluation, Significant Complexity**
  - Clinical presentation with unstable and unpredictable characteristics to patient condition and/or patient has significant cognitive deficits affecting safety, and/or
  - The establishment (evaluation) or update (reevaluation) of a comprehensive plan of care addressing 4 or more dissimilar functional impairments or problems by a 'clinician', and
  - No interventions are furnished during session, and
  - Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by a clinician.

- **E&I Code #4 – Therapy Intervention Minimal, with Observation**
  - Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
  - Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
  - Routine observations are documented by qualified professionals or personnel.

- **E&I Code #5 – Therapy Intervention Minimal, with Assessment**
  - Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during the session, and
  - Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
  - Assessment findings and judgments are documented by clinician.

- **E&I Code #6 – Therapy Intervention Minimal, with Evaluation**
  - Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and
  - Patient receives limited interventions (30 minutes or less of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
  - Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

- **E&I Code #7 – Therapy Intervention Moderate, with Observation**
  - Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and

- Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Routine observations are documented by qualified professionals or personnel.

- **E&I Code #8 – Therapy Intervention Moderate, with Assessment**
  - Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during session, and
  - Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
  - Assessment findings and judgments are documented by clinician.

- **E&I Code #9 – Therapy Intervention Moderate, with Evaluation**
  - Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and
  - Patient receives moderate interventions (31-60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
  - Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

- **E&I Code #10 – Therapy Intervention Significant, with Observation**
  - Clinical presentation is stable with minimal safety issues due to health and/or cognitive status, and
  - Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
  - Routine observations are documented by qualified professionals or personnel.

- **E&I Code #11 – Therapy Intervention Significant, with Assessment**
  - Clinical presentation with evolving or changing characteristics to patient condition, complaints, and/or cognitive status (not affecting safety) requiring assessment of a clinician during session, and
  - Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel,
  - Assessment findings and judgments are documented by clinician.

- **E&I Code #12 – Therapy Intervention Significant, with Evaluation**
  - Clinical presentation with unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation or re-evaluation by a clinician during session, and

- Patient receives significant interventions (More than 60 minutes of 1:1 interventions involving active patient participation, plus any group or modality interventions) from qualified professionals or personnel, and
- Evaluation (or re-evaluation) and initiation of (or updates to) the plan of care, including goals and the selection of interventions is documented by clinician.

Based upon historical utilization patterns, we believe the vast majority of E&I codes submitted would likely be codes 7-8, followed by codes 4-5 and 10-11.

Implementation issues
This proposal would not require a change in statute as outpatient therapy services would continue to be paid under the MPFS, albeit with newly created per-session Level II HCPCS codes instead of the current per-procedure codes. In addition, this proposed option would not impact the outpatient therapy caps policy with or without exceptions as the caps and exceptions process could continue to be managed under the current mechanisms or under the proposed Option #1 listed above.

Because this option would eliminate the reporting of existing per-procedure HCPCS codes for Medicare outpatient therapy services there would no longer be a need for proposed per-HCPCS line MUE edits discussed in Option #2a described earlier. However, this option would still permit the use of the annual per-beneficiary edits discussed in Option #2b.

Implementation would require two to four years as CMS may need to further develop and test the proposed operational definitions for each E&I level code so that clinicians' will be able to code properly and appropriate relative values can be established for each code by discipline. We believe that a pilot study will reveal that the different practice patterns of PT, OT, and SLP services will necessitate separate relative value determinations for each code. As a result, up to 36 total new codes may be needed (12 per-discipline).

There would be significant initial administrative burden on outpatient therapy providers and professionals to learn new codes and update billing systems. However, elimination of the required reporting of 76 individual procedure codes, and the associated claims processing edits, should significantly reduce the administrative burden of reporting therapy services per-session to Medicare in the long-term.

Savings Impact:
The use of bundled per-session payment could result in more appropriate valuation of therapy services, while permitting clinicians more flexibility in determining intervention approaches. Packaging the payments for procedures that address patient complexity and intensity of therapeutic activities has the added advantage of addressing the congressional mandate to pay based on patient condition. Per-session payments that reflect average per-session costs would eliminate payments for extreme amounts of individual services billed per-session. In addition, while the new per-session codes could be budget-neutral, CMS could consider efficiencies created by the process of packaging of individual procedure HCPCS codes into per-session codes through the process of developing relative values for the E&I codes. Combined, these factors could lead to more predictable and reduced therapy expenditures.

Appendix A: Acronyms

ADL	Activities of Daily Living
BBA	Balanced Budget Act
CCI	Correct Coding Initiative
CMM	CMS Centers for Medicare Management
CMS	Centers for Medicare and Medicaid Services
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CSC	Computer Sciences Corporation
CWF	Medicare Common Working File
CY	Calendar Year
DHHS	Department of Health and Human Services
DOTPA	Development of Outpatient Therapy Payment Alternatives
DRA	Deficit Reduction Act
FOTO	Focus on Therapeutic Outcomes, Inc.
GAO	U.S. Government Accountability Office
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
IADL	Instrumental Activities of Daily Living
ICD-9	International Classification of Disease, 9th Edition
ICF	International Classification of Function, Disability and Health
IDR	CMS Integrated Data Repository
IOAS	In-Office Ancillary Services
IOM	Institute of Medicine
LCD	Local Coverage Decision
MAC	Medicare Administrative Contractor
MedPAC	Medicare Payment Advisory Commission
MPFS	Medicare Physician Fee Schedule
MPPR	Multiple Procedure Payment Reductions
MUE	Medically Unlikely Edits
NPI	National Provider Identifier
NPP	Non-physician Practitioner
OIG	Office of Inspector General
OIS	CMS Office of Information Systems
ORDI	CMS Office of Research, Development and Information
ORF	Outpatient Rehabilitation Facility
OT	Occupational Therapy
OTPP	Occupational Therapist in Private Practice
PI	CMS Office of Program Integrity
POC	Plan of Care
PT	Physical Therapy
PTPP	Physical Therapist in Private Practice
RTI	Research Triangle Institute
SLP	Speech-Language Pathology
SLPP	Speech-Language Pathologist in Private Practice
SNF	Skilled Nursing Facility
SOW	Statement of Work
STATS	Short Term Alternatives for Therapy Services
WHO	World Health Organization
the Act	The Social Security Act

