

# Short Term Alternatives for Therapy Services (STATS) Task Order

## CY 2008 Outpatient Therapy Utilization Report



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**Centers for Medicare & Medicaid Services (CMS)**

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## Key CY 2008 Outpatient Therapy Utilization Findings

- **This report does not address the medical necessity of the services described and any differences in utilization patterns presented in the results do not, and should not, be used to imply that one therapy discipline, provider setting or professional specialty provides better outcomes or more cost effective care than another discipline, setting or specialty.**
  - The outpatient therapy utilization patterns and year-to-year trends described in this report are limited to administrative claims data available from submitted claims including beneficiary demographics, diagnosis, and outpatient therapy procedures furnished.
  - Differences in outpatient therapy utilization patterns can be influenced by various factors not available on claims data such as; payment policy changes, local coverage determinations, regional HCPCS price variations, geographic availability of Part A and Part B providers and professionals, degree of impairments to a beneficiary's body structures and functions, degree of a beneficiary's problems in activities and participation, a beneficiary's environmental barriers or facilitators, and other beneficiary personal factors.
  - Currently there are no standardized outpatient therapy functional measures or outcomes measures submitted with Medicare outpatient therapy claims which could help better determine the medical necessity of the services furnished. CMS is currently investigating the development of such an instrument through the Developing Outpatient Therapy Payment Alternatives (DOTPA) project.
  - In addition, it is currently impractical to perform medical review on all outpatient therapy claims to determine medical necessity.
  - Therefore, until additional clinically relevant information is available, the medical necessity of the services furnished in this utilization analysis is assumed by the fact the billed services were submitted, and that services furnished beyond the cap limits were attested to as being medically necessary by use of the KX procedure code modifier by providers and professionals.
- **4.5 million Medicare beneficiaries received outpatient physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services.**
  - This represents 10.5 percent of 42.7 million beneficiaries enrolled in Part B at any time in CY 2008;
    - 4.0 million received outpatient PT services,
    - 973 thousand received outpatient OT services, and
    - 478 thousand received outpatient SLP services.
  - This represents a 1.9 percent increase in beneficiaries receiving outpatient therapy services from calendar year (CY) 2006-2008, and 5.4 percent increase from CY 2004-2008.
- **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.
- **Medicare paid \$4.76 billion for outpatient therapy services.**
  - This represents 2.6 percent of \$183.3 billion in Part B expenditures and 1.0 percent of all Medicare Expenditures (Part A, Part B, and Part D combined).
    - \$3.5 billion paid for PT services (73.5% of total),
    - \$928 million paid for OT services (19.5% of total), and
    - \$336 million paid for SLP services (7.1 % of total).
  - This represents a two-year increase in total outpatient therapy payments from CY 2006-2008 of 16.9 percent (8.5% per year), but only a four-year increase in payments from CY 2004-2008 of 11.4 percent (2.9% per year).
    - PT payments increased 14.5 percent from CY 2006-2008 (7.3% per year) but only increased 8.3 percent from CY 2004-2008 (2.1% per year),
    - OT payments increased 25.5 percent from CY 2006-2008 (6.4% per year) but only increased 19.5 percent from CY 2004-2008 (9.2% per year), and
    - SLP payments increased 24.0 percent from CY 2006-2008 (12.0% per year) but only increased 22.2 percent from CY 2004-2008 (5.6% per year).
  - The rate of growth in payments from CY 2006-2008 was primarily driven by increased service utilization per beneficiary, particularly for OT and SLP services, and from an increase in beneficiaries receiving outpatient therapy from more than one discipline.
- **Outpatient therapy annual per-beneficiary utilization patterns from CY 2004-2008 reflect a utilization limiting influence of the implementation of the therapy caps with exceptions process in CY 2006, but a reduction of the impact by CY 2008.**
  - The mean annual per-beneficiary payment amount for all three therapy disciplines combined in CY 2004 was \$1,001. This declined to \$921 in CY 2006, and then returned to above baseline at \$1,057 in CY 2008.
    - For PT services the mean per-beneficiary payments were \$864 in CY 2004, \$788 in CY 2006 and \$884 in CY 2008.
    - For OT services the mean per-beneficiary payments were \$867 in CY 2004, \$816 in CY 2006 and \$953 in CY 2008.
    - For SLP services the mean per-beneficiary payments were \$634 in CY 2004, \$608 in CY 2006 and \$702 in CY 2008.
  - The only policy change from CY 2006-2008 related to the therapy cap exceptions process was the CY 2007 elimination of the 'Manual Process Exceptions' procedures which required pre-authorization from the contractor beyond the cap limits for conditions that did not meet published criteria for 'Automatic Process Exceptions'.
- **Outpatient therapy services were furnished in five different provider facility settings and by four different professional office specialties.**
  - Provider facility settings;
    - Hospital payments were \$795 million (16.7% of total),
    - Skilled nursing facility (SNF) payments were \$1.5 billion (32.3% of total),

- Comprehensive outpatient therapy facility (CORF) payments were \$162 million (3.4% of total),
    - Outpatient rehabilitation facility (ORF) payments were \$554 million (11.7% of total), and
    - Home health agency (HHA) payments were \$3 million (0.1% of total).
  - Professional office specialties;
    - Individuals enrolled as physical therapist in private practice (PTPP) received payments of \$1.4 billion (28.8% of total),
    - Individuals enrolled as occupational therapists in private practice (OTPP) received payments of \$86 million (1.8% of total),
    - Individuals enrolled as physicians received payments of \$255 million (5.4% of total), and
    - Individuals enrolled as non-physician practitioners (NPP) received payment of \$3 million (0.1% of total).
  - Individual SLPs were not permitted to enroll and bill Medicare in 2008. In 2009, a fifth outpatient therapy professional office specialty, speech-language pathologist in private practice (SLPP), was permitted by law.
- **Outpatient therapy provider enrollment patterns continue to shift from traditional provider facility settings, which may employ multiple therapists and bill under a single provider number, towards professional office specialties, which bill under an individual's provider number. Payment patterns do not appear to be linked to enrollment patterns.**
    - From CY 2006-2008 provider enrollment and provider setting and professional specialty payments shifted as follows;
      - Hospital providers declined 0.4 percent while payments declined 2.6 percent,
      - SNF providers increased 0.8 percent while payments increased 28.7 percent,
      - CORF providers decreased 26.0 percent while payments increased 32.3 percent,
      - ORF providers decreased 11.8 percent while payments increased 10.4 percent,
      - HHA providers decreased 12.6 percent while payments increased 16.1 percent,
      - PTPP professionals increased 12.3 percent while payments increased 26.9 percent,
      - OTPP professionals increased 15.6 percent while payments increased 23.1 percent,
      - Physician professionals decreased 8.6 percent while payments decreased 11.0 percent, and
      - NPP professionals decreased 5.5 percent while payments increased 91.7 percent.
    - The primary discipline driver for the CY 2006-2008 payment reductions in the hospital setting and physician specialty was OT services. The primary discipline driver for payment increases in CORF and HHA settings and NPP specialty was OT services. The primary discipline driver for payment increases in ORF settings was

SLP services, while OT was an important secondary driver. There was no primary discipline driver of SNF payment increases as PT, OT and SLP services increased relatively equally.

- We believe that the ongoing shift in outpatient therapy enrollment from provider facilities to professional offices is due to lower operating costs in professional offices.
  - We suspect that much of the ongoing shift from individual physician and NPP specialty provider numbers to PTPP and OTPP billing for outpatient therapy services since CY 2004 reflects that more physician and NPP employee physical and occupational therapists are obtaining and billing through PTPP and OTPP provider numbers, while assigning benefits to the employer physician or NPP, as opposed to therapists leaving physician/NPP employers en masse to establish private offices. Prior to a CMS policy change in 2003, all service furnished in a physician or NPP office could only be billed under 'incident-to' provisions.
- **Outpatient therapy service disciplines continue to be disproportionately furnished among the nine provider settings or professional specialties.**
    - PT services are distributed primarily across five provider settings or professional office specialties. PTPP represented 39.2 percent of PT payments, followed by SNF (20.8%), hospital (18.0%), ORF (12.3%), and physician (6.8%). Other settings/specialties have negligible PT services.
    - Over half of OT payments were to SNF (58.6%), followed by hospital (12.2%), ORF (11.6%), OTPP (9.2%), and CORF (7.0). Other settings/specialties have negligible OT services.
    - Over three-quarters of SLP payments were to SNF (77.8%), followed by hospital (16.0%), and ORF (4.8%). Other settings/specialties have negligible SLP services.
  - **The age of outpatient therapy users is relatively stable and they tend to be older than the general Medicare population, particularly for OT and SLP users.**
    - Most PT users were in the age 70-74 age group (18.6%) and the fewest were aged 90 or above.
    - Most OT users were in the 80-84 age group (17.1%) and the fewest in the 65-69 age group (11.6%).
    - Most SLP users were in the 85-89 age group (19.1%) and the fewest in the 65-69 age group (8.4 percent).
    - Annual per-beneficiary Medicare payments for PT, OT, and SLP services generally increase with age.
  - **The gender of outpatient therapy users is relatively stable and users are more likely to be female, regardless of therapy type.**
    - While the ratio of females to males in the general Medicare population is 56.4 percent to 43.6 percent, the percentages of outpatient therapy users that are female are 64.9 percent for PT, 67.1 percent for OT, and 62.5 percent for SLP services.
    - Annual per-beneficiary Medicare payments are similar for both genders.

- **Medicare beneficiary use of outpatient therapy services continues to vary by state of residence and outpatient therapy service disciplines continue to be disproportionately furnished across states.**
  - In general, more populous states had more therapy users,
  - Some states have significantly higher proportions of enrolled beneficiaries receiving outpatient therapy services than others, and the mean annual per-beneficiary expenditures per outpatient therapy user also vary significantly between states,
    - The pattern was not similar for PT, OT, and SLP services,
    - State geographic size or Medicare beneficiary population does not appear to be a major factor in the observed variations,
  - The significant variation in percentage of beneficiaries receiving outpatient therapy in each state, significant variation in mean annual per-beneficiary expenditures, and the variation in these patterns across the three therapy disciplines indicates regional differences in practice and/or accessibility of the three different outpatient therapy disciplines. This pattern is consistent with prior years.
  
- **HCPCS procedure use patterns vary by provider setting/professional specialty and by therapy discipline, and the patterns are consistent with prior years.**
  - Fifteen Healthcare Common Procedure Coding System (HCPCS) codes account for 94 percent of all outpatient therapy claim lines and 95 percent of total payments.
  - HCPCS code 97110 – *Therapeutic exercise* accounts for 33 percent of claim lines and 40 percent of all payments.
  - Three HCPCS Codes (97110, 97140 – *Manual therapy*, and 97530 – *Therapeutic activities*) account for 54 percent of claim lines and 60 percent of payments.
  - For PT services, HCPCS codes 97110, 97140, and 97530 account for 58 percent of claim lines and 68 percent of payments.
  - For OT services, HCPCS codes 97110, 97530, and 97535 – *Self-care/home management training* account for 64 percent of claim lines and 72 percent of payments.
  - For SLP services, HCPCS codes 92526 – *Swallowing treatment* and 92507 – *Speech treatment* account for 78 percent of claim lines and 77 percent of payments.
  
- **The majority of outpatient therapy episodes continue to be represented by a limited number of principal claim diagnosis codes, and these ICD-9 codes remain relatively consistent over time.**
  - There were 4.6 million outpatient PT episodes. The top 20 of 6,865 different International Classification of Diseases, 9th Revision (ICD-9) codes represent 55 percent of all PT episodes. The top 100 ICD-9 codes represent 80 percent of all PT episodes. Eighteen of the top 20 PT episode ICD-9 codes were identical to those reported in CY 2006.
  - There were 1.1 million outpatient OT episodes. The top 20 of 5,851 different ICD-9 codes represent 41 percent of all OT episodes. The top 100 ICD-9 codes represent 71 percent of all OT episodes. Sixteen of the top 20 OT episode ICD-9 codes were identical to those reported in CY 2006.
  - There were 534 thousand outpatient SLP episodes. The top 20 of 4,432 different ICD-9 codes represents 57 percent of all SLP episodes. The top 100 ICD-9 codes

represent 83 percent of all SLP episodes. Fourteen of the top 20 SLP episode ICD-9 codes were identical to those reported in CY 2006.

- **Outpatient PT and OT therapy episode treatment patterns from CY 2004-2008 reflect a utilization limiting influence of the implementation of the therapy caps with exceptions process in CY 2006, but a reduction of the impact by CY 2008.**
  - The mean PT episode treatment days in CY 2004 were 11.2 days. This declined to 10.4 days in CY 2006, and then returned to the baseline of 11.2 days in CY 2008.
    - The mean PT episode payment in CY 2004 was \$748. This declined to \$682 in CY 2006, and then returned to slightly above the baseline at \$760 in CY 2008.
    - The mean PT episode payment standard deviation (SD) in CY 2004 was \$1,047. This declined to \$782 in CY 2006, and then returned to a below baseline amount of \$971 in CY 2008.
  - The mean OT episode treatment days in CY 2004 were 11.0 days. This declined to 10.5 days in CY 2006, and then returned to slightly above the baseline to 11.8 days in CY 2008.
    - The mean OT episode payment in CY 2004 was \$777. This declined to \$722 in CY 2006, and then returned to above the baseline at \$833 in CY 2008.
    - The mean OT episode payment standard deviation (SD) in CY 2004 was \$1,016. This declined to \$858 in CY 2006, and then returned to an above the baseline amount of \$1,041 in CY 2008.
  - The mean SLP episode treatment days in CY 2004 were 7.5 days for both CY 2004 and CY 2006. This increased to 8.9 days in CY 2008.
    - The mean SLP episode payment in CY 2004 was \$572. This declined to \$548 in CY 2006, and then returned to above the baseline at \$628 in CY 2008.
    - The mean SLP episode payment standard deviation (SD) in CY 2004 was \$820. This declined to \$718 in CY 2006, and then returned to an above the baseline amount of \$853 in CY 2008.
  - The only policy change from CY 2006-2008 related to the therapy cap exceptions process was the CY 2007 elimination of the ‘Manual Process Exceptions’ procedures which required pre-authorization from the contractor beyond the cap limits for conditions that did not meet published criteria for ‘Automatic Process Exceptions’.
- **The grouping of PT, OT, and SLP episode ICD-9 principal claim diagnoses into a reasonably small number of (discipline-specific body structure and function related) CSC Classification Groups has resulted in relatively stable utilization results over a span of multiple years. The statistical power of using existing administrative claims data within these CSC Classification Groups to predict outpatient therapy episode expenditures is better than published results for Medicare populations and has also remained relatively stable over time.**
  - The strongest results obtained from four different regression models tested on CY 2008 data are from samples that exclude the top 1 percent cost beneficiary episodes; however the results are only slightly better than the model that includes all episodes. The weakest regression results were for samples that excluded single-day episodes and those that excluded single day and top 1 percent cost episodes.

- Adjusted R-Square for the 24 PT CSC Classification Groups sample that excludes top 1 percent cost episodes in CY 2008 was 11.2 percent, compared to 11.2 percent in CY 2006 and 13.1 percent in CY 2004.
  - Adjusted R-Square for 22 OT CSC Classification Groups sample that excludes top 1 percent cost episodes in CY 2008 was 18.7 percent, compared to 17.2 percent in CY 2006 and 18.1 percent in CY 2004.
  - Adjusted R-Square for 8 SLP CSC Classification Group sample that excludes top 1 percent cost episodes in CY 2008 was 24.2 percent, compared to 21.8 percent in CY 2006 and 21.8 percent in CY 2004.
- The predictive power for the PT, OT and SLP CSC Classification Groups samples that; 1) excludes top one percent cost episodes or 2) includes all episodes, is notably stronger than the published Medicare population R-Square value (of nearly nine percent) when using similar administrative claims data.
- The consistent outpatient therapy episode paid amount regression results over time using the CSC Classification Group model to aggregate similar episode ICD-9 diagnosis codes, and other data such as beneficiary age, gender, state, and provider setting/professional office where services are furnished, demonstrate that patient classification and existing administrative claims data could be an important component in the development of a long-term payment model. Further study could add results from functional measurement tools to these administrative data to improve the ability of the classification model to predict outpatient therapy expenditures, which would be necessary for the development of a long-term episode-based payment option.
- **The increased outpatient therapy utilization observed since CY 2006 has dramatically increased the number of beneficiaries who would have been impacted by full enforcement of the outpatient therapy caps in CY 2008 if the exceptions process were not permitted.**
  - 641 thousand beneficiaries benefitted from the exceptions process and received services beyond the combined PT/SLP cap limits, representing 15.3 percent of all PT/SLP users. This is a 23.6 percent increase from the 518 thousand beneficiaries potentially impacted by a PT/SLP cap without exceptions in CY 2006.
  - 185 thousand beneficiaries benefitted from the exceptions process and received services beyond the separate OT cap limits, representing 19.1 percent of all OT users. This is a 32.3 percent increase from the 140 thousand beneficiaries potentially impacted by an OT cap without exceptions in CY 2006.
- **The increased outpatient therapy utilization observed from CY 2006-2008 has dramatically increased the amount of provider payment cuts that would have resulted from full enforcement of the outpatient therapy caps in CY 2008 if the exceptions process were not permitted.**
  - The cap exceptions process permitted providers to receive \$874 million in Medicare payments for PT/SLP services combined in CY 2008 for services furnished beyond the cap limits. This represents a 55.9 percent increase in the dollar impact of the PT/SLP cap on providers/professionals as compared to the CY 2006 impact of \$560 million.

- The cap exceptions process permitted providers to receive \$259 million in Medicare payments for OT services in CY 2008 for services furnished beyond the cap limits. This represents a 65.8 percent increase in the dollar impact of the OT cap on providers/professionals as compared to the CY 2006 impact of \$156 million.
- Overall, beneficiaries benefitted significantly from the outpatient therapy cap exceptions process in CY 2008 and received \$1.1 billion in PT/SLP and OT services above the established cap limits. If the caps were instead fully enforced, total provider/professional payments would have been 23.8 percent lower in CY 2008.
- **Beneficiary gender continues to be a nominal factor in whether a beneficiary would be impacted by the outpatient therapy caps, regardless of therapy type.**
- **Older beneficiaries continue to be more likely to be impacted by the outpatient therapy caps as they are more likely to surpass the cap threshold, and when they do, they require more costly services than younger beneficiaries.**
  - The largest proportion of PT/SLP beneficiaries benefitting from the cap exceptions process were age 80-84 at 17.1 percent of all PT/SLP users while the smallest proportion was for beneficiaries under age 65 at only 10.0 percent. The age group most likely to have PT/SLP users benefitting from the cap exceptions process was beneficiaries aged 90 and above with 23.0 percent of these users surpassing the cap limits while the age group least likely to surpass the cap limits was those under age 65 at 11.3 percent.
  - The largest proportion of OT beneficiaries benefitting from the cap exceptions process were age 85-89 at 19.5 percent of all OT users while the smallest proportion was for beneficiaries age 65-69 at only 8.9 percent. The age group most likely to have OT users benefitting from the cap exceptions process was beneficiaries age 85-89 with 22.2 percent of these users surpassing the cap limits while the age group least likely to surpass the cap limits was age 65-69 at 14.6 percent.
- **There continues to be a wide disparity between states in the likelihood that a beneficiary will benefit from the cap exceptions process, and how much is paid above the cap limits with the exceptions process, and this pattern is not consistent among therapy types.**
  - For the PT/SLP combined cap;
    - The five states with beneficiaries most likely to benefit from the exceptions process were; Florida (23.8%), New Jersey (22.7%), New York (22.3%), Louisiana (20.5%), and Delaware (20.0%).
    - The five states with beneficiaries least likely to need the exceptions process were; North Dakota (3.2%) Iowa (4.8%), Minnesota (5.0%), Oregon (5.1%), and Alaska (5.6%).
    - The net payments above the cap limits per beneficiary that benefitted from the cap exceptions process were highest in Texas (\$1,983 above cap limit) and lowest in North Dakota (\$757 above cap limit).
  - For the OT separate cap;

- The five states with beneficiaries most likely to benefit from the exceptions process were; Florida (39.3%), Louisiana (28.8%), Mississippi (26.5%), Texas (24.9%), and West Virginia (23.2%).
  - The five states with beneficiaries least likely to need the exceptions process were; North Dakota (3.1%) Iowa (3.6%), Alaska (4.6%), Oregon (5.0%), and Minnesota (6.2%).
  - The net payments above the cap limits per beneficiary that benefitted from the cap exceptions process were highest in Hawaii (\$2,006 above cap limit) and lowest in Vermont (\$689 above cap limit).
- **The episode ICD-9 code plays a large role in indicating whether a beneficiary will benefit from the cap exceptions process. This pattern is consistent over time and across all three outpatient therapy disciplines.**
    - For the PT/SLP combined cap, the top 20 principal claim diagnosis codes represents 50.0 percent of all PT/SLP users, 47.7 percent of all users over the PT/SLP cap limits, and 45.6 percent of net payments above the PT/SLP cap limits. Nine of the top ten most common ICD-9 codes in CY 2008 for PT/SLP users over the cap limits are identical to CY 2006 results.
      - Specific common diagnoses with the highest percentage of PT/SLP users benefitting from the cap exceptions process include, patellar tendinitis (48.4%), late effects of stroke-with cognitive deficits (39.5%), late effects of stroke-non-dominant side (37.4%), late effects of stroke-dominant side (36.5%), heart attack (35.5%), osteoarthritis-multiple sites, type II diabetes, late effects of stroke-unspecified, lack of coordination, and Parkinson's disease.
    - For the OT combined cap, the top 20 principal claim diagnosis codes represent 31.3 percent of all OT users, 42.6 percent of all users over the OT cap limits, and 42.8 percent of net payments above the OT cap limits. Seven of the top ten most common ICD-9 codes in CY 2008 for OT users over the cap limits are identical to CY 2006 results.
      - Specific common diagnoses with the highest percentage of OT users benefitting from the cap exceptions process include, patellar tendinitis (79.2%), tenosynovitis of foot and ankle (76.7%), sprains and strains of lumbosacral joint/ligament (71.2), knee bursitis (69.9%), sprains and strains of hip and thigh (69.8%), sprains and strains of knee and leg, Synovitis and tenosynovitis-other, sprains and strains of ankle, thoracic or lumbosacral neuritis, and brachia neuritis or radiculitis.
  - **Beneficiaries are more likely to benefit from the cap exceptions process in some provider settings/professional offices than in others. Since hospital outpatient therapy services are not counted against the therapy cap limits, beneficiaries who are able to access hospital settings are least likely to require the exceptions process to receive necessary outpatient therapy services.**
    - For beneficiaries who were able to access hospital settings, only 3 percent of PT/SLP users and 1 percent of OT users needed the cap exceptions process to complete their care in other settings

- For beneficiaries who were not able to access hospital settings, 19 percent of PT/SLP users and 25 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed SNF settings, 31 percent of PT/SLP users and 26 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed CORF settings, 46 percent of PT/SLP users and 66 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed ORF settings, 21 percent of PT/SLP users and 34 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed HHA settings, 14 percent of PT/SLP users and 11 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed PTPP specialties, 18 percent of PT/SLP users needed the cap exceptions process.
  - For beneficiaries who accessed OTPP specialties, 14 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed physician specialties, 13 percent of PT/SLP users and 9 percent of OT users needed the cap exceptions process.
  - For beneficiaries who accessed NPP specialties, 20 percent of PT/SLP users and 17 percent of OT users needed the cap exceptions process.
- **These findings suggest that, until a long-term payment policy approach that can incorporate clinical information related to beneficiary function and outcomes is implemented, short-term policy changes to required claims data may be necessary to provide CMS with better information related to beneficiary function and intervention complexity. Such changes would improve confidence that medically necessary services are indeed being furnished and that the recent utilization increases are not an indicator of inappropriate use of Medicare Part B Trust Fund resources.**

# 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. CSC is to perform analysis that provides CMS tools required to fulfill Congressional direction and implement CMS policy. The project name is Short Term Alternatives for Therapy Services, or STATS<sup>1</sup>. 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(l) 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 restrictions or limitations, disabilities or changes in physical function and health status.

Medicare outpatient therapy services 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. Funding for the outpatient therapy services benefit is through the Supplementary Medical Insurance Program for the Aged and Disabled (Medicare Part B).

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 the goal of promoting the healing of damaged body structures such as burns and decubiti of the integumentary system.

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).

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<sup>1</sup> Contract Number: GS-23F-8029H, Task Order Number: *HHSM-500-2008-00065C*

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 in a variety of provider facility settings and from individual specialties in professional offices.

These provider facilities include:

- 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. This was extended to speech-language pathologists in 2009 when SLPPs were permitted to bill Medicare<sup>2</sup>. Previously, all services billed by physician and NPP offices were required to bill all PT, OT, and SLP services of employees or contractors under the business owner's provider number. 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 employees 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.

Professional office specialties include:

- Physical therapist in private practice (PTPP),
- Occupational therapist in private practice (OTPP),
- Speech-language pathologist in private practice (SLPP),
- Physician, and
- Non-physician practitioner (NPP).

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<sup>2</sup> 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.

Medicare covers outpatient therapy services when they are furnished by a qualified professional<sup>3</sup> 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<sup>4</sup> 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<sup>5</sup>.

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.

Generally, outpatient therapy provider facilities and professional offices receive coverage and payment policy instructions and billing guidance from their regional Medicare Administrative Contractor (MAC), who may also establish local coverage decision (LCD) policies to clarify rules when there is no specific 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 MACs who process the claims. There are two types of claim forms used for outpatient therapy services depending on the type of enrollment. 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 PTPP, OTPP, SLPP, physician, or NPP submit the CMS 1500 form, or the 837I electronic equivalent to be reimbursed for outpatient therapy services.

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

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<sup>3</sup> 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..."

<sup>4</sup> The Medicare Benefit Policy Manual, Chapter 5, Section 220(A) defines outpatient therapy 'clinician' as "...a physician, nonphysician practitioner, or a therapist (but not to an assistant, aide or other personnel)..."

<sup>5</sup> The Medicare Benefit Policy Manual, Chapter 15, Section 220.1

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) for Providers	CMS-1500 for Professionals
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<sup>6</sup>, 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 that the services were not medically necessary.

## **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

<sup>6</sup> 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.

caps were implemented in a modified per-provider format throughout calendar year (CY) 1999. However, they were subsequently suspended 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 Congressional action, full implementation of the outpatient therapy caps (with the hospital exception) will be enforced by CMS beginning on January 1, 2011.

Under prior task orders from 2000-2008, 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 performed 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:

- CSC – CY2006 Therapy Utilization<sup>7</sup>,
- CSC – 2006 Therapy Cap Report<sup>8</sup>,
- CSC – CY2006 Therapy Edit Tables<sup>9</sup>,
- CSC – Utilization and Edit<sup>10</sup>,
- CSC – Pilot Report<sup>11</sup>,
- AdvanceMed – Edit Report<sup>12</sup>,
- AdvanceMed – Costliest Report<sup>13</sup>,
- AdvanceMed – Model Report<sup>14</sup>,
- AdvanceMed – Final Report<sup>15</sup>, and

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<sup>7</sup> 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*.

<sup>8</sup> 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*.

<sup>9</sup> 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*.

<sup>10</sup> 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*.

<sup>11</sup> 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*.

<sup>12</sup> 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*.

<sup>13</sup> 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*.

<sup>14</sup> 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*.

<sup>15</sup> Ciolek, D.E. and Hwang W. *Final Project Report*. November 15, 2004. Contract Number *500-99-0009/0009*.

- DynCorp Report – Outpatient Therapy Utilization<sup>16</sup>.

Other analytic reports available at <http://www.cms.gov/TherapyServices/> include the Urban Institute's 2001 analysis of the impact of the therapy caps<sup>17</sup> and 2002 report on standards of outpatient therapy supervision of therapy/therapist assistants<sup>18</sup>, and the 2006 Focus on Therapeutic Outcomes, Inc. (FOTO) demonstration of pay-for-performance concepts for outpatient physical and occupational therapy services<sup>19</sup>.

In addition, the Medicare Payment Advisory Commission (MedPAC)<sup>20</sup>, the U.S. Government Accountability Office (GAO)<sup>21</sup>, and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (DHHS)<sup>22</sup> 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.

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), per visit, per diagnostic category,
- Develop a tiered cap that allows for higher limits for targeted patients with greater needs,
- Intensify and expand medical review efforts,
- Eliminate the outpatient therapy caps altogether,
- 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.
- Modify the exceptions process to limit services that exceed caps.

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

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<sup>16</sup> 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.

<sup>17</sup> 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.

<sup>18</sup> Maxwell, S., Boccuti, and Tong, K. *Supervision of Physical Therapist Assistants: Analysis of State Regulations*. August 2002. Contract Number 500-95-0055.

<sup>19</sup> 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

<sup>20</sup> MedPAC web address: <http://www.medpac.gov>

<sup>21</sup> GAO web address: <http://www.gao.gov>

<sup>22</sup> OIG web address: <http://www.oig.hhs.gov>

*Outpatient Therapy Services Pilot Report 2006*<sup>9</sup> and in reports by MedPAC<sup>23</sup> and the GAO<sup>24</sup>, 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 an effort 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 planned as 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,.

### **1.3 Report Purpose**

This report provides an updated analysis of the utilization of outpatient therapy services using claims data for services furnished during CY 2008. Outpatient therapy services include all services meeting Medicare requirements under a PT, OT, or SLP plan of care (POC) as described in Medicare Manuals<sup>25</sup>.

The results contained in this report describe a variety of distinct patterns of utilization, including:

- Analysis of annual therapy expenditures;
  - In the aggregate,
  - By type of therapy,
  - By setting/specialty,
  - By individual claim lines,
  - By various demographic variables

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<sup>23</sup> Medicare Payment Advisory Commission. Report to Congress: Increasing the Value of Medicare. *Chapter 6 – Toward better value in purchasing outpatient therapy services*. June 2006.

<sup>24</sup> 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.

<sup>25</sup> Specifically, the Medicare Benefit Policy Manual, Chapter 15, Sections 200 and 230, and the Medicare Claims Processing Manual, Chapter 5.

- By HCPCS procedures,
- By principal claim diagnosis,
- By CSC classification group,
- Analysis of utilization patterns by episode, and
- Analysis of the potential impact of full implementation of the therapy caps without exceptions.

In particular, this report will highlight utilization changes between CY 2008 and earlier years to identify any emerging trends that may be relevant to ongoing discussions and potential recommendations related to policy options.

## **2 - Data Analysis Methodology**

For the most part, the claims analysis methodology used in this study replicated the methodology described on CSC's prior analysis of CY 2002-2006 outpatient therapy claims. The previously developed analytic models that were used to identify outpatient therapy services under the MPFS and the individuals who received those services were updated to reflect policy as it applied in CY 2008. Once claims attributable to individuals were matched, and final action claims were identified, individual patient identifiers were encrypted and various analyses were performed.

### **2.1 Source of Data for Analysis**

CSC was able to obtain an extract of 100% of outpatient therapy claims data with CY 2008 dates of service, processed from January 2008 through June 2009, from the CMS STARS National Database (NDB). These claims data were later merged with Medicare Denominator files that CMS provided, which describe beneficiary demographics for CY 2008. All analyses were performed on the STATS therapy server located at CSC in Baltimore, MD.

### **2.2 Creation of Therapy Data Sets of Analysis**

The programming logic used to extract the outpatient therapy data replicated those used to extract the data used in the prior studies. The current extraction included HCPCS codes that were introduced after CY 2006 and excluded codes that no longer were considered outpatient therapy services in 2008. This was confirmed by reviewing CMS Transmittal: R1377CP – 2008 *Annual Update to the Therapy Code List* issued on November 23, 2007. Appendix B 'STATS Therapy HCPCS Analysis Logic identifies how the characteristics of individual claims data HCPCS codes, facility bill type, line specialty codes, and therapy discipline modifiers, were used to apply Transmittal R1377CP requirements to identify whether individual HCPCS codes met the criteria of outpatient therapy services or not. The following bullets highlight how the data was then sorted by therapy type and therapy setting in the various analytic tables in this report.

#### **Therapy Type:**

- For provider facility claims, therapy type could be identified either by the claim line Revenue Center code, or by the therapy discipline modifier (GP = PT plan of care, GO = OT plan of care, and GN = SLP plan of care). In our analysis, all therapy claim lines had a single Revenue Center Code while a very small percentage either did not have a therapy discipline modifier, or had more than one therapy discipline modifier. As a result, we determined it was most appropriate to use the claim line Revenue Center Codes to identify 42, 43, and 44 to identify PT, OT and SLP services respectively.
- For professional office claims, therapy type could only be identified by the therapy discipline modifier. However, a very small percentage of outpatient therapy claim line procedures that should have been identified with a therapy discipline modifier either were missing the required modifier, or contained more than one therapy discipline modifier making the determination of therapy discipline impossible. As a result, we determined to report professional office claim therapy type in tables using the following criteria; 'PT' if GP modifier used, 'OT' if GO modifier used, 'SLP' if GN modifier used, '>=2 Modifiers' if two or more therapy modifiers were appended to a therapy HCPCS claim

line, and 'No Modifiers' if no required therapy modifiers were appended to a therapy HCPCS claim line.

### **Therapy Provider Setting/Professional Specialty:**

- For provider facility claims, the Claim Bill Type code was used to differentiate setting for all services on the claim as follows;
  - Hospital –12X or 13X,
  - SNF – 22X or 23X,
  - CORF – 75X,
  - ORF – 74X, and
  - HHA –34X.
  
- For professional office claims, there is not sufficient information on the claim to clearly differentiate setting. However, there is sufficient information in the Line Specialty Code to identify the specialty of the clinician responsible for the services submitted on each outpatient therapy claim line. They are;
  - PTPP – 65,
  - OTPP – 67,
  - SLPP – Could not bill professional office claims in 2008 (specialty code 15 became available in 2009),
  - Physician – 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23,24 25, 26, 27, 28, 29, 30, 31, 33, 34, 36, 37, 38, 39, 40, 41, 44, and 46,
  - NPP – 50, 89, and 97

### **2.3 Episode Determination**

The current Medicare Benefits Policy Manual, Chapter 15, Section 220(A) defines an '*episode of outpatient therapy*' as "...the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that discipline in that setting..." For data analysis purposes, this definition does not result in sufficient claims data information to clearly differentiate the initiation and completion of distinct outpatient therapy episodes. For this reason, we continue to use the operational definition of an outpatient therapy episode developed for the prior CSC analysis of CY 2002, 2004, and 2006 outpatient therapy claims. The key components of the CSC operational definition of an outpatient therapy 'episode' are:

- An episode describes the date of the beneficiary's first encounter until the last encounter for the specific therapy discipline (PT, OT, or SLP).
- A treatment date describes an individual calendar date that the outpatient therapy service was furnished.
- A first encounter describes the first paid date of service for the specific therapy discipline (which may include evaluation procedures, treatment procedures, or both), as long as there were no paid treatment dates within 60 calendar days for that discipline prior to the first encounter date.