Appendix B: Outpatient Therapy Assessment Tools

AM-PAC (Activity Measure for Post-Acute Care)
CreCare: www.crecare.com

- Disciplines: PT and OT
- Time window: Episode of care
- Data collection: Patient Survey - Paper short form or Computer Assisted Test (CAT)
- Published in per-reviewed journal: Yes
- 2010 PQRI data registry: No
- National Quality Forum (NQF) Endorsed Standards: Yes (2 measures)
- National Quality Measures Clearinghouse (NQMC): Yes (3 measures)
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

CARE-F and CARE-C
RTI, International Developing Outpatient Therapy Payment Alternatives (DOTPA) Project: http://optherapy.rti.org

- Disciplines: PT, OT and SLP
- Time window: Episode of care
- Data Collection: Patient survey and clinician entered data (paper)
- Published in per-reviewed journal: No
- 2010 PQRI Data Registry: No
- National Quality Forum (NQF) Outcomes Measures: No
- National Quality Forum (NQF) Endorsed Standards: No
- Benchmark data feedback to clinician: Unavailable – study data collection pending
- Mapping to ICF: Possible

CareConnections Outcomes Systems
Therapeutic Associates, Inc.: www.careconnections.com

- Disciplines: PT and OT
- Time window: Episode of care
- Data collection: Patient Survey (data entered online later)
- Published in per-reviewed journal: Yes
- 2010 PQRI data registry: No
- National Quality Forum (NQF) Endorsed Standards: No
- National Quality Measures Clearinghouse (NQMC): Yes (1 measure)
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

LIFEware
Uniform Data Systems for Medical Rehabilitation (UDS-MR): www.udsmr.com

- Disciplines: PT and OT
- Time window: Episode of care

- Data collection: Patient Survey and clinician entered data (paper or web-based)
- Published in per-reviewed journal: Yes
- 2010 PQRI data registry: No – but collects PQRI measures
- National Quality Forum (NQF) Endorsed Standards: No
- National Quality Measures Clearinghouse (NQMC): No
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

NOMS (National Outcomes Measurement System)
American Speech-Language-Hearing Association (ASHA): www.asha.org

- Disciplines: SLP
- Time window: Episode of care
- Data collection: Clinician entered data – Paper or web-based data entry
- Published in peer-reviewed journal: Yes
- 2010 PQRI data registry: Yes through ASHA and Cedaron Medical
- National Quality Forum (NQF) Endorsed Standards: Yes (8 measures)
- National Quality Measures Clearinghouse (NQMC): Yes (15 measures)
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

OPTIMAL (Outpatient Physical Therapy Improvement in Movement Assessment Log)
American Physical Therapy Association (APTA): www.apta.org

- Disciplines: PT
- Time window: Episode of care
- Data collection: Patient survey – Paper or data entry into documentation software
- Published in per-reviewed journal: Yes
- 2010 PQRI data registry: Yes - Through Cedaron Medical
- National Quality Forum (NQF) Endorsed Standards: No
- National Quality Measures Clearinghouse (NQMC): Yes (1 measure)
- Benchmark data feedback to clinician: Possible with documentation software
- Mapping to ICF: Possible

Patent Inquiry
Focus on Therapeutic Outcomes, Inc. (FOTO): www.fotoinc.com

- Disciplines: PT and OT
- Time window: Episode of care
- Data collection: Patient Survey - Paper short form or Computer Assisted Test (CAT)
- Published in per-reviewed journal: Yes
- PQRI data registry: Yes - Through FOTO, Inc.
- National Quality Forum (NQF) Endorsed Standards: Yes (7 measures)
- National Quality Measures Clearinghouse (NQMC): Yes (6 measures)
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

ROM (Rehabilitation Outcome Measure)

Accu-Med Services, Cypress Therapy Management: www.accu-med.com

- Disciplines: PT, OT and SLP
- Time window: Episode of care
- Data collection: Clinician entered - Web-based data entry
- Published in per-reviewed journal: No
- 2010 PQRI data registry: No
- National Quality Forum (NQF) Endorsed Standards: No
- National Quality Measures Clearinghouse (NQMC): No
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

RPM (Rehab Performance Manager)

Agility Health: www.agilityhealth.com

- Disciplines: PT and OT
- Time window: Episode of care
- Data collection: Patient survey and clinician entered data (web-based)
- Published in per-reviewed journal: No
- 2010 PQRI data registry: No
- National Quality Forum (NQF) Endorsed Standards: No
- National Quality Measures Clearinghouse (NQMC): No
- Benchmark data feedback to clinician: Yes
- Mapping to ICF: Possible

Appendix C: STATS Stakeholder Workgroup Participants

Name	Nominating Organization	Workgroup		
		Clinical	Assessment	Policy
Alan Leventhal, PT	Council of Licensed Physiotherapists of New York, Inc. (CLPNY)			X
Alexis Ahlstrom	American Health Care Association (AHCA)			X
Alice Kay Pierce, SLP	Restore Therapy Services		X	
Bernard Patashnik	American Speech-Language-Hearing Association (ASHA)			X
Beth Sarfaty, PT	Select Medical Corporation			X
Bill Goulding, SLP	National Association for the Support of Long Term Care (NASL)		X	
Bill Cummins, SLP	Accu-Med Services		X	
Carl Granger, MD	Uniform Data System for Medical Rehabilitation (UDSMR)		X	
Carol Bazell	Centers for Medicare and Medicaid Services (CMS Staff)	X	X	X
Carole Lewis, PT	Computer Sciences Corporation (CSC) - At large	X		
Carolann Tokarz, PT	Select Medical Corporation			
Carolyn Zollar	American Medical Rehabilitation Providers Association (AMRPA)			X
Cassandra Black	CMS Staff	X	X	X
Connie Rusynyk, OT	AHCA		X	
Dan Ciolek, PT	CSC Staff	X	X	X
Dave Boerkel, OT	NASL			X
David Bott	CMS Staff	X	X	X
Dennis Hart, PT	Focus on Therapeutic Outcomes, Inc. (FOTO), & PTPN		X	
Dorothy Shannon	CMS Staff	X	X	X
Elaine Craddy Adams, OT	American Occupational Therapy Association (AOTA)			X
Ellen Strunk, PT	American Physical Therapy Association (APTA)		X	
Gayle Lee	APTA			X
George Olsen	National Association of Rehab Providers and Agencies (NARA)			X
Gerald Brennan, PT	NARA		X	
Glenda Mack, PT	AHCA	X		
Helene Fearon, PT	CSC Invited	X	X	X
James Kelley, PT	UDSMR	X		
James Matheson, PT	Colleague		X	
Jamie Stark	American Medical Rehabilitation Providers Association (AMRPA) & Select Medical Corporation		X	
Janet Borwn, SLP	ASHA	X		
Janet Mastrangelo, PT	HCR ManorCare			X
Jerry Connolly, PT	FOTO			X
Joan MacIsaac, SLP	CSC Staff	X	X	X
Joanne Baird, OT	AOTA	X		
Judy Thomas, OT	AOTA			X

Name	Nominating Organization	Workgroup		
		Clinical	Assessment	Policy
Kate Romanow	ASHA			X
Kirk Bentzen, PT	Glendale Adventist Medical Center		X	
Larry Benz, PT	Colleagues			X
Linda Kurland, SLP	Colleagues			X
Margaret Rogers, SLP	ASHA		X	
Mark Werneke, PT	FOTO & CentraState Medical Center	X		
Mark Richards, PT	NASL	X		
Mary Foto, OT	AOTA	X		
Mary Casper, SLP	HCR ManorCare	X		
Mary Wagner, SLP	NARA	X		
Mary Van De Camp, SLP	Colleague			X
Mary Jo McGuire, OT	AOTA		X	
Melissa Honsinger, SLP	Idaho Elks Rehabilitation Hospital (IERH)			X
Mitchel Kaye, PT	PTPN	X		
Monica Robinson, OT	AOTA	X		
Nancy Richman, OT	AOTA		X	
Nancy Krolikowski, OT	Cedaron Medical, Inc.		X	
Nicole Cafarella	AHCA			X
Nikesh Patel, PT	Select Medical Corporation	X		
Pamela Roberts, OT	California Hospital Association (CHA)	X		
Pamela West	CMS Staff	X	X	X
Pat Newberry, PT	AHCA	X		
Paul Rockar, PT	APTA	X		
Richard Moed	CREcare			X
Rick Gawenda, PT	APTA	X		
Rick Black, PT	HCR-Manor Care		X	
Rob Mullen	ASHA		X	
Robert Wainner, PT	American Academy of Orthopaedic Manual Physical Therapists (AAOMPT)	X		
Sheri Harrison, PT	IERH	X		
Stephen Haley, PT	CREcare		X	
Steve Levine, PT	APTA			X
Susan Davies, PT	Restore Therapy Services	X		
Tammy Schneider	UDSMR			X
Thelma Milentz, PT	APTA		X	
Trent Casper, PT	Colleague	X		
Wenke Hwang	CSC Staff	X	X	X
Whitney May	CMS Staff	X		

Appendix D: Impact of Existing and Proposed HCPCS Edits for PT Claim Lines

This table provides the estimated impact on provider/professional claim payments for refining the existing national edits to outpatient PT HCPCS claim lines so that payments will be limited to no more than the number of units historically billed for 98 percent of PT claim lines. The refined edits would prevent payment for outliers at the top 2 percent. The table columns contain the following information:

- **HCPCS** – Contains the 5-digit alphanumeric outpatient therapy HCPCCS code
- **Code Description** – Contains the short definition of the outpatient therapy HCPCS code.
- **Timed or Untimed Code** – Indicates whether the HCPCS code is billed as a per-session code or in timed increments (e.g. usually 15 minutes). T = Timed, U = Untimed, N/A – Contractor determines code value.
- **Provider PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Provider facility claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Provider facility claim lines in CY 2008.
- **Professional PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Professional office claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Professional office claim lines in CY 2008.
- **Provider Edit Units** – Proposed edit limit (maximum number allowed) for PT service HCPCS for Provider facility claim lines.
- **Professional Edit Units** – Proposed edit limit (maximum number allowed) for PT service HCPCS for Professional office claim lines.
- **Type of Edit** – Indicates whether the Provider Edit Units or Professional Edit Units limits are existing Deficit Reduction Act (DRA) edits, existing public MUE edits (Published MUE), or new edits proposed in this report (Proposed new).
- **Impact of Edits Provider** – Indicates the estimated impact on provider facility PT payments if edit limits listed were imposed (based upon CY 2008 utilization).
- **Impact of Edits Professional** – Indicates the estimated impact on professional office PT payments if edit limits listed were imposed (based upon CY 2008 utilization).