- A last encounter describes the last paid date of service for the specific therapy discipline, or the treatment date preceding a sixty-day break in paid treatment dates.
- The number of episode days is the number of actual treatment dates between the first encounter and the last encounter, and not the calendar date span.
- The episode diagnosis or CSC classification group is identified by the principal claim diagnosis reported on the first claim submitted during the identified episode.
- In the case of overlapping therapy disciplines, separate episodes are identified for each therapy type.

## **2.4 Estimating Claim Line Paid and Allowed Amounts**

Medicare outpatient therapy claim line paid amounts reflect the unit price (allowed amount) per HCPCS procedure code times the number of units of that procedure, less 20 percent coinsurance and less any applicable remaining Part B annual deductible. Since outpatient therapy is only payable if the beneficiary is under the care of a physician, it is rare for the deductible to be applied to outpatient therapy services since the deductible has most likely been exhausted by prior physician or NPP office visits or for various diagnostic tests. The most common exceptions are episodes that overlap calendar years as new deductible amounts apply each year.

The current Medicare claims data structure presents a unique challenge in determination of the exact allowed amount for a specific claim line submitted by institutional providers. In the National Claims History (NCH) file database, Medicare paid amounts, or Medicare liability, are clearly identified by *Line NCH Payment Amount* data in professional office claims and *Revenue Center Payment Amount* data in institutional provider setting claims. In addition, the Medicare allowed amounts, which reflect the paid amounts plus any deductibles and coinsurance, are clearly identified by the *Line Allowed Charge Amount* data in professional office claims. However, due to the complexity of facility-based claims processing, there is no corresponding single data field in institutional provider setting claims data to reflect the Medicare allowed amount for a given claim line. Without such direct data, provider setting claims allowed amounts data requires the creation of calculated estimates of the provider setting allowed amounts.

One methodology that has been described to estimate the Medicare allowed amount for institutional provider setting outpatient therapy claim lines is to multiply the *Revenue Center Rate Amount* and the *Revenue Center Unit Amount*. This methodology assumes that the *Revenue Center Rate Amount* consistently reflects the true unit price (allowed amount) per HCPCS procedure code, and that Medicare has a liability to pay for the services billed on the claim line. However, our analysis of provider setting claims data indicates that this methodology can err in an overestimation of the allowed amount, and therefore overestimate beneficiary liability. For example, Medicare data may indicate a *Revenue Center Rate Amount* for a claim line in which no Medicare payment is issued when Medicare was secondary payer and therefore not liable for the services. In another example, Medicare data may indicate aberrations in the *Revenue Center Pricing Indicator Codes* and *Revenue Center Discount Indicator Codes* that are used to identify if deviations from standard methods of calculating payment amounts were applied by the MAC. In both examples, multiplying the *Revenue Center Rate Amount* and the *Revenue Center Unit Amount* can create an overestimation bias of the Medicare allowed amount for the affected provider setting claim lines.

In our prior analysis of outpatient therapy claims from CY 1998 through 2006, CSC provided a streamlined conservative estimate of outpatient therapy allowed amounts by multiplying the known Medicare paid amount by 1.25. This estimate reflects the 20 percent Part B coinsurance and presumes no deductible applied to the outpatient therapy claim line. In prior analyses, we determined that this method would underestimate allowed amount by less than one percent. Upon further investigations, we found no evidence that indicates any systemic bias resulting from this estimation against any specific therapy type, provider setting/professional specialty, diagnosis, or beneficiary sub-group.

In comparison to the alternative estimation methodology which is subject to an overestimation error (with unknown statistical bias), we have concluded it is more appropriate to continue to use the methodology of multiplying the known Medicare paid amount by 1.25 to estimate the Medicare allowed amounts described in this report. This determination is based on two considerations: 1) to remain consistent to and comparable to CSC prior analyses from CY 1998 through 2006; and 2) the alternative method has thus far generated results that are very consistent to what have been previously been reported by CSC.

### **3 - Outpatient Therapy Utilization Results – CY 2008**

CSC believes that nearly 100% of outpatient therapy claims were accurately matched with individual beneficiaries, and only final action claims were analyzed. The overall results were compared with our parallel analysis of CY 2008 claims using the CMS Integrated Data Repository (IDR) as a data source with nearly identical results. However, CSC is presenting these results as estimates due to rounding error and claim coding error (e.g. when therapy HCPCS do not have a therapy modifier appended to the claim line), a practice that has successfully been followed in similar CSC reports. By using a 100% extract, these results are much more precise than analyses that only use a 5% file or other sample derived<sup>26</sup> databases. In this section, we will provide detailed analyses of outpatient therapy utilization during CY 2008 in terms of overall utilization, and utilization by therapy type, therapy provider setting/professional specialty, HCPCS use, and by episode.

Detailed data tables in Microsoft Excel workbooks and Section 508 compliant comma separated value (.csv) file formats that are referenced, are submitted as attachments to this report. Appendix C provides a mapping of the Excel workbooks and their worksheets to the corresponding .csv filenames.

#### **3.1 Overall Outpatient Therapy Utilization**

During CY 2008 4,503,178 individuals received some form of Medicare outpatient therapy services. This represents 10.5% of 42.7 million Part B enrollees<sup>27</sup>. Of these enrollees, 3.96 million (9.3%) received PT services, 973 thousand (2.3%) received OT services, and 478 thousand (1.1%) received SLP services.

As Table 2 summarizes, payments for outpatient therapy services in CY 2008 totaled \$4.76 billion. PT services accounted for \$3.5 billion, or 73.5 percent, OT services accounted for \$928 million or 19.5 percent, and SLP services accounted for \$336 million or 7.1 percent of all outpatient therapy payments (Figure 1). The mean annual payment for all therapy users was \$1,057, while it was \$884 for PT, \$953 for OT, and \$702 for SLP users. The mean paid per PT episode was \$760, while it was \$833 for OT and \$628 for SLP episodes.

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<sup>26</sup> The 5% extract file is used to provide population estimates that are relatively accurate for high level utilization analyses in large populations. The random extract of beneficiaries assumes that there is a normal distribution of the sub-population under study (e.g. outpatient therapy users). Results obtained from the 5% file are then multiplied by a factor of 20 to obtain an estimate for the entire population. However, outpatient therapy users represent only a small proportion of Medicare beneficiaries. In prior CSC utilization analyses using 100% files, we have identified that the sub population of outpatient therapy users is not representative of the total Medicare population (e.g. therapy users are more likely to be female, to be older, and to live in certain states). As a result, there are significant differences in utilization results generated by 5% file data analysis versus 100% file data analysis. Therefore, utilization analyses of 100% data are more effective in helping avoid unintended consequences of flawed policy on any sub-population (e.g. outpatient therapy users) that is based upon improper conclusions drawn from skewed data.

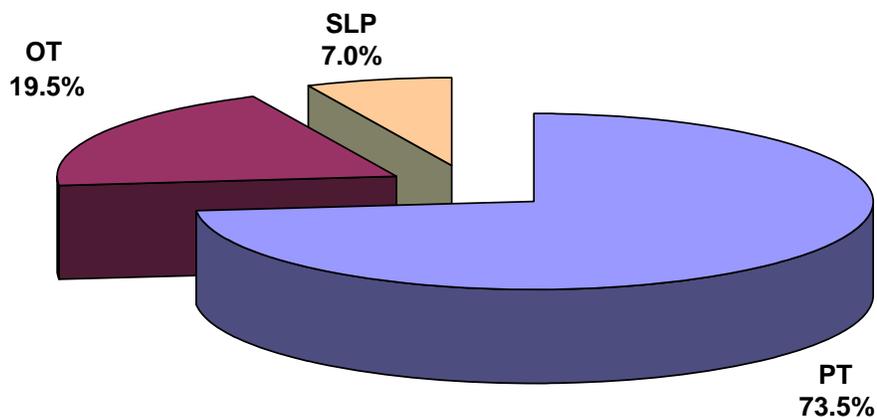
<sup>27</sup> For this report, we refer to Part B enrollees as individuals that were enrolled in Part B Medicare at any time during CY 2008. As a result, these estimates may be higher than other published reports that count enrollees on a specific date during the year (e.g. July 1), or that only count enrollees that are enrolled in Part B for the entire year.

The total Medicare outpatient therapy expenditures in CY 2008 of \$4.76 billion represent only 2.6 percent of total Medicare Part B expenditures of \$183.3 billion, and only 1.0 percent of all Medicare expenditures (Part A, Part B and Part D combined)<sup>28</sup>.

**Table 2. Summary of outpatient therapy utilization by therapy type<sup>29</sup>**

CY 2008	Users	Total Paid	Mean Paid per User	Mean Paid per Episode
All	4,503,178	\$4,760,051,098	\$1,057	N/A <sup>30</sup>
PT	3,955,285	\$3,496,865,018	\$884	\$760
OT	973,222	\$927,619,507	\$953	\$833
SLP	477,988	\$335,566,573	\$702	\$628

**Figure 1. Distribution of outpatient therapy payments by therapy type in CY 2008<sup>31</sup>**



**Trend Spotlight – Overall outpatient therapy utilization change CY 1998-2008**

Figure 2 provides a graphic reflection of the overall outpatient therapy utilization trend from CY 1998-2008. As described in prior studies<sup>32</sup>, from CY 1998 through 2007, with the exception of CY 1999, the total number of beneficiaries receiving outpatient therapy services has increased annually. Also, with the exception of CY 1999 and 2006, the total payments for outpatient therapy services have increased annually, with the rate of growth in payments exceeding the rate of growth in beneficiaries treated. The drop in beneficiaries treated and total payments in CY 1999 coincided with the implementation of the therapy caps in all settings except hospitals, as

<sup>28</sup> Overall Medicare expenditure data as reported in Table II.B.1 of the 2009 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 12, 2009.

<sup>29</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

<sup>30</sup> Mean episode paid for all outpatient therapy users (across disciplines) is not presented to be consistent with existing outpatient therapy policy described in Section 2.3 Episode Determination. Outpatient therapy episodes are only defined and presented in this report as being discipline-specific.

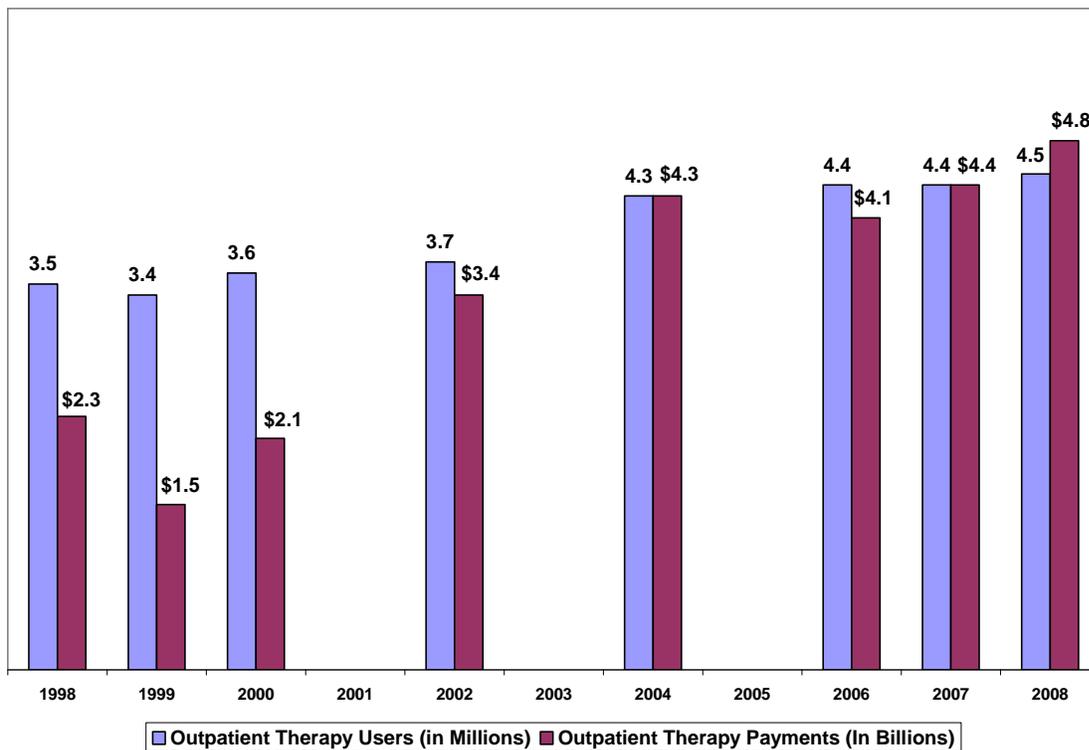
<sup>31</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

<sup>32</sup> In addition to the prior CSC studies that described outpatient therapy utilization for CY 1998-CY 2006, this report (e.g. Figure 2) also refers to the CY 2007 analysis performed by RTI in their June 2009 report titled, *Developing Outpatient Therapy Payment Alternatives (DOTPA): 2007 Utilization Report*.

well as the MPFS fee schedule replacing cost-based payments in provider facilities during that year.

The drop in total payments in CY 2006 coincided with the reinstatement of the caps (including the exceptions process) in that year. Beginning in CY 2007, the ‘Manual Process Exceptions’ were eliminated from the cap exceptions process meaning that (for certain diagnoses) provider facilities and professional offices no longer were required to obtain Medicare contractor preauthorization to use the KX modifier to receive an exception from the cap limits. From CY 2007 to 2008 the number of outpatient therapy users increased 2.3%; however, the total payments increased 8.8%. The trend of payments increasing at a higher rate than the rate of increase in the number of beneficiaries from CY 2006-2008 suggests that the initial cost-containment impact of the caps with the exceptions process slowed, but did not stop the increase in use of therapy services.

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



### 3.2 Provider Setting and Professional Specialty

#### 3.2.1 Number of provider settings and specialty professionals

Prior to CY 2003, professional office claims data from PTPP, OTPP, physician and NPP professional offices could clearly be identified as distinct setting as all services furnished were billed using the provider number of the business owner. For example, all services billed by a physician or his/her PT, OT, or SLP employee was identified as ‘physician setting’ services.

However, beginning in 2003, CMS began issuing PTPP and OTPP provider numbers to individual physical therapists, and occupational therapists who requested them, even if they worked as employees of, or contracted to physicians or NPPs. This practice was extended to speech-language pathologists in 2009 when these professionals could enroll as SLPPs. In a physician or NPP professional office, the employer has the option to bill Medicare claim lines using the physician's or NPP's provider number under the 'incident-to' provisions, or they can bill Medicare claim lines using their employee therapist's PTPP, OTPP, or SLPP provider number.

As a result, any outpatient utilization analysis describing CY 2003 to the present do not represent PTPP, OTPP, SLPP, physician, or NPP billed services as an outpatient therapy 'setting' as the available claims data can no longer provide that differentiation. In this report, we now refer to such utilization as being performed under the professional office specialties as identified by the provider code submitted on the outpatient therapy claim line.

***Trend Spotlight – Change in the number of enrolled provider facilities and individual professionals submitting outpatient therapy claims CY 2000-2008***

*During CY 2008, there were 22,134 different facility providers that furnished outpatient therapy services. As Table 3 reveals, this represents a 1.9 percent reduction in the number of facility providers that furnished outpatient therapy services from CY 2006-2008. Settings with fewer providers in CY 2008 were HHA, with 27.6 percent fewer facilities, CORF (-26.0%), ORF (-11.8%), and hospital (-0.4%). SNF was the only facility provider setting with an increase in the number of individual facilities furnishing outpatient therapy services increasing from 14,267 to 14,375 facilities from CY 2006-2008 (an increase of 0.8 percent).*

**Table 3. Number of outpatient therapy facility providers and individually identified professionals that submitted claims for outpatient therapy services in CY 2008**

Provider Setting/ Professional Specialty	CY 2000	CY 2004	CY 2006	CY 2008	CY 2006- 2008
All	69,984	93,459	96,917	100,067	3.3%
Individual Providers	21,951	22,868	22,562	22,134	-1.9%
Hospital	5,601	5,326	4,958	4,937	-0.4%
SNF	13,445	14,088	14,267	14,375	0.8%
CORF	464	613	553	409	-26.0%
ORF	2,441	2,569	2,509	2,214	-11.8%
HHA	N/A	272	275	199	-27.6%
Individual Professionals	48,033	70,591	74,355	77,933	4.8%
PTPP	11,602	33,704	41,980	47,148	12.3%
OTPP	1,040	3,790	4,824	5,577	15.6%
Physician	34,803	32,205	26,783	24,482	-8.6%
NPP	588	892	768	726	-5.5%

*In contrast, from CY 2006-2008, there was a 4.8 percent increase in the number of individuals from professional offices identified as having furnished outpatient therapy services from 74,355 in CY 2006 to 77,933 in CY 2008. OTPP specialty individuals increased by 15.6 percent and PTPP specialty individuals increased 12.3 percent. The number of individual physicians and*

*NPPs identified on professional claim lines as having personally furnished or supervised incident-to outpatient therapy services declined by 8.6 percent and 5.5 percent respectively. This change corresponds with improved Medicare manual descriptions of the qualifications of therapists, skilled services and services incident to physician services.*

*It should be noted that neither the number of individual clinicians that furnish outpatient therapy services in provider settings, nor physician or NPP specialties can be determined through claims data. For example, hospitals, depending on their size, may employ from one to dozens of PTs, OTs, and SLPs to furnish services billed under a single hospital provider number. There is nothing in the Medicare claims data than can be used to verify if the reduction in the number of the number of hospitals, CORFs, ORFs, or HHAs reflect a real reduction in the number of treating clinicians in these settings, or if the clinicians just relocated to another of the remaining provider settings. Similarly, when physicians or NPPs bill incident-to services of employee therapists, claims data cannot identify how many clinicians are furnishing services under the physicians or NPPs provider number.*

### 3.2.2 Utilization by provider setting and professional specialty

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.