Key:

***** = Not listed due to existing edit

~ = Not listed due to fewer than 100 claim lines of data in CY 2008

= No edit exists or is recommended

HCPCS	Code Description	Timed or Untimed Codes	Provider PT 98th/99th Percentile Units	Professional PT 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
64550	Apply neurostimulator	U	1/1	1/1	1	1	Proposed new	$2,376.05	$0.00
90901	Biofeedback train, any method	U	*	*	1	1	Published MUE	$2,379.40	$581.19
92506	Speech/hearing evaluation	U	*	*	0	0	DRA	$1,589.99	$49,580.61
92507	Speech/hearing therapy	U	*	*	1	1	Published MUE	$1,983.58	$19,608.19

HCPCS	Code Description	Timed or Untimed Codes	Provider PT 98th/99th Percentile Units	Professional PT 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
92508	Speech/hearing therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
92520	New 1/1/2010 Laryngeal function studies	U	#	#	1	1	Proposed new	$0.00	$0.00
92526	Oral function therapy	U	*	*	1	1	Published MUE	$1,252.01	$4,708.65
92597	Oral speech device eval	U	*	*	0	0	DRA	$0.00	$514.96
92605	Eval for nonspeechdevice rx	U	*	*	#	#	Bundled	$0.00	$0.00
92606	Nonspeech device service	U	*	*	#	#	Bundled	$0.00	$0.00
92607	Ex for speech device rx, 1hr	T	*	*	0	0	DRA	$0.00	$99.34
92608	Ex for speech device rx, addl	T	~	~	#	#	Proposed new	$0.00	$0.00
92609	Use of speech device service	U	~	~	#	#	Proposed new	$0.00	$0.00
92610	Evaluate swallowing function	U	*	*	1	1	Published MUE	$0.00	$0.00
92611	Motion fluroscopy/swallow	U	*	*	0	0	DRA	$3,215.40	$75.19
92612	Endoscopy swallow tst (fees)	U	*	*	0	0	DRA	$0.00	$716.61
92614	Laryngoscopic sensory test	U	*	*	0	0	DRA	$0.00	$0.00
92616	Fees w/laryngeal sense test	U	*	*	0	0	DRA	$0.00	$0.00
95831	Limb muscle testing, manual	U	1/1	1/2	1	1	Proposed new	$3,609.91	$19,645.46
95832	Limb muscle testing, manual	U	*	*	1	1	Published MUE	$16.95	$0.00
95833	Limb muscle testing, manual	U	*	*	1	1	DRA	$0.00	$25.18
95834	Limb muscle testing, manual	U	*	*	1	1	DRA	$0.00	$70.01
95851	Range of motion measurements	U	1/1	3/3	1	3	Proposed new	$3,051.69	$6,848.62
95852	Range of motion measurements	U	*	*	1	1	Published MUE	$354.22	$414.74
96105	Assessment of aphasia	T	~	~	#	#	Proposed new	$0.00	$0.00
96125	New 1/1/2008 Stand cognitiv perf testing per hour	T	*	*	2	2	Published MUE	$0.00	$0.00
96110	Developmental test, lim	U	*	*	1	1	DRA	$0.00	$0.00
96111	Developmental test, extend	U	*	*	1	1	DRA	$0.00	$0.00
97001	PT evaluation	U	*	*	1	1	DRA	$173.16	$16,645.49
97002	PT re-evaluation	U	*	*	1	1	DRA	$0.00	$3,718.91
97003	OT evaluation	U	*	*	0	0	DRA	$40,452.41	$179,211.88
97004	OT re-evaluation	U	*	*	0	0	DRA	$2,592.91	$21,462.21

HCPCS	Code Description	Timed or Untimed Codes	Provider PT 98th/99th Percentile Units	Professional PT 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97010	Hot or cold packs therapy	U	*	*	#	#	Bundled	$924.15	$140.39
97012	Mechanical traction therapy	U	*	*	1	1	Published MUE	$25,193.34	$83,093.35
97016	Vasopneumatic device therapy	U	*	*	1	1	Published MUE	$28,657.67	$19,854.09
97018	Paraffin bath therapy	U	*	*	1	1	Published MUE	$1,726.05	$4,552.73
97022	Whirlpool therapy	U	*	*	1	1	Published MUE	$17,242.62	$8,230.51
97024	Diathermy eg, microwave	U	*	*	1	1	Published MUE	$24,352.35	$1,375.64
97026	Infrared therapy	U	*	*	1	1	Published MUE	$9,700.98	$9,857.54
97028	Ultraviolet therapy	U	*	*	1	1	Published MUE	$669.42	$1,684.97
97032	Electrical stimulation	T	2/2	3/3	2	3	Proposed new	$199,481.33	$827,662.29
97033	Electric current therapy	T	2/2	3/4	2	3	Proposed new	$29,202.84	$87,872.69
97034	Contrast bath therapy	T	1/1	2/1	1	2	Proposed new	$2,947.26	$5,615.85
97035	Ultrasound therapy	T	1/2	2/2	1	2	Proposed new	$422,140.21	$55,338.05
97036	Hydrotherapy	T	5/5	1/2	1	5	Proposed new	$100.26	$3,655.63
97039	Physical therapy treatment	N/A	*	*	#	#	Contractor	$0.00	$0.00
97110	Therapeutic exercises	T	4/4	4/4	4	4	Proposed new	$4,969,885.40	$1,892,440.75
97112	Neuromuscular reeducation	T	3/3	3/4	3	3	Proposed new	$1,756,933.46	$2,566,185.28
97113	Aquatic therapy/exercises	T	4/4	4/5	4	4	Proposed new	$206,322.70	$324,524.79
97116	Gait training therapy	T	2/3	2/2	2	2	Proposed new	$3,624,622.94	$348,354.25
97124	Massage therapy	T	2/2	3/3	2	3	Proposed new	$81,601.71	$241,543.01
97139	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
97140	Manual therapy	T	3/3	3/3	3	3	Proposed new	$2,073,549.19	$2,584,400.83
97150	Group therapeutic procedures	U	*	*	1	1	Published MUE	$347,707.06	$231,532.74
97530	Therapeutic activities	T	3/4	4/4	3	4	Proposed new	$4,317,249.21	$257,131.18
97532	Cognitive skills development	T	4/4	4/4	4	4	Proposed new	$1,420.40	$0.00
97533	Sensory integration	T	2/3	2/2	2	2	Proposed new	$1,316.17	$1,628.62
97535	Self care management training	T	3/4	4/4	3	4	Proposed new	$198,363.87	$84,289.10
97537	Community/work reintegration	T	5/6	4/4	5	4	Proposed new	$4,991.69	$182.38
97542	Wheelchair management training	T	4/5	5/6	4	5	Proposed new	$103,342.73	$4,938.41
97597	Active wound care =< 20 cm	U	*	*	1	1	Published MUE	$178,754.54	$26,406.47

HCPCS	Code Description	Timed or Untimed Codes	Provider PT 98th/99th Percentile Units	Professional PT 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97598	Active wound care > 20 cm	U	*	*	1	1	Published MUE	$65,019.41	$5,389.09
97602	Wound(s) care non-selective	U	*	*	#	#	Bundled	$4,999.78	$0.00
97605	Neg press wound tx, < 50 cm	U	*	*	1	1	Published MUE	$8,663.95	$15.28
97606	Neg press wound tx, > 50 cm	U	*	*	1	1	Published MUE	$2,192.89	$232.86
97750	Physical performance test	T	4/5	4/4	4	4	Proposed new	$53,447.74	$37,333.52
97755	Assistive technology assess	T	10+/10+	6/8	8	6	Proposed new	$3,758.38	$2,533.12
97760	Orthotic mgmt and training	T	4/4	4/4	4	4	Proposed new	$43,900.78	$3,615.47
97761	Prosthetic training	T	4/4	4/4	4	4	Proposed new	$16,854.33	$2,046.56
97762	C/O for orthotic/prosth use	T	3/4	3/4	3	3	Proposed new	$6,655.30	$1,534.51
97799	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
0029T	Magnetic tx for incontinence	U	~	1/1	#	1	Proposed new	$0.00	$0.00
G0281	Elec stim unattend for press	U	*	*	1	1	Published MUE	$37,171.91	$0.00
G0283	Elec stim other than wound	U	*	*	1	1	Published MUE	$94,216.65	$3,909.70
G0329	Electromagnetic tx for ulcers	U	*	*	1	1	Published MUE	$46,590.90	$0.00

Appendix E: Impact of Existing and Proposed HCPCS Edits for OT Claim Lines

This table provides the estimated impact on provider/professional claim payments for refining the existing national edits to outpatient PT HCPCS claim lines so that payments will be limited to no more than the number of units historically billed for 98 percent of OT claim lines. The refined edits would prevent payment for outliers at the top 2 percent. The table columns contain the following information:

- **HCPCS** – Contains the 5-digit alphanumeric outpatient therapy HCPCCS code
- **Code Description** – Contains the short definition of the outpatient therapy HCPCS code.
- **Timed or Untimed Code** – Indicates whether the HCPCS code is billed as a per-session code or in timed increments (e.g. usually 15 minutes). T = Timed, U = Untimed, N/A – Contractor determines code value.
- **Provider PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Provider facility claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Provider facility claim lines in CY 2008.
- **Professional PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Professional office claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Professional office claim lines in CY 2008.
- **Provider Edit Units** – Proposed edit limit (maximum number allowed) for OT service HCPCS for Provider facility claim lines.
- **Professional Edit Units** – Proposed edit limit (maximum number allowed) for OT service HCPCS for Professional office claim lines.
- **Type of Edit** – Indicates whether the Provider Edit Units or Professional Edit Units limits are existing Deficit Reduction Act (DRA) edits, existing public MUE edits (Published MUE), or new edits proposed in this report (Proposed new).
- **Impact of Edits Provider** – Indicates the estimated impact on provider facility OT payments if edit limits listed were imposed (based upon CY 2008 utilization).
- **Impact of Edits Professional** – Indicates the estimated impact on professional office OT payments if edit limits listed were imposed (based upon CY 2008 utilization).

Key:

***** = Not listed due to existing edit

~ = Not listed due to fewer than 100 claim lines of data in CY 2008

= No edit exists or is recommended

HCPCS	Code Description	Timed or Untimed Codes	Provider OT 98th Percentile Units	Professional OT 98th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
64550	Apply neurostimulator	U	1/1	1/1	1	1	Proposed new	$116.95	$0.00
90901	Biofeedback train, any method	U	*	*	1	1	Published MUE	$124.48	$258.55
92506	Speech/hearing evaluation	U	*	*	0	0	DRA	$3,715.51	$15,519.35
92507	Speech/hearing therapy	U	*	*	1	1	Published MUE	$2,719.97	$1,575.56