**Figure 3. Outpatient therapy payments by treatment setting/specialty<sup>33</sup>**

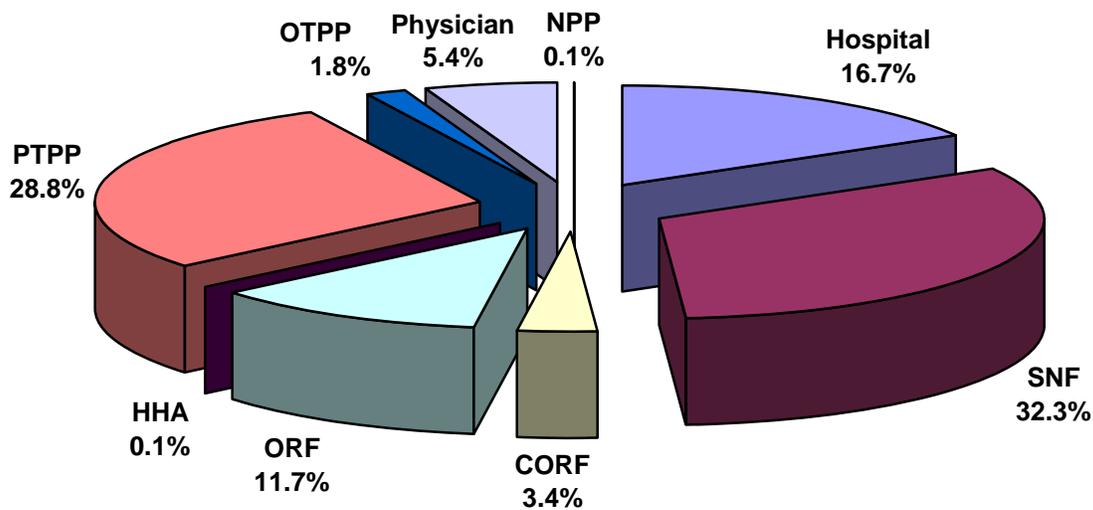


Figure 3 demonstrates the relative proportion of outpatient therapy payments made to the five provider settings and four professional office specialties in CY 2008 and reflects that 77.7 percent of all outpatient therapy service payments were issued to three settings/specialties; SNF

<sup>33</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

(32.3%), PTPP (28.8%), and hospital (16.7%). Table 4 summarizes the number of claim lines, total paid, mean paid per line, and percent of total payments for CY 2008 for each provider setting and professional office specialty.

**Table 4. Outpatient therapy payments by setting/specialty<sup>34</sup>**

Provider Setting/ Professional Specialty	Number of Claim Lines	Total Paid	Mean Paid per Line	Percent of Total Paid
All	150,109,065	\$4,761,679,039	\$31.72	100.0%
All Provider Settings	92,209,054	\$3,046,110,735	\$33.03	64.1%
All Hospital	22,301,980	\$794,778,153	\$35.64	16.7%
All SNF	45,602,547	\$1,532,087,374	\$33.60	32.3%
All CORF	6,099,601	\$162,006,814	\$26.56	3.4%
All ORF	18,121,347	\$554,495,141	\$30.60	11.7%
All HHA	83,579	\$2,743,254	\$32.82	0.1%
All Professional Specialties	57,900,011	\$1,715,568,304	\$29.63	36.0%
All PTPP Specialty	45,840,701	\$1,372,019,477	\$29.93	28.8%
All OTPP Specialty	2,534,005	\$85,605,500	\$33.78	1.8%
All Physician Specialty	9,409,622	\$255,005,285	\$27.10	5.4%
All NPP Specialty	115,683	\$2,938,042	\$25.40	0.1%

During CY 2008, provider settings accounted for \$3.05 billion or 64.1 percent of outpatient therapy payments, while professional office specialties accounted for \$1.72 billion in payments. The majority of provider setting payments went to SNF (\$1.53 billion), hospital (\$795 million), and ORF (\$554 million). CORF payments of \$162 million and HHA payments of \$2.74 million represented only 3.4 percent and 0.1 percent of all outpatient therapy payments respectively. The majority of professional office specialty payments went to individuals with PTPP provider numbers at \$1.37 billion followed by individuals with physician specialty provider numbers at \$255 million. OTPP specialty payments of \$85.6 million and NPP specialty payments of \$2.94 million represented only 1.8 percent and 0.1 percent of all outpatient therapy payments respectively.

The modest differences in mean payments per line could indicate more intensive treatments or a higher proportion of higher priced one-on-one procedures in settings with higher means, as opposed to lower intensity services or lower priced supervised modalities in settings/specialties with lower mean payments per line.

***Trend Spotlight - Outpatient therapy payment change by setting/specialty CY 2004-2008***

*Medicare outpatient therapy payments to provider settings/professional specialties have shifted at different rates between CY 2004 and CY 2008. As presented in Table 5, overall payments were \$4.27 billion in CY 2004 when there were no outpatient therapy caps, and then declined to \$4.07 billion in CY 2006 when the outpatient therapy caps were implemented with the exceptions process, and then increased to \$4.76 billion in CY 2008 after the exceptions process was modified in CY 2007.*

<sup>34</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

**Table 5. Outpatient therapy payment change by setting/specialty CY 2004-2008**

Provider Setting/ Professional Specialty	Paid 2004	Paid 2006	Paid 2008	Paid Change 2006- 2008	Paid Change 2004- 2008
All	\$4,274,391,862	\$4,072,563,388	\$4,761,679,039	16.9%	11.4%
All Provider Settings	\$2,824,063,258	\$2,633,387,392	\$3,046,110,735	15.7%	7.9%
All Hospital	\$838,837,762	\$815,647,413	\$794,778,153	-2.6%	-5.3%
All SNF	\$1,237,575,461	\$1,190,464,520	\$1,532,087,374	28.7%	23.8%
All CORF	\$155,839,168	\$122,466,513	\$162,006,814	32.3%	4.0%
All ORF	\$587,521,718	\$502,446,420	\$554,495,141	10.4%	-5.6%
All HHA	\$4,289,149	\$2,362,526	\$2,743,254	16.1%	-36.0%
All Professional Specialties	\$1,450,328,604	\$1,439,175,996	\$1,715,568,304	19.2%	18.3%
All PTPP Specialty	\$975,121,682	\$1,081,570,926	\$1,372,019,477	26.9%	40.7%
All OTPP Specialty	\$63,843,109	\$69,540,973	\$85,605,500	23.1%	34.1%
All Physician Specialty	\$409,137,606	\$286,531,414	\$255,005,285	-11.0%	-37.7%
All NPP Specialty	\$2,226,207	\$1,532,683	\$2,938,042	91.7%	32.0%

*From CY 2006-2008, only the hospital setting (-2.6%) and physician specialty (-11.0%) received lower total payments. From CY 2004-2008, hospital (-5.3%), ORF (15.6%), HHA (-36.0%), and physician (-37.7%) saw a decline in total payments. In contrast, total payments increased for SNF (23.8%), CORF (4.0%), PTPP (40.7%), OTPP (34.1%), and NPP (32.0%). Most of the provider setting/specialty payment increases occurred between CY 2006-2008 suggests that the initial cost-containment impact of the caps with the exceptions process slowed, but did not stop the increase in use of therapy services in certain settings or specialties. Specific payment increases were seen from CY 2006-2008 for SNF (28.7%), CORF (32.3%), ORF (10.4%), HHA (16.1%), PTPP (26.9%), OTPP (23.1%), and NPP (91.7%).*

***Trend Spotlight – Outpatient therapy payment change per enrolled provider number CY 2004-2008***

*While overall payments continue to shift between provider settings/professional specialties, it is important to keep in perspective that there is also a concurrent change in the number of enrolled provider settings and professional specialties as described in Section 3.2.1. Gross changes in payments per provider/specialty may be more reflective of enrollment changes than an indicator of increases or decreases in utilization for that setting/specialty. While Table 3 demonstrates the four-year shift in provider/specialty enrollment patterns, and Table 5 demonstrates the four-year shift in provider/specialty total payments, Table 6 below indicates the four-year trends in payments per enrolled provider/specialist. For example, although CORF (-26.0%), HHA (-27.6%), and NPP (-5.5%) had a decline in the number of provider numbers billing outpatient therapy services from CY 2006-2008, CORF had an increase in payments per provider of 78.9 percent, HHA increased 60.5 percent, and NPP increased 102.8 percent. This reflects a significant increase in utilization by the remaining providers/specialists in these categories.*

**Table 6. Outpatient therapy payment change per enrolled provider number CY 2004-2008**

Provider Setting/ Professional Specialty	CY 2004	CY 2006	CY 2008	CY 2004-2008	CY 2006-2008	2004-2008 per year	2006-2008 per year
All	\$45,735.48	\$42,021.15	\$26,751.01	-41.5%	-36.3%	-10.4%	-18.2%
Provider Settings	\$123,494.11	\$116,717.82	\$137,621.34	11.4%	17.9%	2.9%	9.0%
Hospital	\$157,498.64	\$164,511.38	\$160,984.03	2.2%	-2.1%	0.6%	-1.1%
SNF	\$87,846.07	\$83,441.83	\$106,579.99	21.3%	27.7%	5.3%	13.9%
CORF	\$254,223.77	\$221,458.43	\$396,104.68	55.8%	78.9%	14.0%	39.4%
ORF	\$228,696.66	\$200,257.64	\$250,449.48	9.5%	25.1%	2.4%	12.5%
HHA	\$15,768.93	\$8,591.00	\$13,785.20	-12.6%	60.5%	-3.1%	30.2%
Professional Specialties	\$20,545.52	\$19,355.47	\$22,013.37	7.1%	13.7%	1.8%	6.9%
PTPP	\$28,931.93	\$25,763.96	\$29,100.27	0.6%	12.9%	0.1%	6.5%
OTPP	\$16,845.15	\$14,415.62	\$15,349.74	-8.9%	6.5%	-2.2%	3.2%
Physician	\$12,704.16	\$10,698.26	\$10,416.03	-18.0%	-2.6%	-4.5%	-1.3%
NPP	\$2,495.75	\$1,995.68	\$4,046.89	62.2%	102.8%	15.5%	51.4%

*In contrast, PTPP and OTPP had an increase in provider numbers billing Medicare from CY 2006-2008 of 12.3 percent and 15.6 percent respectively. However, these specialties only saw an increase of payments for individuals enrolled as PTPP of 12.9 percent and for individuals enrolled as OTPP of 6.5 percent from CY 2006-2008. This reflects a more modest increase in utilization for these specialties than the overall payment trends for PTPP and OTPP would suggest. The modest 2.6 percent reduction in payments per individual physician provider number from CY 2006-2008 is much smaller than the -11.0 percent reduction in payments across all physician specialties during the same period and suggests that much of the overall physician payment reduction is driven by fewer physicians billing outpatient therapy services under their personal provider numbers under incident-to provisions.*

### **3.2.4 Utilization by therapy type within each provider setting and professional specialty**

As Table 7 and Figure 4 demonstrate, in addition to differences in where outpatient therapy services are furnished, there are significant differences in what types of therapy services are furnished in each provider setting or professional office specialty. Overall, PT services represent 73.4 percent of all outpatient therapy payments, followed by OT services at 19.5 percent, and SLP services at 7.0 percent.

**Table 7. Outpatient therapy payments by type of therapy within each setting/specialty<sup>35</sup>**

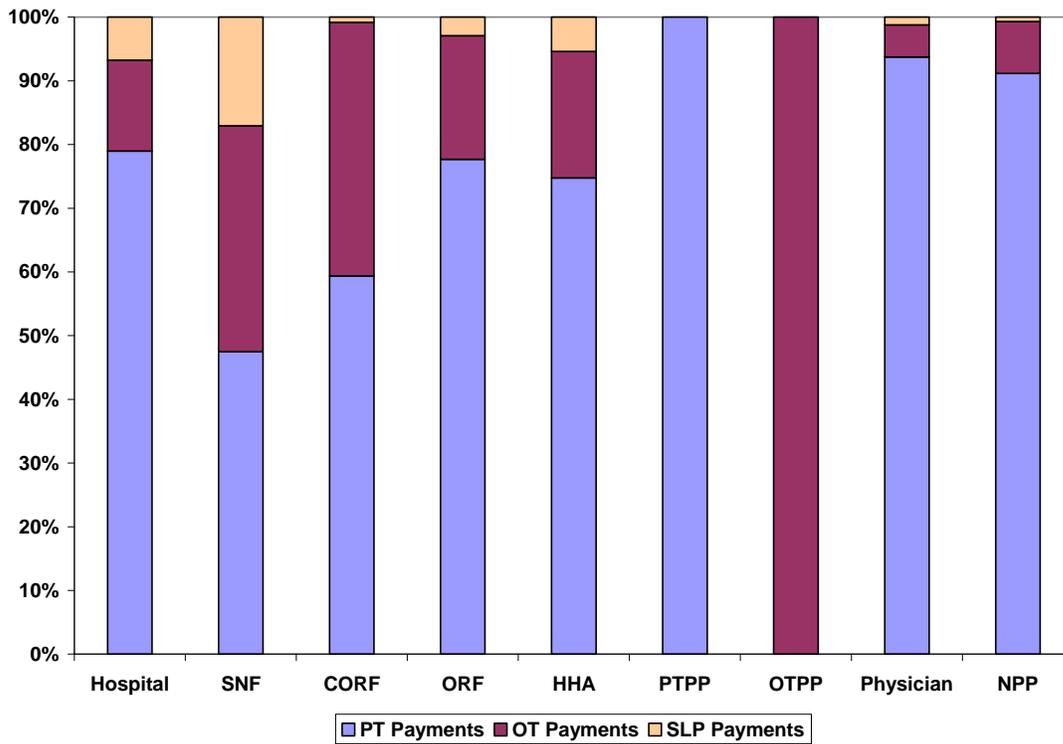
Provider Setting/ Professional Specialty	PT Paid	OT Paid	SLP Paid	Percent PT	Percent OT	Percent SLP
All	\$3,496,854,636	\$927,613,680	\$335,562,982	73.4%	19.5%	7.0%
Provider Settings	\$1,884,552,068	\$829,086,967	\$332,471,701	61.9%	27.2%	10.9%
Hospital	\$627,610,795	\$113,450,900	\$53,716,458	79.0%	14.3%	6.8%
SNF	\$727,817,967	\$543,214,946	\$261,054,461	47.5%	35.5%	17.0%
CORF	\$96,178,773	\$64,513,597	\$1,314,445	59.4%	39.8%	0.8%
ORF	\$430,893,710	\$107,362,646	\$16,238,785	77.7%	19.4%	2.9%
HHA	\$2,050,823	\$544,879	\$147,552	74.8%	19.9%	5.4%
Professional Specialties	\$1,612,302,568	\$98,526,713	\$3,091,281	94.0%	5.7%	0.2%
PTPP	\$1,371,530,877	\$0	\$0	100.0%	0.0%	0.0%
OTPP	\$0	\$85,456,683	\$0	0.0%	99.8%	0.0%
Physician	\$238,103,636	\$12,832,412	\$3,070,668	93.4%	5.0%	1.2%
NPP	\$2,668,054	\$237,618	\$20,613	90.8%	8.1%	0.7%

In provider settings, PT services only represent 61.9 percent of provider setting payments, with the highest percentage in hospitals (79.0%) and the lowest in CORF (59.4%). OT services represent 27.2 percent of provider setting payments with the highest percentage in CORF (39.8%) and the lowest in hospital (14.3%). SLP services represent 10.9 percent of provider setting payments with the highest percentage in SNF (17.0%) and the lowest in CORF (0.8%).

In contrast, in professional office specialties, PT services dominate payments at 94.0 percent, followed by OT at 5.7 percent, and SLP at 0.2 percent of all professional specialty payments. All identified PTPP and OTPP specialty payments reflect PT and OT payments respectively as physical therapists and occupational therapists enrolled in Medicare may only bill for their specialty. However, they may bill for their specialty either furnished in a therapist's private practice or when employed by a physician or NPP office practice. Since physician and NPP specialties may bill under a PT, OT or SLP plan of care for their own services or 'incident to' services of therapist employees/contractors, the distribution of payments by therapy type is allocated as follows. For physician specialty billing, 93.4 percent of payments were for PT services, 5.0 percent for OT services and 1.2 percent for SLP services. For NPP specialty billed services, 90.8 percent was paid for PT services, 8.1 percent for OT services and 0.7 percent for SLP services. Claims do not identify whether the physician or NPP personally provided these services.

<sup>35</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

**Figure 4. Outpatient therapy payments by therapy type within each setting/specialty<sup>36</sup>**

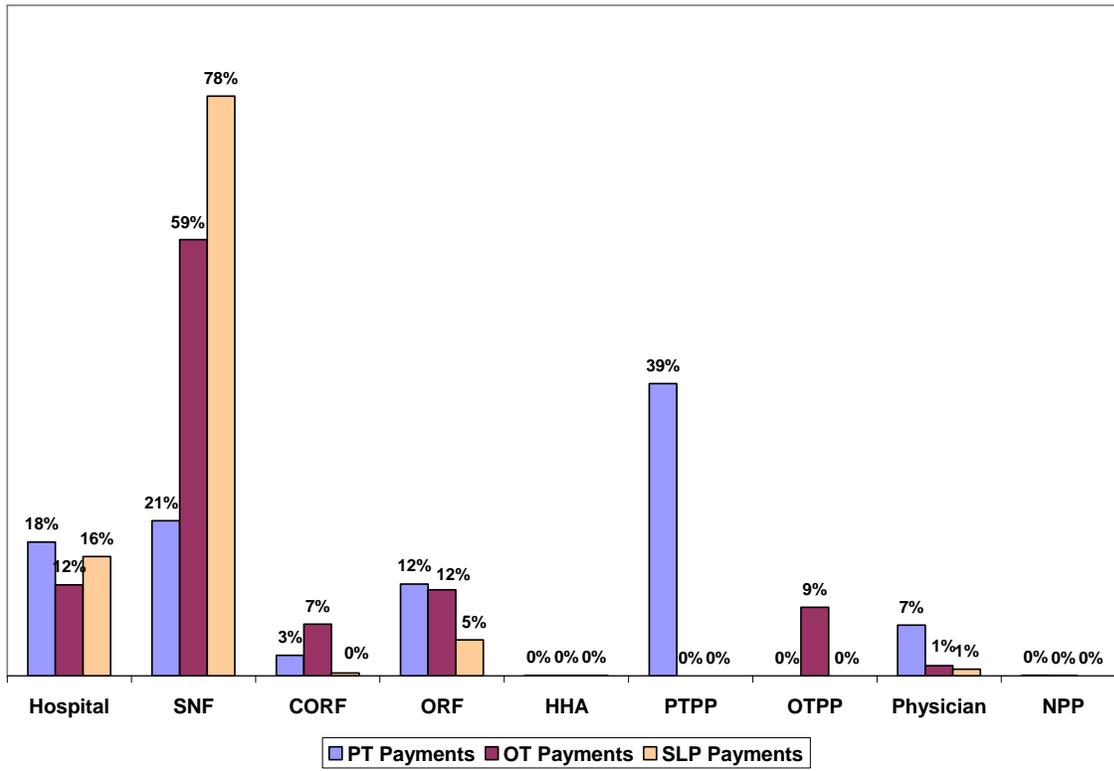


### 3.2.5 Utilization by therapy type across provider settings and professional specialties

As demonstrated in Figure 5, during CY 2008, PT services were distributed primarily across five provider settings or professional office specialties. PTPP represented 39 percent of PT payments followed by SNF (21%), hospital (18%), ORF (12%) and physician (7%). Over half of OT payments were to SNF (59%), followed by hospital, (12%), ORF (12%), and OTPP (9%). Over three-quarters of all SLP payments were issued to SNF (78%), followed by hospital (16%), and ORF (5%). Other settings received negligible percentages of payments per therapy type.

<sup>36</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

**Figure 5. Distribution of outpatient therapy payments for each therapy type across settings/specialties<sup>37</sup>**



***Trend Spotlight – Outpatient PT OT SLP payment change within each setting/specialty 2004-2008***

*Just as payment trends of all outpatient therapy services combined varied by the provider setting/professional specialty, they also changed by the type of therapy within each setting/specialty. However, the rate of change differed depending on the therapy discipline. The following three tables indicate the total outpatient therapy payment changes for PT, OT, and SLP services within each provider setting/professional specialty.*

*For PT services (Table 8), from CY 2006-2008 the largest increases in total payments within a setting/specialty were for services billed by NPP (86.1%), SNF (27.4%), PTPP (26.9%), and CORF (25.1%). Only physicians (-10.4%) and hospitals (-2.3%) show a decline in PT payments. However, over the four-year span from CY 2004-2008, only PTPP (40.7%), SNF (20.5%), and NPP (28.3%) saw an increase in total PT payments. In contrast, five other settings/specialties saw a decline in total PT payments from CY 2004-2008. They were; physician (-39.2%), HHA (-32.7%), ORF (-11.0%), CORF (-7.1%), and hospital (-5.5%).*

<sup>37</sup> Appendix C: STATS Excel file – CY 2008\_Utilization Summary

**Table 8. PT payment change by setting/specialty CY 2004-2008**

Provider Setting/ Professional Specialty	Paid 2004	Paid 2006	Paid 2008	Paid Change 2006- 2008	Paid Change 2004- 2008
All	\$3,227,862,000	\$3,053,523,075	\$3,496,854,636	14.5%	8.3%
Provider Settings	\$1,858,801,274	\$1,704,866,337	\$1,884,552,068	10.5%	1.4%
Hospital	\$664,044,726	\$642,122,763	\$627,610,795	-2.3%	-5.5%
SNF	\$604,095,180	\$571,112,627	\$727,817,967	27.4%	20.5%
CORF	\$103,498,704	\$76,857,191	\$96,178,773	25.1%	-7.1%
ORF	\$484,117,205	\$412,937,028	\$430,893,710	4.3%	-11.0%
HHA	\$3,045,459	\$1,836,728	\$2,050,823	11.7%	-32.7%
Professional Specialties	\$1,369,060,726	\$1,347,859,128	\$1,612,302,568	19.6%	17.8%
PTPP	\$975,121,682	\$1,080,773,317	\$1,371,530,877	26.9%	40.7%
OTPP	\$0	\$0	\$0	--	--
Physician	\$391,858,977	\$265,651,823	\$238,103,636	-10.4%	-39.2%
NPP	\$2,080,067	\$1,433,989	\$2,668,054	86.1%	28.3%

For OT services (Table 9), from CY 2006-2008 the largest increases in total payments within a setting/specialty were for NPP (208.7%), HHA (51.0%), CORF (46.7%), ORF (35.5%), SNF (29.7%), and OTTP (23.0%). Only physician (-23.4%) and hospital (-4.2%) saw a decline in OT payments. Over the four-year span from CY 2004-2008, NPP (78.0%), OTTP (33.9%), CORF (30.1%), SNF (26.1%), and ORF (19.5%) saw an increase in total OT payments. In contrast, three other settings/specialties saw a decline in total OT payments from CY 2004-2008. They were; HHA (-25.7%), hospital (-7.7%), and physician (-2.1%).

**Table 9. OT payment change by setting/specialty CY 2004-2008**

Provider Setting/ Professional Specialty	Paid 2004	Paid 2006	Paid 2008	Paid Change 2006- 2008	Paid Change 2004- 2008
All	\$770,874,142	\$747,138,853	\$927,613,680	24.2%	20.3%
Provider Settings	\$693,796,082	\$660,829,831	\$829,086,967	25.5%	19.5%
Hospital	\$122,855,080	\$118,383,851	\$113,450,900	-4.2%	-7.7%
SNF	\$430,765,862	\$418,891,159	\$543,214,946	29.7%	26.1%
CORF	\$49,580,588	\$43,988,726	\$64,513,597	46.7%	30.1%
ORF	\$89,860,719	\$79,205,318	\$107,362,646	35.5%	19.5%
HHA	\$733,834	\$360,777	\$544,879	51.0%	-25.7%
Professional Specialties	\$77,078,060	\$86,309,022	\$98,526,713	14.2%	27.8%
PTPP	\$0	\$0	\$0	--	--
OTTP	\$63,843,109	\$69,471,901	\$85,456,683	23.0%	33.9%
Physician	\$13,101,463	\$16,760,148	\$12,832,412	-23.4%	-2.1%
NPP	\$133,488	\$76,973	\$237,618	208.7%	78.0%

For SLP services (Table 10), from CY 2006-2008 the largest increases in total payments within a setting/specialty were for ORF (57.6%), NPP (41.8%), SNF (30.2%), and physician (6.6%).

*CORF (-18.9%), HHA (-10.6%) and hospital (-2.6%) saw a decline in SLP payments. Over the four-year span from CY 2004-2008, NPP (156.1%), SNF (28.8%), ORF (19.8%), and hospital (3.4%) saw an increase in total SLP payments. In contrast, three other settings/specialties saw a decline in total SLP payments from CY 2004-2008. They were; HHA (-71.1%), CORF (-52.3%), and physician (-2.6%).*

**Table 10. SLP payment change by setting/specialty CY 2004-2008**

Provider Setting/ Professional Specialty	Paid 2004	Paid 2006	Paid 2008	Paid Change 2006- 2008	Paid Change 2004- 2008
All	\$274,637,075	\$270,585,218	\$335,562,982	24.0%	22.2%
Provider Settings	\$271,477,573	\$267,691,225	\$332,471,701	24.2%	22.5%
Hospital	\$51,943,327	\$55,140,799	\$53,716,458	-2.6%	3.4%
SNF	\$202,714,913	\$200,460,734	\$261,054,461	30.2%	28.8%
CORF	\$2,757,804	\$1,620,596	\$1,314,445	-18.9%	-52.3%
ORF	\$13,551,668	\$10,304,075	\$16,238,785	57.6%	19.8%
HHA	\$509,861	\$165,121	\$147,552	-10.6%	-71.1%
Professional Specialties	\$3,159,502	\$2,893,993	\$3,091,281	6.8%	-2.2%
PTPP	\$0	\$0	\$0	--	--
OTPP	\$0	\$0	\$0	--	--
Physician	\$3,151,455	\$2,879,454	\$3,070,668	6.6%	-2.6%
NPP	\$8,048	\$14,539	\$20,613	41.8%	156.1%

*As discussed before regarding all outpatient therapy services, the drivers of these PT, OT and SLP payment trends within each provider setting/professional specialty are complex and include; 1) the implementation of the outpatient therapy caps with exceptions process in CY 2006, 2) the modification of the exceptions process in CY 2007 to eliminate the 'Manual Process Exceptions' due to limited use and limited denial rated by contractors, 3) the ongoing shift of provider enrollment from facilities to office settings and from physician employees under incident-to provisions to PTPP and OTTP employees, and 4) increases in utilization. It is notable that the rate and direction of payment change trends is different by therapy discipline (e.g. PT, OT, and SLP trends vary significantly in the CORF setting) and these differences should be considered. Although the dollar amounts paid to NPPs are currently low, the increases in payment for therapy services in the past 4 years are notable.*

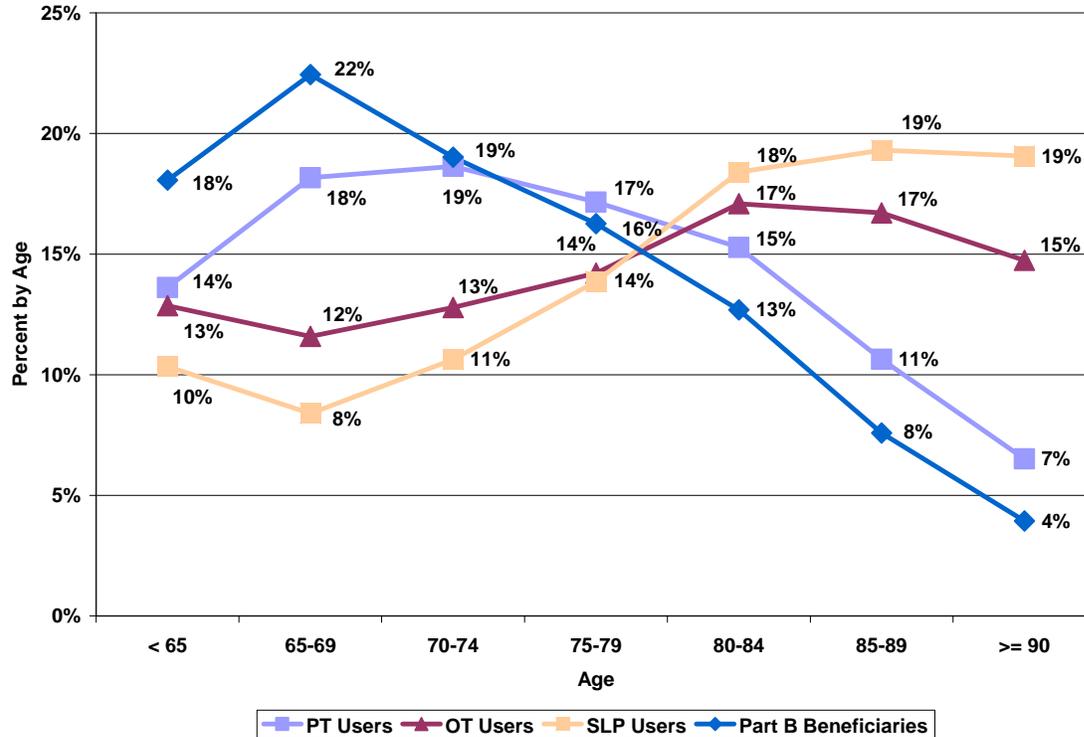
### **3.3 Outpatient Therapy Demographics**

#### **3.3.1 Age demographics**

The age demographic of outpatient therapy users differs from the general Medicare population, and the pattern for the three therapy types differs from each other. As demonstrated in Figure 6, the age distribution of Medicare Part B beneficiaries is skewed toward the younger age groups with a peak at the 65-69 age group (22.4%), with the lowest percent of enrollees in the age 90 or above age group (3.9%). In contrast, outpatient therapy users tend to be older than the general Medicare population. The distribution pattern of PT users was somewhat similar to the general

Medicare population, however, Most PT users were in the 70-74 age group (18.6%) and the fewest (6.5%) were aged 90 or above.

**Figure 6. Outpatient therapy user age demographics in CY 2008<sup>38</sup>**



In contrast, most OT users tended to be in the older age groups as only 11.6 percent of outpatient OT users were in the 65-69 age group, while the 17.1 percent of OT users were in the 80-84 age group. The oldest age group, 90 and above represented 14.7 percent of those all outpatient OT users. The age demographic distribution for outpatient SLP users was similar to the OT user pattern but even more skewed towards older beneficiaries. While only 8.4 percent of outpatient SLP users aged 65-69 received outpatient SLP services, 19.3 percent of SLP users aged 85-89, and 19.1 percent of those aged 90 and above received outpatient SLP services.

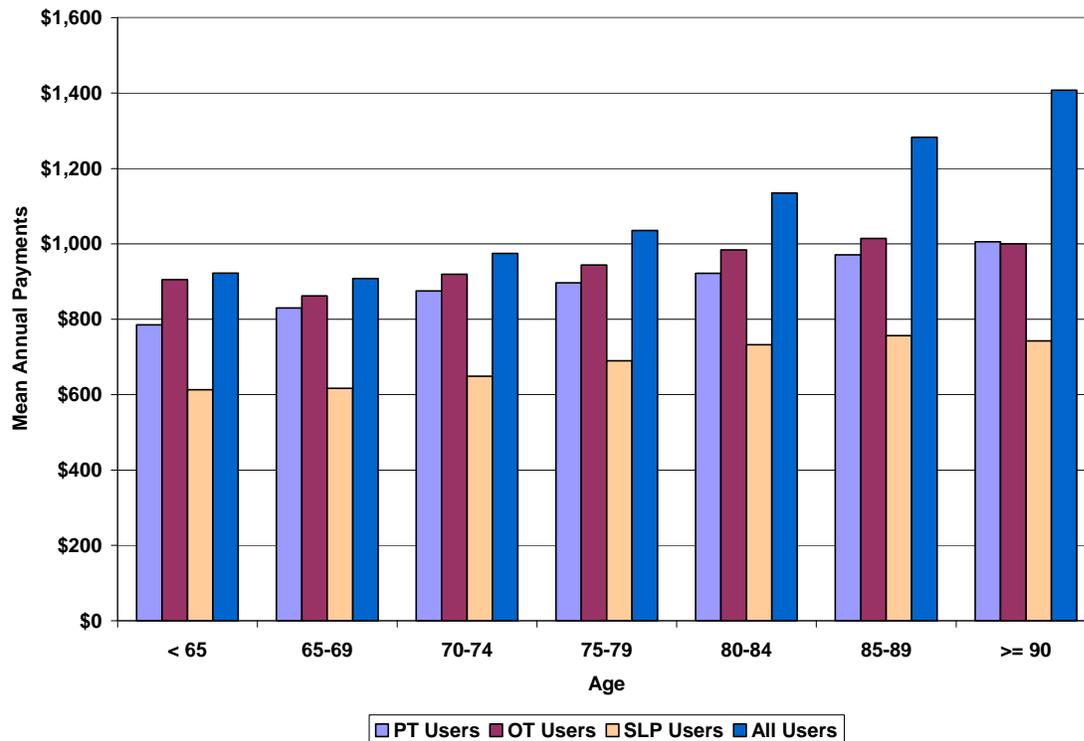
As Figure 7 demonstrates, outpatient therapy mean annual payments per therapy user generally increase with age. For PT services, the lowest mean annual payments were for individuals under age 65, at \$785. The mean annual PT payments increased with each subsequent age group with a peak at age 90 and above of \$1,005. For OT services, the lowest mean annual payment was for individuals under age 65-69, at \$862, while the highest mean annual payment was for individuals age 85-89 at \$1,014. For SLP services, the lowest mean annual payment was for beneficiaries under age 65, at \$613, while those aged 85-89 had the highest mean annual payment of \$757.

When the mean annual payments for all three therapy types are combined, the increase by age is more dramatic. When all three therapy types are combined, individuals age 65-69 only averaged

<sup>38</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

\$908 in annual payments while those aged 90 and above averaged \$1,408. Since the mean annual payments for all users combined, without regard to age group is \$1,057, this reflects that as individual Medicare beneficiaries get older, they are more likely to receive more outpatient therapy services from any individual therapy discipline, and will more likely receive outpatient therapy services from more than one therapy discipline.