HCPCS	Code Description	Timed or Untimed Codes	Provider OT 98th Percentile Units	Professional OT 98th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
92508	Speech/hearing therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
92520	New 1/1/2010 Laryngeal function studies	U	#	#	1	1	Proposed new	$0.00	$0.00
92526	Oral function therapy	U	*	*	1	1	Published MUE	$22,887.82	$0.00
92597	Oral speech device eval	U	*	*	1	1	DRA	$0.00	$0.00
92605	Eval for nonspeechdevice rx	U	*	*	#	#	Bundled	$0.00	$0.00
92606	Nonspeech device service	U	*	*	#	#	Bundled	$0.00	$0.00
92607	Ex for speech device rx, 1hr	T	*	*	1	1	DRA	$0.00	$0.00
92608	Ex for speech device rx, addl	T	~	~	#	#	Proposed new	$0.00	$0.00
92609	Use of speech device service	U	~	~	#	#	Proposed new	$0.00	$0.00
92610	Evaluate swallowing function	U	*	*	1	1	Published MUE	$828.29	$0.00
92611	Motion fluroscopy/swallow	U	*	*	1	1	DRA	$0.00	$0.00
92612	Endoscopy swallow tst (fees)	U	*	*	1	1	DRA	$0.00	$0.00
92614	Laryngoscopic sensory test	U	*	*	1	1	DRA	$0.00	$0.00
92616	Fees w/laryngeal sense test	U	*	*	1	1	DRA	$0.00	$0.00
95831	Limb muscle testing, manual	U	2/2	1/1	2	1	Proposed new	$94.65	$0.00
95832	Limb muscle testing, manual	U	*	*	1	1	Published MUE	$402.65	$64.12
95833	Limb muscle testing, manual	U	*	*	1	1	DRA	$0.00	$0.00
95834	Limb muscle testing, manual	U	*	*	1	1	DRA	$0.00	$0.00
95851	Range of motion measurements	U	2/2	~	2	#	Proposed new	$91.91	$0.00
95852	Range of motion measurements	U	*	*	1	1	Published MUE	$1,320.43	$109.02
96105	Assessment of aphasia	T	~	~	#	#	Proposed new	$0.00	$0.00
96125	New 1/1/2008 Stand cognitiv perf testing per hour	T	4/4	*	2	2	Published MUE	$895.08	$77.78
96110	Developmental test, lim	U	*	*	1	1	DRA	$0.00	$0.00
96111	Developmental test, extend	U	*	*	1	1	DRA	$0.00	$0.00
97001	PT evaluation	U	*	*	0	0	DRA	$48,864.48	$109,632.63
97002	PT re-evaluation	U	*	*	0	0	DRA	$6,430.16	$108.78
97003	OT evaluation	U	*	*	1	1	DRA	$477.19	$1,741.72
97004	OT re-evaluation	U	*	*	1	1	DRA	$0.00	$27.82
97010	Hot or cold packs therapy	U	*	*	#	#	Bundled	$99.08	$0.08

HCPCS	Code Description	Timed or Untimed Codes	Provider OT 98th Percentile Units	Professional OT 98th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97012	Mechanical traction therapy	U	*	*	1	1	Published MUE	$165.19	$1,751.55
97016	Vasopneumatic device therapy	U	*	*	1	1	Published MUE	$13,723.46	$467.54
97018	Paraffin bath therapy	U	*	*	1	1	Published MUE	$6,788.63	$1,030.39
97022	Whirlpool therapy	U	*	*	1	1	Published MUE	$8,132.36	$1,248.32
97024	Diathermy eg, microwave	U	*	*	1	1	Published MUE	$28,013.63	$28.36
97026	Infrared therapy	U	*	*	1	1	Published MUE	$470.19	$445.11
97028	Ultraviolet therapy	U	*	*	1	1	Published MUE	$0.00	$293.98
97032	Electrical stimulation	T	2/2	4/4	2	4	Proposed new	$74,977.92	$9,994.26
97033	Electric current therapy	T	2/2	2/2	2	2	Proposed new	$10,176.58	$1,439.28
97034	Contrast bath therapy	T	1/1	2/2	1	2	Proposed new	$3,362.37	$59.87
97035	Ultrasound therapy	T	2/2	2/2	2	2	Proposed new	$16,303.43	$13,129.42
97036	Hydrotherapy	T	3/4	1/1	3	1	Proposed new	$199.24	$0.00
97039	Physical therapy treatment	N/A	*	*	#	#	Contractor	$0.00	$0.00
97110	Therapeutic exercises	T	4/4	4/4	4	4	Proposed new	$1,640,339.68	$154,699.80
97112	Neuromuscular reeducation	T	3/4	4/4	3	4	Proposed new	$1,507,503.41	$81,820.11
97113	Aquatic therapy/exercises	T	4/4	4/4	4	4	Proposed new	$3,979.92	$699.91
97116	Gait training therapy	T	3/3	2/2	3	2	Proposed new	$1,829.56	$651.58
97124	Massage therapy	T	2/2	2/2	2	2	Proposed new	$30,227.09	$18,204.32
97139	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
97140	Manual therapy	T	4/4	4/4	4	4	Proposed new	$445,417.55	$111,294.71
97150	Group therapeutic procedures	U	*	*	1	1	Published MUE	$151,625.11	$2,105.90
97530	Therapeutic activities	T	4/4	4/4	4	4	Proposed new	$1,523,768.11	$80,429.30
97532	Cognitive skills development	T	4/4	4/4	4	4	Proposed new	$48,127.90	$3,746.65
97533	Sensory integration	T	4/4	4/4	4	4	Proposed new	$1,558.88	$1,154.87
97535	Self care management training	T	4/4	5/6	4	5	Proposed new	$1,694,618.10	$108,374.37
97537	Community/work reintegration	T	8/10+	4/4	8	4	Proposed new	$18,283.12	$985.01
97542	Wheelchair management training	T	4/5	9/10+	4	8	Proposed new	$294,999.15	$2,324.85
97597	Active wound care =< 20 cm	U	*	*	1	1	Published MUE	$6,292.55	$3,207.15
97598	Active wound care > 20 cm	U	*	*	1	1	Published MUE	$3,873.20	$59.55
97602	Wound(s) care non-selective	U	*	*	#	#	Bundled	$34.12	$0.00