**Figure 7. Outpatient therapy annual per-user payments CY 2008 by age<sup>39</sup>**



***Trend Spotlight – Outpatient therapy utilization changes by age CY 2004-2008***

*Outpatient therapy utilization by the beneficiary age demographic remains consistent with patterns observed in prior years.*

**3.3.2 Gender demographics**

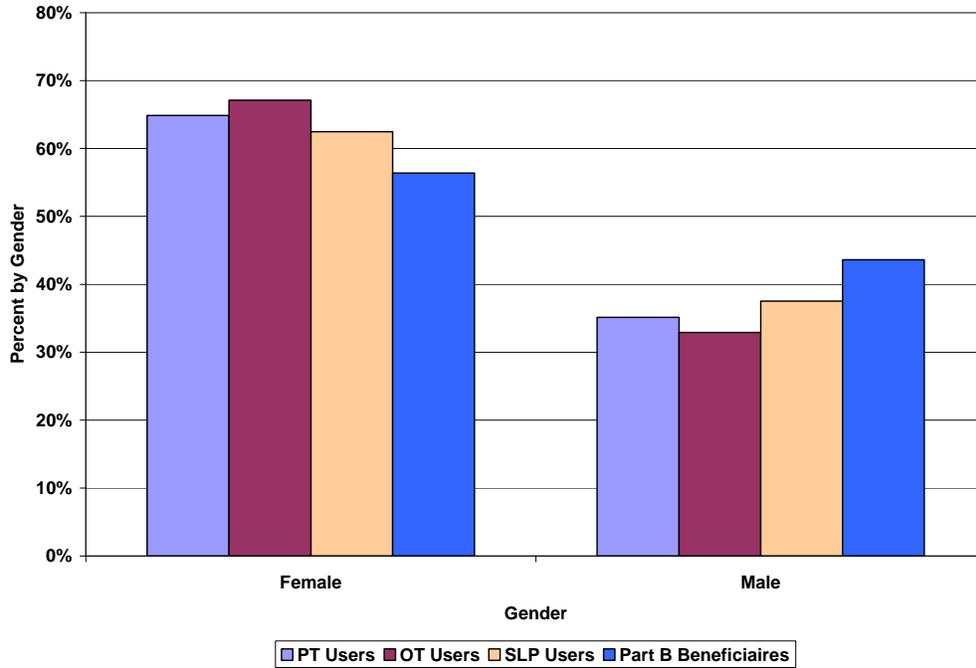
Outpatient therapy users are more likely to be female, regardless of therapy type. As demonstrated in Figure 8, while the ratio of females to males in the general Medicare population is 56.4 percent to 43.6 percent, the percentages of outpatient therapy users that are female are 64.9 percent for PT, 67.1 percent for OT, and 62.5 percent for SLP services.

As Figure 9 demonstrates, outpatient therapy mean annual payments per therapy user by gender were very similar within each therapy type and when all therapy types were combined. For outpatient PT services, the mean annual payments for males of \$890 were slightly higher than that for females, at \$881. For OT services, females, at \$957, had a slightly higher mean annual payment than males, at \$945. The difference in mean annual payments by gender was largest for

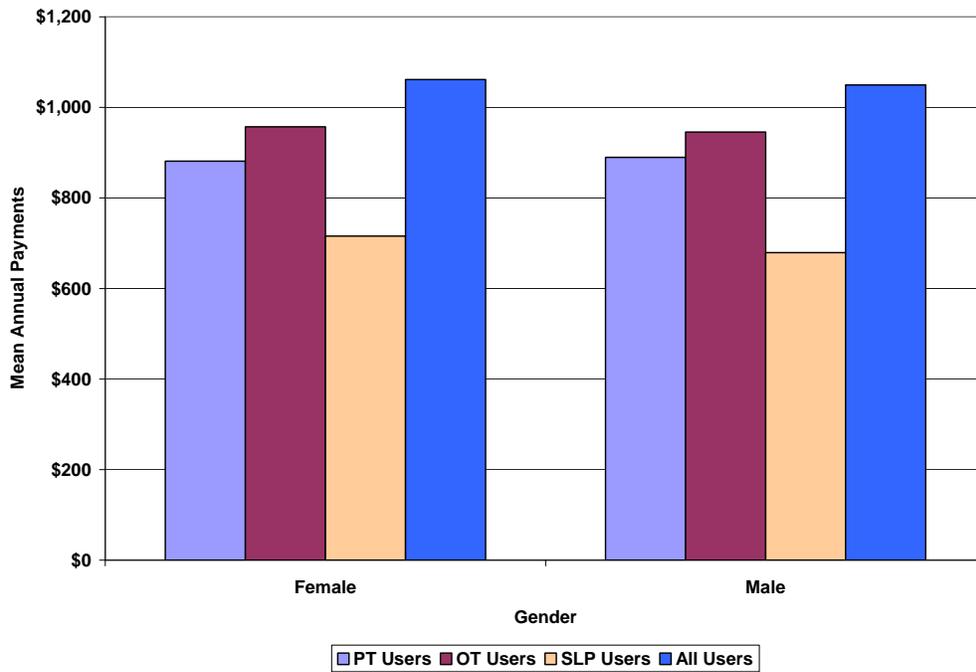
<sup>39</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

SLP services where females averaged \$716, while males averaged \$679. When all three therapy types are combined, the mean annual payment for females of \$1,061 was slightly higher than males, at \$1,049.

**Figure 8. Outpatient therapy user gender demographics in CY 2008<sup>40</sup>**



**Figure 9. Outpatient therapy annual per-user payments CY 2008 by gender<sup>41</sup>**



<sup>40</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

<sup>41</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

### ***Trend Spotlight – Outpatient therapy utilization changes by gender CY 2004-2008***

*Outpatient therapy utilization by the beneficiary gender demographic remains consistent with patterns observed in prior years.*

### **3.3.3 State demographics**

Medicare beneficiary use of outpatient therapy services varies somewhat by geographic region. In general, more populous states had more outpatient therapy users. However, the utilization patterns across states are not identical for the three therapy types. As presented in Table 11, for all outpatient therapy services combined, 33.6 percent of all users lived in five states. Florida led with 8.6 percent, followed by California (8.5%), New York (7.0%), Texas (5.6%), and Illinois (4.8%). For PT services, 33.6 percent of all users lived in five states. California led with 8.8 percent, followed by Florida (8.7%), New York (7.2%), Texas (5.5%), and Illinois (4.8%). For OT services, 32.4 percent of all users lived in 5 states. Florida led with 10.8 percent, followed by California (6.1%), Texas (6.0%), Pennsylvania (5.9%), and Ohio (5.4%). For SLP services, 32.4 percent of all users lived in 5 states. Florida led with 7.4 percent, followed by Texas (6.6%), California (6.6%), Pennsylvania (6.3%), and Ohio (5.7%).

**Table 11. Percent of outpatient therapy users by state<sup>42</sup>**

Rank	PT OT SLP State	Percent of All PT/OT/SLP Users	PT State	Percent of All PT Users	OT State	Percent of All OT Users	SLP State	Percent of All SLP Users
All	All	100.0%	All	100.0%	All	100.0%	All	100.0%
1	FL	8.6%	CA	8.8%	FL	10.8%	FL	7.4%
2	CA	8.5%	FL	8.7%	CA	6.1%	TX	6.6%
3	NY	7.0%	NY	7.2%	TX	6.0%	CA	6.6%
4	TX	5.6%	TX	5.6%	PA	5.9%	PA	6.3%
5	IL	4.8%	IL	4.8%	OH	5.4%	OH	5.7%

Medicare beneficiary use of outpatient therapy services within each state varies by geographic region. As presented in Table 12, some states have a higher proportion of eligible beneficiaries receiving outpatient therapy services than others, and these utilization patterns are not similar for the three therapy types. State geographic size or Medicare beneficiary population does not appear to be a major factor in the observed variations.

For all outpatient therapy services combined, New Hampshire had the highest percentage of Part B enrollees to receive outpatient PT, OT, and/or SLP services at 15.3 percent, followed by Delaware (15.2%), Connecticut (14.9%), Vermont (14.3%), and Maryland (13.7%). This is compared to the national rate of 10.5 percent of beneficiaries in all states receiving outpatient PT, OT, and/or SLP services. The five states with the lowest percentage of PT, OT, and/or SLP users per Part B enrollee were; Hawaii (6.6%), Oregon (7.1%), Nevada (7.6%), West Virginia (7.9%), and Oklahoma (8.1%).

<sup>42</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

Delaware had the highest percentage of Part B enrollees to receive outpatient PT services at 13.8 percent, followed by New Hampshire (13.2%), Connecticut (12.9%), Vermont (12.7%), and New Jersey (12.3%). This is compared to the national rate of 9.3 percent of beneficiaries in all states receiving outpatient PT services. The five states with the lowest percentage of PT users per Part B enrollee were; Hawaii (5.9%), Oregon (6.4%), West Virginia (6.8%), Nevada (6.9%), and Louisiana (7.1%).

Indiana had the highest percentage of Part B enrollees to receive outpatient OT services at 3.8 percent, followed by New Hampshire (3.7%), North Dakota (3.5%), Florida (3.4%), and Connecticut (3.3%). This is compared to the national rate of 2.3% of beneficiaries in all states receiving outpatient OT services. The five states with the lowest percentage of OT users per Part B enrollee were; Hawaii (0.9%), Oregon (1.1%), Arizona (1.2%), Nevada (1.3%), and Utah (1.3%).

The District of Columbia had the highest percentage of Part B enrollees to receive outpatient SLP services at 1.8 percent, followed by Indiana (1.6%), Connecticut (1.6%), Ohio (1.5%), and Missouri (1.5%). This is compared to the national rate of 1.1 percent of beneficiaries in all states receiving outpatient SLP services. The five states with the lowest percentage of SLP users per Part B enrollee were; Nevada (0.5%), Arizona (0.5%), Oregon (0.6%), Hawaii (0.6%), and Alaska (0.7%).

**Table 12. Percent of enrollees in each state using outpatient therapy<sup>43</sup>**

Rank	PT OT SLP State	Percent of Enrollees in State Using PT/OT/SLP	PT State	Percent of Enrollees in State Using PT	OT State	Percent of Enrollees in State Using OT	SLP State	Percent of Enrollees in State Using SLP
All	All	10.5%	All	9.3%	All	2.3%	All	1.1%
1	NH	15.3%	DE	13.8%	IN	3.8%	DC	1.8%
2	DE	15.2%	NH	13.2%	NH	3.7%	IN	1.6%
3	CT	14.9%	CT	12.9%	ND	3.5%	CT	1.6%
4	VT	14.3%	VT	12.7%	FL	3.4%	OH	1.5%
5	MD	13.7%	NJ	12.3%	CT	3.3%	MO	1.5%
47	OK	8.1%	LA	7.1%	UT	1.3%	AK	0.7%
48	WV	7.9%	NV	6.9%	NV	1.3%	HI	0.6%
49	NV	7.6%	WV	6.8%	AZ	1.2%	OR	0.6%
50	OR	7.1%	OR	6.4%	OR	1.1%	AZ	0.5%
51	HI	6.6%	HI	5.9%	HI	0.9%	NV	0.5%

As presented in Table 13, the mean annual expenditures per outpatient therapy user varied notably between states, with therapy users in some states receiving extensively more outpatient therapy on average than therapy users in other states. State geographic size or Medicare beneficiary population does not appear to be a major factor in the observed variations. However, the observed patterns differed by state depending upon the type of therapy furnished, indicating potential regional differences in practice patterns or the accessibility of the three different outpatient therapy disciplines.

<sup>43</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

**Table 13. Mean annual paid per therapy user by state<sup>44</sup>**

Rank	PT OT SLP State	Mean Paid per PT/OT/S LP User	PT State	Mean Paid per PT User	OT State	Mean Paid per OT User	SLP State	Mean Paid per Therapy User
All	All	\$1,057	All	\$884	All	\$953	All	\$702
1	FL	\$1,532	NJ	\$1,155	FL	\$1,593	MS	\$1,349
2	LA	\$1,353	FL	\$1,147	MS	\$1,394	LA	\$1,104
3	MS	\$1,336	NY	\$1,146	LA	\$1,225	TX	\$898
4	NJ	\$1,250	MD	\$1,048	TX	\$1,162	WV	\$836
5	TX	\$1,191	DE	\$1,002	WV	\$1,079	FL	\$831
47	MT	\$652	OR	\$594	MN	\$487	SD	\$423
48	OR	\$645	WI	\$582	OR	\$486	MT	\$419
49	IA	\$590	IA	\$521	MT	\$479	ND	\$411
50	MN	\$587	MN	\$494	IA	\$415	NY	\$394
51	ND	\$485	ND	\$416	ND	\$357	IA	\$356

For all outpatient therapy services combined, Florida outpatient therapy users had the highest mean annual payments for outpatient PT, OT, and/or SLP services at \$1,532, followed by Louisiana (\$1,353), Mississippi (\$1,336), New Jersey (\$1,250), and Texas (\$1,191). This is compared to the national mean annual payment of \$1,057 for beneficiaries in all states receiving outpatient PT, OT, and/or SLP services. The five states with the lowest percentage of PT, OT, and/or SLP mean annual payments were; North Dakota (\$485), Minnesota (\$587), Iowa (\$590), Oregon (\$645), and Montana (\$652). The variance in mean annual payments from the state with the highest mean payment, Florida (\$1,532), and the state with the lowest mean payment, North Dakota (\$485), is \$1,047.

New Jersey PT users had the highest mean annual PT payments at \$1,155, followed by Florida (\$1,147), New York (\$1,146), Maryland (\$1,048), and Delaware (\$1,002). This is compared to the national mean annual PT payment of \$884 for beneficiaries in all states receiving outpatient PT services. The five states with the lowest mean annual PT payments were; North Dakota (\$416), Minnesota (\$494), Iowa (\$521), Wisconsin (\$582), and Oregon (\$594). The variance in mean annual PT payments from the state with the highest mean payment, New Jersey (\$1,155), and the state with the lowest mean payment, North Dakota (\$416), is \$739.

Florida OT users had the highest mean annual OT payments at \$1,593, followed by Mississippi (\$1,394), Louisiana (\$1,225), Texas (\$1,162), and West Virginia (\$1,079). This is compared to the national mean annual OT payment of \$953 for beneficiaries in all states receiving outpatient OT services. The five states with the lowest mean annual OT payments were; North Dakota (\$357), Iowa (\$415), Montana (\$479), Oregon (\$486), and Minnesota (\$487). The variance in mean annual OT payments from the state with the highest mean payment, Florida (\$1,593), and the state with the lowest mean payment, North Dakota (\$357), is \$1,236.

<sup>44</sup> Appendix C: STATS Excel file – CY 2008\_Demographics

Mississippi SLP users had the highest mean annual SLP payments at \$1,349, followed by Louisiana (\$1,104), Texas (\$898), West Virginia (\$836), and Florida (\$831). This is compared to the national mean annual SLP payment of \$702 for beneficiaries in all states receiving outpatient SLP services. The five states with the lowest mean annual SLP payments were; Iowa (\$356), New York (\$394), North Dakota (\$411), Montana (\$419), and South Dakota (\$423). The variance in mean annual SLP payments from the state with the highest mean payment, Mississippi (\$1,349), and the state with the lowest mean payment, Iowa (\$356), is \$993.

### ***Trend Spotlight – Outpatient therapy utilization changes by state CY 2004-2008***

*Outpatient therapy utilization by state demographic continues to demonstrate a number of variations. In general, more populous states have more therapy users. However, some states have significantly higher proportions of enrolled beneficiaries receiving outpatient therapy services than others, and the mean annual expenditures per outpatient therapy user also vary significantly between states. This pattern is not similar for PT, OT and SLP services, but the patterns for those services are consistent with prior years. In addition, state geographic size or Medicare beneficiary population does not appear to be a major factor in the observed variations. The significant variation in percentage of beneficiaries receiving outpatient therapy in each state, significant variation in mean annual per-beneficiary expenditures, and the variation in these patterns across the three therapy disciplines indicates regional differences in practice and/or accessibility of the three different outpatient therapy disciplines.*

## **3.4 Outpatient Therapy Payment Distribution Percentiles**

A number of different factors influence the provider setting or professional office specialty where an individual receives outpatient therapy services, such as: recommendations from a referring physician or NPP, proximity of the facility or office to the beneficiary's residence, whether the beneficiary requires the services of one or more therapy disciplines, and the clinical characteristics of the beneficiary. These factors, in addition to the beneficiary's response to treatment all impact the amount of therapy services a beneficiary may receive in any given year.

The percentile tables in this section provide an indication of the per-beneficiary Medicare payments provided in CY 2008 for each provider setting/professional specialty as a percentile within each setting/specialty. In other words, the tables indicate the paid dollar threshold for the beneficiary at that particular percentile for all beneficiaries who received services from that setting/specialty or outpatient therapy discipline reported by the columns.

### **3.4.1 Payment distribution percentiles by provider setting and professional specialty**

Table 14 provides an indication of the per-beneficiary Medicare payments provided in CY 2008 for PT, OT and SLP services combined in each provider setting and by each professional office specialty as a percentile within each setting/specialty. All payments issued for outpatient therapy services to all nine settings/specialties are included in these tables.

For all beneficiaries in all settings, the highest Medicare payment for an individual in CY 2008 for all PT, OT, and/or SLP services was \$68,567 from the PTPP enrolled specialty. It is unknown if this patient was treated in a physical therapist's private practice office, a physician's

office, or a NPP office. However, in this instance, since PTPP specialty was identified, the services billed at the claim line can be directly linked to a physical therapist, either billing independently, or as an employee or contractor to a physician or NPP.