HCPCS	Code Description	Timed or Untimed Codes	Provider OT 98th Percentile Units	Professional OT 98th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97605	Neg press wound tx, < 50 cm	U	*	*	1	1	Published MUE	$156.63	$0.00
97606	Neg press wound tx, > 50 cm	U	*	*	1	1	Published MUE	$114.17	$0.00
97750	Physical performance test	T	9/10+	10+/10+	8	8	Proposed new	$17,032.34	$11,816.68
97755	Assistive technology assess	T	9/10+	6/8	8	6	Proposed new	$1,821.40	$100.41
97760	Orthotic mgmt and training	T	4/4	4/4	4	4	Proposed new	$124,184.45	$4,221.82
97761	Prosthetic training	T	4/4	3/3	4	3	Proposed new	$465.28	$80.10
97762	C/O for orthotic/prosth use	T	3/4	3/3	3	3	Proposed new	$18,870.65	$1,150.27
97799	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
0029T	Magnetic tx for incontinence	U	~	~	#	#	Proposed new	$0.00	$0.00
G0281	Elec stim unattend for press	U	*	*	1	1	Published MUE	$1,546.39	$0.00
G0283	Elec stim other than wound	U	*	*	1	1	Published MUE	$33,190.89	$5.42
G0329	Electromagnetic tx for ulcers	U	*	*	1	1	Published MUE	$3,092.03	$0.00

Appendix F: Impact of Existing and Proposed HCPCS Edits for SLP Claim Lines

This table provides the estimated impact on provider/professional claim payments for refining the existing national edits to outpatient PT HCPCS claim lines so that payments will be limited to no more than the number of units historically billed for 98 percent of SLP claim lines. The refined edits would prevent payment for outliers at the top 2 percent. The table columns contain the following information:

- **HCPCS** – Contains the 5-digit alphanumeric outpatient therapy HCPCCS code
- **Code Description** – Contains the short definition of the outpatient therapy HCPCS code.
- **Timed or Untimed Code** – Indicates whether the HCPCS code is billed as a per-session code or in timed increments (e.g. usually 15 minutes). T = Timed, U = Untimed, N/A – Contractor determines code value.
- **Provider PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Provider facility claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Provider facility claim lines in CY 2008.
- **Professional PT 98th/99th Percentile Units** – The first number represents the maximum number of HCPCS units billed for this HCPCS code in 98 percent of Professional office claim lines in CY 2008. The second number (after the forward slash) represents the maximum number of HCPCS units billed for this HCPCS code in 99 percent of Professional office claim lines in CY 2008.
- **Provider Edit Units** – Proposed edit limit (maximum number allowed) for SLP service HCPCS for Provider facility claim lines.
- **Professional Edit Units** – Proposed edit limit (maximum number allowed) for SLP service HCPCS for Professional office claim lines.
- **Type of Edit** – Indicates whether the Provider Edit Units or Professional Edit Units limits are existing Deficit Reduction Act (DRA) edits, existing public MUE edits (Published MUE), or new edits proposed in this report (Proposed new).
- **Impact of Edits Provider** – Indicates the estimated impact on provider facility SLP payments if edit limits listed were imposed (based upon CY 2008 utilization).
- **Impact of Edits Professional** – Indicates the estimated impact on professional office SLP payments if edit limits listed were imposed (based upon CY 2008 utilization).

Key:

***** = Not listed due to existing edit

~ = Not listed due to fewer than 100 claim lines of data in CY 2008

= No edit exists or is recommended

HCPCS	Code Description	Timed or Untimed Codes	Provider SLP 98th/99th Percentile Units	Professional SLP 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
64550	Apply neurostimulator	U	~	~	#	#	Proposed new	$0.00	$0.00
90901	Biofeedback train, any method	U	*	*	1	1	Published MUE	$0.00	$0.00
92506	Speech/hearing evaluation	U	*	*	1	1	DRA	$100.34	$0.00
92507	Speech/hearing therapy	U	*	*	1	1	Published MUE	$1,426,826.25	$406.08

HCPCS	Code Description	Timed or Untimed Codes	Provider SLP 98th/99th Percentile Units	Professional SLP 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
92508	Speech/hearing therapy	U	*	*	1	1	Published MUE	$37,213.12	$0.00
92520	New 1/1/2010 Laryngeal function studies	U	-	-	1	1	Proposed new	$0.00	$0.00
92526	Oral function therapy	U	*	*	1	1	Published MUE	$3,076,903.04	$63.23
92597	Oral speech device eval	U	*	*	1	1	DRA	$0.00	$0.00
92605	Eval for nonspeechdevice rx	U	*	*	#	#	Bundled	$0.00	$0.00
92606	Nonspeech device service	U	*	*	#	#	Bundled	$0.00	$0.00
92607	Ex for speech device rx, 1hr	T	*	*	1	1	DRA	$0.00	$236.21
92608	Ex for speech device rx, addl	T	5/6	~	5	#	Proposed new	$905.12	$0.00
92609	Use of speech device service	U	1/1	1/2	1	1	Proposed new	$10,022.09	$0.00
92610	Evaluate swallowing function	U	*	*	1	1	Published MUE	$165,927.30	$0.00
92611	Motion fluroscopy/swallow	U	*	*	1	1	DRA	$0.00	$0.00
92612	Endoscopy swallow tst (fees)	U	*	*	1	1	DRA	$0.00	$0.00
92614	Laryngoscopic sensory test	U	*	*	1	1	DRA	$0.00	$0.00
92616	Fees w/laryngeal sense test	U	*	*	1	1	DRA	$0.00	$0.00
95831	Limb muscle testing, manual	U	~	~	#	#	Proposed new	$0.00	$0.00
95832	Limb muscle testing, manual	U	*	*	1	1	Published MUE	$0.00	$0.00
95833	Limb muscle testing, manual	U	*	*	0	0	DRA	$0.00	$0.00
95834	Limb muscle testing, manual	U	*	*	0	0	DRA	$0.00	$0.00
95851	Range of motion measurements	U	~	~	#	#	Proposed new	$0.00	$0.00
95852	Range of motion measurements	U	*	*	1	1	Published MUE	$0.00	$0.00
96105	Assessment of aphasia	T	4/4	~	4	#	Proposed new	$1,781.11	$0.00
96125	New 1/1/2008 Stand cognitiv perf testing per hour	T	4/4	*	2	2	Published MUE	$454.32	$0.00
96110	Developmental test, lim	U	*	*	1	1	DRA	$0.00	$0.00
96111	Developmental test, extend	U	*	*	1	1	DRA	$0.00	$0.00
97001	PT evaluation	U	*	*	0	0	DRA	$1,529.71	$222.48
97002	PT re-evaluation	U	*	*	0	0	DRA	$146.66	$0.00
97003	OT evaluation	U	*	*	0	0	DRA	$3,075.83	$0.00
97004	OT re-evaluation	U	*	*	0	0	DRA	$0.00	$0.00

HCPCS	Code Description	Timed or Untimed Codes	Provider SLP 98th/99th Percentile Units	Professional SLP 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97010	Hot or cold packs therapy	U	*	*	#	#	Bundled	$1.00	$0.00
97012	Mechanical traction therapy	U	*	*	1	1	Published MUE	$43.40	$0.00
97016	Vasopneumatic device therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
97018	Paraffin bath therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
97022	Whirlpool therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
97024	Diathermy eg, microwave	U	*	*	1	1	Published MUE	$11.99	$0.00
97026	Infrared therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
97028	Ultraviolet therapy	U	*	*	1	1	Published MUE	$0.00	$0.00
97032	Electrical stimulation	T	4/4	2/2	4	2	Proposed new	$180.72	$0.00
97033	Electric current therapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97034	Contrast bath therapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97035	Ultrasound therapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97036	Hydrotherapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97039	Physical therapy treatment	N/A	*	*	#	#	Contractor	$0.00	$0.00
97110	Therapeutic exercises	T	3/4	1/1	3	1	Proposed new	$60,980.61	$217.63
97112	Neuromuscular reeducation	T	4/4	2/2	4	2	Proposed new	$2,701.24	$0.00
97113	Aquatic therapy/exercises	T	~	~	#	#	Proposed new	$0.00	$0.00
97116	Gait training therapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97124	Massage therapy	T	~	~	#	#	Proposed new	$0.00	$0.00
97139	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
97140	Manual therapy	T	4/4	4/4	4	4	Proposed new	$81.64	$17.06
97150	Group therapeutic procedures	U	*	*	1	1	Published MUE	$1,319.43	$0.00
97530	Therapeutic activities	T	4/4	2/2	4	2	Proposed new	$4,441.49	$46.85
97532	Cognitive skills development	T	5/5	4/4	5	4	Proposed new	$77,317.85	$93.23
97533	Sensory integration	T	3/4	~	3	#	Proposed new	$7,211.87	$0.00
97535	Self care management training	T	4/4	~	4	#	Proposed new	$2,915.76	$0.00
97537	Community/work reintegration	T	5/6	~	5	#	Proposed new	$440.65	$0.00
97542	Wheelchair management training	T	~	~	#	#	Proposed new	$0.00	$0.00
97597	Active wound care =< 20 cm	U	*	*	1	1	Published MUE	$0.00	$0.00

HCPCS	Code Description	Timed or Untimed Codes	Provider SLP 98th/99th Percentile Units	Professional SLP 98th/99th Percentile Units	Provider Edit Units	Professional Edit Units	Type of Edit	Impact of Edits Provider	Impact of Edits Professional
97598	Active wound care > 20 cm	U	*	*	1	1	Published MUE	$0.00	$0.00
97602	Wound(s) care non-selective	U	*	*	#	#	Bundled	$0.00	$0.00
97605	Neg press wound tx, < 50 cm	U	*	*	1	1	Published MUE	$0.00	$0.00
97606	Neg press wound tx, > 50 cm	U	*	*	1	1	Published MUE	$54.82	$0.00
97750	Physical performance test	T	6/6	~	6	#	Proposed new	$41.83	$0.00
97755	Assistive technology assess	T	~	~	#	#	Proposed new	$0.00	$0.00
97760	Orthotic mgmt and training	T	~	~	#	#	Proposed new	$0.00	$0.00
97761	Prosthetic training	T	~	~	#	#	Proposed new	$0.00	$0.00
97762	C/O for orthotic/prosth use	T	~	~	#	#	Proposed new	$0.00	$0.00
97799	Physical medicine procedure	N/A	*	*	#	#	Contractor	$0.00	$0.00
0029T	Magnetic tx for incontinence	U	~	~	#	#	Proposed new	$0.00	$0.00
G0281	Elec stim unattend for press	U	*	*	1	1	Published MUE	$0.00	$0.00
G0283	Elec stim other than wound	U	*	*	1	1	Published MUE	$496.66	$24.13
G0329	Electromagnetic tx for ulcers	U	*	*	1	1	Published MUE	$0.00	$0.00