**Table 14. Payment distribution percentiles for all outpatient therapy services by setting/specialty<sup>45</sup>**

Percentile	All Paid	Hospital Paid	SNF Paid	CORF Paid	ORF Paid	HHA Paid	PTPP Paid	OTPP Paid	Physician Paid	NPP Paid
100th	\$68,567	\$48,877	\$56,949	\$29,856	\$39,598	\$12,453	\$68,567	\$21,095	\$43,686	\$16,517
99th	\$7,988	\$3,588	\$11,692	\$12,476	\$8,230	\$6,060	\$5,074	\$4,652	\$4,714	\$6,005
98th	\$5,968	\$2,722	\$9,330	\$10,570	\$6,089	\$4,573	\$3,953	\$3,642	\$3,204	\$3,968
97th	\$4,891	\$2,280	\$8,009	\$9,548	\$5,150	\$3,782	\$3,363	\$3,046	\$2,556	\$2,821
96th	\$4,174	\$2,005	\$7,113	\$9,057	\$4,281	\$3,015	\$2,972	\$2,722	\$2,124	\$2,002
95th	\$3,672	\$1,807	\$6,456	\$8,438	\$3,688	\$2,514	\$2,688	\$2,460	\$1,838	\$1,565
94th	\$3,291	\$1,655	\$5,926	\$7,803	\$3,303	\$2,138	\$2,472	\$2,240	\$1,628	\$1,424
93rd	\$2,997	\$1,531	\$5,490	\$7,190	\$3,034	\$1,925	\$2,294	\$2,065	\$1,474	\$1,303
92nd	\$2,787	\$1,428	\$5,121	\$6,716	\$2,852	\$1,799	\$2,141	\$1,910	\$1,448	\$1,206
91st	\$2,584	\$1,339	\$4,796	\$6,491	\$2,678	\$1,593	\$2,013	\$1,785	\$1,390	\$1,092
90th	\$2,407	\$1,263	\$4,516	\$6,260	\$2,499	\$1,468	\$1,900	\$1,674	\$1,318	\$999
89th	\$2,252	\$1,196	\$4,266	\$6,081	\$2,334	\$1,432	\$1,802	\$1,577	\$1,244	\$917
88th	\$2,116	\$1,136	\$4,045	\$5,873	\$2,189	\$1,326	\$1,713	\$1,497	\$1,175	\$853
87th	\$1,996	\$1,082	\$3,845	\$5,642	\$2,067	\$1,251	\$1,635	\$1,448	\$1,113	\$789
86th	\$1,889	\$1,033	\$3,661	\$5,339	\$1,957	\$1,182	\$1,564	\$1,415	\$1,054	\$744
85th	\$1,792	\$987	\$3,490	\$4,977	\$1,858	\$1,139	\$1,503	\$1,363	\$1,001	\$702
84th	\$1,705	\$946	\$3,335	\$4,572	\$1,767	\$1,084	\$1,448	\$1,318	\$953	\$660
83rd	\$1,625	\$907	\$3,194	\$4,277	\$1,686	\$1,026	\$1,448	\$1,266	\$908	\$618
82nd	\$1,553	\$872	\$3,062	\$4,024	\$1,610	\$987	\$1,418	\$1,218	\$865	\$578
81st	\$1,490	\$839	\$2,941	\$3,753	\$1,543	\$949	\$1,382	\$1,167	\$826	\$541
80th	\$1,448	\$808	\$2,840	\$3,578	\$1,487	\$906	\$1,345	\$1,121	\$789	\$505
75th	\$1,240	\$679	\$2,362	\$2,980	\$1,306	\$739	\$1,175	\$921	\$639	\$376
50th	\$575	\$310	\$1,067	\$1,389	\$694	\$276	\$621	\$365	\$237	\$109
25th	\$223	\$111	\$428	\$508	\$331	\$80	\$287	\$124	\$72	\$35

There are significant differences between each setting/specialty regarding the amount of payments issued for PT, OT, and SLP services combined at each percentile threshold. At each percentile reported except 100th, CORF had the highest payment for an individual. For example, at the 95<sup>th</sup> percentile, CORF had the highest beneficiary payment at \$8,438, followed by SNF (\$6,456), and ORF (\$3,688), all which were higher than the \$3,672 representing the paid amount at the 95<sup>th</sup> percentile for all settings/specialties combined. It is notable that these three settings typically offer multiple discipline services and often more complex clinical conditions, which may account, in part, to the higher payments at similar percentiles. The settings/specialties with 95<sup>th</sup> percentile payment thresholds at the lowest levels were NPP (\$1,565), hospital (\$1,807), and physician (\$1,838). It is notable that these three settings commonly provide single discipline services to individual beneficiaries who may have less complex clinical conditions, which may account, in part, for the lower payments at similar percentiles.

<sup>45</sup> Appendix C: STATS Excel file – CY 2008\_Percentile

***Trend Spotlight – Outpatient therapy per-beneficiary utilization percentile changes by setting/specialty CY 2004-2008***

*Although the per-beneficiary dollar thresholds of each outpatient therapy setting/specialty percentile have increased since CY 2006, the relative proportion of the percentile tables across settings/specialties remains consistent. For example, CORF, SNF and ORF demonstrate higher per-beneficiary payments at similar percentiles and NPP, hospital, and physician providers/settings demonstrate lower payments at similar percentiles.*

**3.4.2 Payment distribution percentiles by therapy type**

Table 15 provides an indication of the per-beneficiary Medicare payments provided in CY 2008 for PT, OT, SLP, and PT/SLP combined services as a percentile within each therapy type. All payments issued for outpatient therapy services to all nine settings/specialties are included in these tables.

**Table 15. Payment distribution percentiles for all outpatient therapy services by therapy type<sup>46</sup>**

Percentile	All Paid	PT Paid	OT Paid	SLP Paid	PT/SLP Paid
100th	\$68,567	\$68,567	\$25,677	\$23,911	\$68,567
99th	\$7,988	\$5,263	\$5,987	\$4,616	\$5,720
98th	\$5,968	\$4,132	\$4,807	\$3,630	\$4,443
97th	\$4,891	\$3,505	\$4,200	\$3,095	\$3,760
96th	\$4,174	\$3,098	\$3,730	\$2,730	\$3,297
95th	\$3,672	\$2,804	\$3,368	\$2,469	\$2,970
94th	\$3,291	\$2,569	\$3,100	\$2,260	\$2,714
93rd	\$2,997	\$2,373	\$2,888	\$2,085	\$2,503
92nd	\$2,787	\$2,210	\$2,701	\$1,939	\$2,323
91st	\$2,584	\$2,070	\$2,524	\$1,818	\$2,172
90th	\$2,407	\$1,950	\$2,361	\$1,707	\$2,040
89th	\$2,252	\$1,845	\$2,217	\$1,610	\$1,926
88th	\$2,116	\$1,751	\$2,094	\$1,523	\$1,824
87th	\$1,996	\$1,668	\$1,983	\$1,456	\$1,733
86th	\$1,889	\$1,593	\$1,881	\$1,393	\$1,652
85th	\$1,792	\$1,527	\$1,790	\$1,335	\$1,578
84th	\$1,705	\$1,469	\$1,709	\$1,280	\$1,514
83rd	\$1,625	\$1,448	\$1,635	\$1,232	\$1,461
82nd	\$1,553	\$1,415	\$1,564	\$1,184	\$1,448
81st	\$1,490	\$1,372	\$1,503	\$1,136	\$1,405
80th	\$1,448	\$1,332	\$1,467	\$1,089	\$1,361
75th	\$1,240	\$1,138	\$1,265	\$902	\$1,161
50th	\$575	\$562	\$521	\$364	\$561
25th	\$223	\$232	\$157	\$109	\$223

For all beneficiaries in all settings, the highest Medicare payment for an individual in CY 2008 for all PT, OT, and/or SLP services was \$68,567 for PT services. Since the same result is identified at the 100<sup>th</sup> percentile for PT/SLP services combined, it is clear that this individual only received PT services during CY 2008.

<sup>46</sup> Appendix C: STATS Excel file – CY 2008\_Percentile

There are notable differences between each therapy type regarding the amount of payments issued for outpatient therapy services at each percentile threshold. For example, at the 95<sup>th</sup> percentile all therapies combined had the highest beneficiary payment at \$3,672, followed by OT (\$3,368), PT/SLP combined (\$2,970), PT (\$2,804), and SLP (\$2,469). This pattern was generally consistent at the top 50 percentiles with the exception that the order of OT and All Paid percentile payments reversed in magnitude below the 85<sup>th</sup> percentile.

***Trend Spotlight – Outpatient therapy per-beneficiary utilization percentile changes by therapy type CY 2004-2008***

*Although the per-beneficiary dollar thresholds of each outpatient therapy setting/specialty percentile have increased since CY 2006, the relative proportion of the percentile tables across disciplines remains consistent. For example, OT services demonstrate higher per-beneficiary payments at similar percentiles and SLP services demonstrate lower payments at similar percentiles.*

**3.5 HCPCS Utilization**

**3.5.1 Most frequently reported HCPCS**

During CY 2008, 150 million outpatient therapy service claim lines received payments totaling \$4.76 billion. The mean paid amount per claim line was \$31.72. As Table 16 presents, a total of 15 HCPCS codes account for 94 percent of all claim lines and 95 percent of total payments.

**Table 16. Most frequently reported outpatient therapy HCPCS codes<sup>47</sup>**

HCPCS Code	Number of Claim Lines	Total Allowed	Total Paid	Mean Allowed per Line	Mean Paid per Line	Percent of Total Lines	Percent of Total Paid
All	150,109,065	5,993,274,964	\$4,761,679,039	\$39.93	\$31.72	100.00%	100.00%
97110	49,241,140	2,415,868,309	\$1,918,666,705	\$49.06	\$38.96	32.80%	40.29%
97140	17,611,730	589,126,510	\$466,395,765	\$33.45	\$26.48	11.73%	9.79%
97530	16,493,243	713,829,862	\$569,112,777	\$43.28	\$34.51	10.99%	11.95%
97112	12,124,813	450,627,756	\$358,870,206	\$37.17	\$29.60	8.08%	7.54%
G0283	9,424,321	106,092,269	\$84,094,458	\$11.26	\$8.92	6.28%	1.77%
97116	9,384,542	261,049,120	\$208,612,417	\$27.82	\$22.23	6.25%	4.38%
97035	7,004,079	80,606,191	\$63,791,270	\$11.51	\$9.11	4.67%	1.34%
97535	4,714,019	214,315,167	\$171,263,350	\$45.46	\$36.33	3.14%	3.60%
97001	4,195,428	289,757,567	\$226,015,713	\$69.07	\$53.87	2.79%	4.75%
97032	3,038,233	57,478,800	\$45,470,257	\$18.92	\$14.97	2.02%	0.95%
92526	2,830,682	228,513,834	\$182,801,479	\$80.73	\$64.58	1.89%	3.84%
97150	1,752,846	31,003,841	\$24,695,816	\$17.69	\$14.09	1.17%	0.52%
92507	1,513,370	93,791,514	\$75,002,206	\$61.98	\$49.56	1.01%	1.58%
97124	1,240,661	32,188,705	\$25,506,985	\$25.94	\$20.56	0.83%	0.54%
97113	1,162,921	99,307,975	\$78,872,047	\$85.40	\$67.82	0.77%	1.66%

<sup>47</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

Most notably, HCPCS code 97110 (Therapeutic exercises) accounts for 33 percent of all claim lines and 40 percent of all outpatient therapy payments. The next two most frequently reported and paid outpatient therapy HCPCS codes were 97140 (Manual therapy) and 97530 (Therapeutic activities), which accounted for 12 and 11 percent of the total claim lines each, and 10 and 12 percent of the total outpatient therapy payments each. In total, these three HCPCS codes accounted for 54 percent of all outpatient therapy claim lines and 60 percent of all outpatient therapy payments.

### 3.5.2 HCPCS - Percent of claim lines by setting

Comparing the relative HCPCS code use patterns of the nine outpatient therapy provider settings, and professional office specialties, reveals different patterns of treatment approaches. These differences may be related to variations in patient populations, conditions being treated, the type of therapy furnished (e.g. PT, OT, or SLP services), and discipline related approaches to treatment. For example, Table 17 indicates that while HCPCS code 97140 (Manual therapy) was used in about 12 percent of all outpatient therapy claim lines, the code was more commonly used in PTPP claim lines (19%), and less commonly reported in SNF claim lines (1%). This is consistent with the fact that PTPPs more commonly treat younger beneficiaries and beneficiaries with orthopedic conditions than SNF settings, and such beneficiaries may be more responsive to manual therapy interventions in PTPP than other procedures more commonly used for SNF users.

**Table 17. Percent of outpatient therapy HCPCS claim lines in each setting/specialty<sup>48</sup>**

HCPCS Code	Percent of Total Lines	Hospital	SNF	CORF	ORF	HHA	PTPP	OTPP	Physician	NPP
97110	32.80%	33.99%	30.12%	23.51%	31.34%	34.50%	34.81%	33.08%	27.85%	23.90%
97140	11.73%	12.52%	0.99%	17.81%	14.75%	3.74%	19.17%	16.00%	14.85%	12.24%
97530	10.99%	5.04%	18.37%	13.56%	11.46%	13.13%	6.91%	13.25%	6.00%	5.57%
97112	8.08%	4.24%	11.31%	6.04%	7.33%	9.64%	7.52%	6.11%	7.47%	8.02%
G0283	6.28%	5.57%	1.62%	9.39%	7.79%	1.66%	9.81%	3.37%	9.18%	7.98%
97116	6.25%	4.18%	12.78%	7.37%	5.69%	15.07%	2.30%	0.16%	0.69%	2.65%
97035	4.67%	5.18%	0.90%	4.69%	5.06%	2.68%	6.81%	5.93%	10.08%	8.47%
97535	3.14%	1.25%	6.39%	5.98%	3.72%	5.63%	0.55%	6.51%	0.62%	3.73%
97001	2.79%	5.62%	1.49%	1.21%	2.60%	4.09%	3.33%	0.07%	1.97%	0.92%
97032	2.02%	0.82%	0.44%	5.18%	1.29%	0.42%	2.61%	1.90%	9.07%	8.45%
92526	1.89%	0.66%	5.67%	0.11%	0.45%	0.92%	0.00%	0.01%	0.05%	0.01%
97150	1.17%	2.45%	0.65%	0.23%	1.87%	0.12%	1.05%	0.39%	0.66%	0.68%
92507	1.01%	1.92%	2.02%	0.19%	0.71%	1.54%	0.01%	0.04%	0.20%	0.11%
97124	0.83%	0.69%	0.20%	0.41%	0.66%	1.30%	0.88%	0.91%	4.48%	3.66%
97113	0.77%	2.02%	0.05%	0.30%	0.95%	0.04%	1.03%	0.10%	0.29%	0.04%

In another example, while HCPCS code 97116 (Gait training) was used for about 6 percent of all outpatient therapy claim lines, the code was more commonly used in 15 percent of HHA and 13 percent of SNF claim lines, while least commonly used in less than 1 percent of OTPP and physician claim lines. This is consistent with the fact that gait training is more likely to be

<sup>48</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

performed under a PT POC and in settings more likely to provide services to temporarily non-ambulatory beneficiaries such as SNF or HHA.

The timed modality code 97035 (Ultrasound) also demonstrated setting/specialty differences as it was most commonly used in 10 percent of physician claim lines and 8 percent of NPP claim lines while the code was only used in less than one percent of SNF claim lines. This may not be unusual as ultrasound is more likely to be used in the very early stages of an orthopedic condition, and such conditions more commonly seen by physician and NPP specialists, while the majority of beneficiaries treated by SNF providers present with sub-acute and chronic conditions.

In addition, physician and NPP use of ultrasound and 97124 (Massage) is also much higher than other provider settings, and PTPP and OTPP specialties and suggests that either there is a difference in treatment approaches, or that there are discernable differences in the clinical presentations of patient populations treated by physician and NPP specialties from other provider setting and PTPP and OTPP specialties.

### 3.5.3 HCPCS - Percent of payments by setting

Since each HCPCS code is priced differently, the relative overall payments to providers/specialties may be impacted depending on the services most frequently billed. Table 18 demonstrates the percentage of each setting/specialty payments related to the 15 most commonly paid outpatient therapy HCPCS codes.

**Table 18. Percent of outpatient therapy HCPCS payments in each setting/specialty**<sup>49</sup>

HCPCS Code	Percent of Total Paid	Hospital	SNF	CORF	ORF	HHA	PTPP	OTPP	Physician	NPP
97110	40.29%	47.01%	30.40%	35.94%	41.65%	38.89%	47.83%	39.17%	38.55%	33.35%
97530	11.95%	5.50%	18.19%	15.41%	13.10%	13.21%	8.20%	16.39%	8.66%	7.21%
97140	9.79%	9.87%	0.81%	15.41%	11.70%	2.85%	17.20%	13.87%	14.65%	12.43%
97112	7.54%	4.30%	9.45%	5.98%	6.90%	8.59%	7.29%	6.18%	10.23%	9.62%
97001	4.75%	8.80%	2.39%	2.52%	4.62%	6.53%	5.80%	0.10%	3.89%	1.64%
97116	4.38%	2.87%	8.35%	5.75%	4.12%	10.77%	1.73%	0.11%	0.55%	2.05%
92526	3.84%	1.21%	10.91%	0.27%	0.92%	1.84%	0.01%	0.01%	0.12%	0.02%
97535	3.60%	1.35%	7.24%	6.17%	4.18%	6.79%	0.50%	8.26%	0.85%	8.56%
G0283	1.77%	1.37%	0.42%	3.31%	2.27%	0.45%	2.91%	0.89%	3.14%	2.41%
97113	1.66%	3.50%	0.11%	0.80%	2.25%	0.15%	2.42%	0.23%	0.82%	0.08%
92507	1.58%	2.78%	2.91%	0.38%	1.15%	2.40%	0.01%	0.06%	0.37%	0.21%
97035	1.34%	1.29%	0.25%	1.64%	1.50%	0.75%	2.04%	1.60%	3.63%	3.07%
97003	1.26%	1.91%	1.94%	1.59%	0.97%	1.84%	0.01%	6.89%	0.45%	0.30%
97032	0.95%	0.31%	0.20%	2.60%	0.58%	0.20%	1.17%	0.87%	6.00%	7.51%
97124	0.54%	0.36%	0.11%	0.29%	0.41%	0.68%	0.57%	0.59%	3.83%	3.33%

While HCPCS code 97110 (Therapeutic exercise) was the most commonly used code for all settings/specialties and also represented the highest percentage of total payments for each setting/specialty, different patterns were present for other, less commonly billed outpatient

<sup>49</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

therapy HCPCS codes. For example, HCPCS code 97530 (Therapeutic activities) represented 12 percent of all outpatient therapy payments; it represented 18 percent of SNF payments while only representing 6 percent of hospital payments. In another example, while the timed modality code 97032 (Electrical stimulation, manual) represented less than 1 percent of all outpatient therapy payments, it represented 4 percent of physician and 3 percent of NPP outpatient therapy payments.

### 3.5.4 Most commonly reported PT HCPCS

As presented in Table 19, the ten most commonly reported outpatient PT HCPCS codes in CY 2008 represent 94 percent of all outpatient PT claim lines and 94 percent of all PT payments. Six of the top ten PT HCPCS codes represent active treatments (97110 – Therapeutic exercise, 97140 – Manual therapy, 97530 – Therapeutic activities, 97112 – Neuromuscular reeducation, 97116 – Gait training, and 97150 – Group therapeutic procedures), one code represents evaluation (97001 – PT evaluation), and three codes represent modalities (G0283 – Electrical stimulation, unattended, 97035 - Ultrasound, and 97032 - Electrical stimulation, manual). The two most commonly reported PT HCPCS represent 48 percent of all PT claim lines, while the six most commonly reported PT HCPCS represent 81 percent of all PT claim lines, indicating that only a few of the 76 available outpatient therapy HCPCS codes describe the vast majority of outpatient PT services.

**Table 19. Most commonly reported PT HCPCS<sup>50</sup>**

HCPCS Code	Number of Claim Lines	Total Allowed	Total Paid	Mean Allowed per Line	Mean Paid per Line	Percent of Total Lines	Percent of Total Paid
All	116,970,982	\$4,410,035,426	\$3,496,854,636	\$37.70	\$29.90	100.00%	100.00%
97110	40,861,541	\$2,028,628,192	\$1,609,508,765	\$49.65	\$39.39	34.93%	46.03%
97140	15,663,155	\$522,875,425	\$413,603,244	\$33.38	\$26.41	13.39%	11.83%
97530	11,004,467	\$458,608,887	\$365,112,308	\$41.67	\$33.18	9.41%	10.44%
97112	9,682,749	\$354,153,229	\$281,748,901	\$36.58	\$29.10	8.28%	8.06%
97116	9,372,585	\$260,708,244	\$208,340,697	\$27.82	\$22.23	8.01%	5.96%
G0283	8,569,611	\$96,337,813	\$76,304,597	\$11.24	\$8.90	7.33%	2.18%
97035	6,325,144	\$72,654,871	\$57,463,080	\$11.49	\$9.08	5.41%	1.64%
97001	4,191,694	\$289,495,316	\$225,815,932	\$69.06	\$53.87	3.58%	6.46%
97032	2,715,918	\$51,494,749	\$40,701,558	\$18.96	\$14.99	2.32%	1.16%
97150	1,531,559	\$27,069,717	\$21,551,239	\$17.67	\$14.07	1.31%	0.62%

<sup>50</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

### 3.5.5 Most commonly reported OT HCPCS

As presented in Table 20, the ten most commonly reported outpatient OT HCPCS codes in CY 2008 represent 93 percent of all outpatient OT claim lines and 97 percent of all OT payments.

**Table 20. Most commonly reported OT HCPCS<sup>51</sup>**

HCPCS Code	Number of Claim Lines	Total Allowed	Total Paid	Mean Allowed per Line	Mean Paid per Line	Percent of Total Lines	Percent of Total Paid
All	27,488,023	1,161,538,485	\$927,613,680	\$42.26	\$33.75	100.00%	100.00%
97110	8,298,577	383,982,328	\$306,569,935	\$46.27	\$36.94	30.19%	33.05%
97530	5,449,072	253,500,308	\$202,627,102	\$46.52	\$37.19	19.82%	21.84%
97535	4,097,082	192,194,558	\$153,686,122	\$46.91	\$37.51	14.90%	16.57%
97112	2,422,002	95,648,592	\$76,465,131	\$39.49	\$31.57	8.81%	8.24%
97140	1,938,649	65,907,286	\$52,524,618	\$34.00	\$27.09	7.05%	5.66%
97003	1,027,121	75,188,399	\$59,831,073	\$73.20	\$58.25	3.74%	6.45%
G0283	848,308	9,684,230	\$7,734,846	\$11.42	\$9.12	3.09%	0.83%
97035	672,053	7,866,552	\$6,262,314	\$11.71	\$9.32	2.44%	0.68%
97542	469,573	21,714,953	\$17,368,613	\$46.24	\$36.99	1.71%	1.87%
97760	344,790	16,022,637	\$12,800,899	\$46.47	\$37.13	1.25%	1.38%

Seven of the top ten OT HCPCS codes represent active treatments (97110 – Therapeutic exercise, 97530 – Therapeutic activities, 97535 – Self-care/home management training), 97112 – Neuromuscular reeducation, 97140 – Manual therapy, 97542 – Wheelchair management, and 97760 – Orthotic(s) management and training), one code represents evaluation (97003 – OT evaluation), and two codes represent modalities (G0283 – Electrical stimulation, unattended and 97035 – Ultrasound). The two most commonly reported OT HCPCS represent 50 percent of all OT claim lines, while the five most commonly reported OT HCPCS represent 81 percent of all OT claim lines, indicating that only a few of the 76 available outpatient therapy HCPCS codes describe the vast majority of outpatient OT services.

### 3.5.6 Most commonly reported SLP HCPCS

As presented in Table 21, the ten most commonly reported outpatient SLP HCPCS codes in CY 2008 represent 99 percent of all outpatient SLP claim lines and 99 percent of all SLP payments. Seven of the top ten SLP HCPCS codes represent active treatments (92526 – Swallowing treatment, 92507 – Speech treatment, 97532 – Development of cognitive skills, 97110 – Therapeutic exercise, 92508 – Speech treatment, group, 97530 – Therapeutic activities, and 97112 – Neuromuscular reeducation), and three codes represent evaluation (92610 – Swallowing evaluation, 92506 – Speech evaluation, and 92611 – Swallowing evaluation, fluoroscopic). The two most commonly reported SLP HCPCS represent 78 percent of all SLP claim lines, while the four most commonly reported SLP HCPCS represent 91 percent of all SLP claim lines, indicating that only a few of the 76 available outpatient therapy HCPCS codes describe the vast majority of outpatient SLP services.

<sup>51</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

**Table 21. Most commonly reported SLP HCPCS <sup>52</sup>**

HCPCS Code	Number of Claim Lines	Total Allowed	Total Paid	Mean Allowed per Line	Mean Paid per Line	Percent of Total Lines	Percent of Total Paid
All	5,583,758	\$419,575,220	\$335,562,982	\$75.14	\$60.10	100.00%	100.00%
92526	2,824,523	\$227,959,898	\$182,359,619	\$80.71	\$64.56	50.58%	54.34%
92507	1,508,520	\$93,458,437	\$74,739,033	\$61.95	\$49.54	27.02%	22.27%
97532	438,860	\$23,516,525	\$18,812,889	\$53.59	\$42.87	7.86%	5.61%
92610	318,815	\$31,414,852	\$25,126,739	\$98.54	\$78.81	5.71%	7.49%
92506	155,121	\$21,647,151	\$17,284,259	\$139.55	\$111.42	2.78%	5.15%
92611	104,216	\$11,038,984	\$8,827,526	\$105.92	\$84.70	1.87%	2.63%
97110	63,518	\$2,565,099	\$2,052,048	\$40.38	\$32.31	1.14%	0.61%
92508	55,392	\$1,612,834	\$1,290,102	\$29.12	\$23.29	0.99%	0.38%
97530	33,318	\$1,429,419	\$1,143,338	\$42.90	\$34.32	0.60%	0.34%
97112	16,606	\$681,521	\$545,113	\$41.04	\$32.83	0.30%	0.16%

***Trend Spotlight – Outpatient therapy HCPCS utilization changes CY 2004-2008***

*The outpatient therapy HCPCS utilization patterns appear consistent with that observed in prior years, both overall and by therapy type. For example, the top fifteen reported outpatient therapy HCPCS overall are identical to those reported in CY 2006 and nearly identical to CY 2004, and the frequency rank is nearly identical. This consistency suggests that the presence or absence of therapy caps does not affect the type of procedures furnished by outpatient therapy clinicians, but may affect procedure volume.*

**3.6 Episode Utilization**

The current outpatient therapy claims reporting requirements create challenges in describing the condition being treated. While professional office claims (CMS 1500 form or electronic equivalent) permit ICD-9 diagnosis codes to be attributed to each claim line, provider setting claims (CMS-450/UB-04 or electronic equivalent) do not have that option. Providers submitting outpatient therapy claims can only report diagnosis at the claim level. Since provider claims contain multiple revenue centers to permit billing for PT, OT, and SLP services, it is not possible to determine whether the principal claim diagnosis or any other diagnosis code on the claim is attributed to the PT, OT, or SLP services being billed. However, with the exception of SNF and CORF provider settings, the vast majority of outpatient therapy claims have only one type of therapy being billed. For the following episode analyses, beneficiary episode diagnosis is determined by the principal claim diagnosis of the first outpatient therapy claim submitted during the identified episode period. Section 2.3 provides more detail regarding episode determination procedures used in this report.

<sup>52</sup> Appendix C: STATS Excel file – CY 2008\_HCPCS\_Professional and CY 2008\_HCPCS\_Provider

### 3.6.1 PT episodes by principal claim ICD-9 code

During CY 2008, 6,865 different ICD-9 diagnosis codes were listed as principal claim diagnoses for 4.6 million outpatient PT episodes. However, most PT episodes were represented by only a few ICD-9 diagnosis codes. As Table 22 indicates, the top 20 most commonly reported principal claim diagnoses for PT services represented 55 percent of all PT episodes.

**Table 22. Most common outpatient PT episodes by principal claim ICD-9<sup>53</sup>**

Episode ICD-9	Number of Episodes	Mean Episode Days	SD Episode Days	Mean Episode Paid	SD Episode Paid	Mean Episode Claim Lines	SD Episode Claim Lines	Percent of Episodes	Cumulative Percent of Episodes
All	4,603,770	11.2	11.7	\$760	\$971	25.4	31.5	100.00%	100.00%
V57.1	544,485	9.7	9.1	\$547	\$602	16.6	18.1	11.83%	11.83%
724.2	356,174	9.6	9.1	\$658	\$953	23.0	27.0	7.74%	19.56%
781.2	220,556	12.9	13.0	\$952	\$1,105	28.8	34.2	4.79%	24.35%
719.41	165,692	10.9	9.8	\$707	\$750	25.4	26.8	3.60%	27.95%
719.46	156,308	10.7	9.5	\$729	\$762	24.0	26.3	3.40%	31.35%
719.7	148,721	14.3	13.7	\$999	\$1,059	32.6	35.5	3.23%	34.58%
723.1	144,684	9.5	8.7	\$617	\$742	24.0	26.3	3.14%	37.72%
728.87	101,206	14.2	14.6	\$937	\$1,056	30.6	36.1	2.20%	39.92%
715.16	85,422	13.0	11.9	\$990	\$1,052	32.9	38.2	1.86%	41.78%
719.45	77,123	9.8	8.9	\$642	\$690	21.2	22.8	1.68%	43.45%
724.02	72,443	11.6	11.0	\$845	\$974	27.4	32.4	1.57%	45.02%
726.10	69,463	12.4	11.3	\$888	\$968	31.7	34.8	1.51%	46.53%
724.4	68,486	11.8	11.4	\$924	\$1,075	34.0	39.6	1.49%	48.02%
729.5	56,309	8.9	9.9	\$582	\$826	20.5	28.7	1.22%	49.24%
715.96	51,682	12.8	11.8	\$961	\$1,177	31.3	36.8	1.12%	50.37%
722.52	48,103	9.8	8.7	\$677	\$727	23.5	25.4	1.04%	51.41%
724.5	44,958	8.8	8.9	\$565	\$689	19.7	24.3	0.98%	52.39%
V43.65	44,190	15.9	11.7	\$1,170	\$1,023	35.0	33.0	0.96%	53.35%
V57.89	44,076	12.2	12.8	\$758	\$907	23.3	28.5	0.96%	54.31%
724.3	41,633	10.7	10.8	\$772	\$1,014	27.9	35.0	0.90%	55.21%

The most commonly reported principal claim ICD-9 code for PT episodes was the nonspecific V57.1 (Care involving the use of rehabilitation procedures, physical therapy) which represented 12 percent of outpatient PT episodes. The second most commonly reported principal claim ICD-9 code for PT episodes was 724.2 (Lumbago - low back pain/syndrome) which represented 8 percent of all outpatient PT episodes. The top 100 principal claim ICD-9 codes represent 80 percent of all PT episodes and 90 percent could be identified by the top 238 principal claim ICD-9 diagnosis codes reported.

### 3.6.2 OT episodes by principal claim ICD-9 code

During CY 2008, 5,851 different ICD-9 diagnosis codes were listed as principal claim diagnoses for 1.1 million outpatient OT episodes. However, most OT episodes were represented by only a few ICD-9 diagnosis codes. As Table 23 indicates, the top 20 most commonly reported principal claim diagnoses for OT services represented 41 percent of all OT episodes. The most commonly reported principal claim ICD-9 code for OT episodes was the nonspecific V57.21 (Care

<sup>53</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_ICD-9\_PT

involving the use of rehabilitation procedures, occupational therapy) which represented 6 percent of outpatient OT episodes. The second most commonly reported principal claim ICD-9 code for OT episodes was 728.87 (Muscle weakness, generalized) which represented 5 percent of all outpatient OT episodes. The top 100 principal claim ICD-9 codes represent 71 percent of all OT episodes and 90 percent could be identified by the top 413 principal claim ICD-9 diagnosis codes reported.

**Table 23. Most common outpatient OT episodes by principal claim ICD-9<sup>54</sup>**

Episode ICD-9	Number of Episodes	Mean Episode Days	SD Episode Days	Mean Episode Paid	SD Episode Paid	Mean Episode Claim Lines	SD Episode Claim Lines	Percent of Episodes	Cumulative Percent of Episodes
All	1,113,346	11.8	13.3	\$833	\$1,041	24.7	32.0	100.00%	100.00%
V57.21	66,559	7.9	9.3	\$490	\$643	14.2	18.9	5.98%	5.98%
728.87	59,659	14.7	14.6	\$1,010	\$1,099	28.1	31.3	5.36%	11.34%
719.7	32,172	15.4	14.8	\$1,101	\$1,144	32.2	34.4	2.89%	14.23%
781.2	31,050	13.7	13.8	\$1,048	\$1,136	31.4	37.6	2.79%	17.02%
V57.1	30,066	8.8	11.0	\$561	\$791	15.0	21.2	2.70%	19.72%
V57.89	28,257	11.6	13.1	\$780	\$973	20.3	25.9	2.54%	22.25%
781.3	21,769	14.9	14.4	\$1,166	\$1,206	30.9	34.0	1.96%	24.21%
331.0	18,841	12.9	13.3	\$820	\$952	22.8	27.7	1.69%	25.90%
781.92	18,777	11.3	12.0	\$701	\$864	18.8	24.4	1.69%	27.59%
354.0	17,186	6.3	7.2	\$431	\$603	15.4	23.0	1.54%	29.13%
436	14,776	16.0	16.8	\$1,101	\$1,285	30.8	37.2	1.33%	30.46%
719.44	14,492	7.1	7.9	\$458	\$582	16.5	21.2	1.30%	31.76%
332.0	14,411	14.6	14.4	\$1,055	\$1,167	28.5	32.9	1.29%	33.05%
728.2	14,381	15.9	16.0	\$1,109	\$1,254	30.8	34.5	1.29%	34.35%
428.0	13,542	14.9	15.1	\$1,027	\$1,152	29.3	33.6	1.22%	35.56%
715.09	13,339	16.0	14.8	\$1,270	\$1,298	36.3	37.0	1.20%	36.76%
719.41	12,983	11.1	10.6	\$742	\$804	24.5	26.2	1.17%	37.93%
401.9	12,307	16.4	16.1	\$1,168	\$1,276	33.3	36.9	1.11%	39.03%
799.3	12,169	13.1	14.1	\$876	\$1,031	24.2	29.6	1.09%	40.13%
780.79	11,524	12.3	14.1	\$804	\$1,009	23.3	30.3	1.04%	41.16%

### 3.6.3 SLP episodes by principal claim ICD-9 code

During CY 2008, 4,432 different ICD-9 diagnosis codes were listed as principal claim diagnoses for 534 thousand outpatient SLP episodes. However, most SLP episodes were represented by only a few ICD-9 diagnosis codes. As Table 24 indicates, the top 20 most commonly reported principal claim diagnoses for SLP services represented 57 percent of all SLP episodes. The most commonly reported principal claim ICD-9 code for SLP episodes was 787.20 – Dysphagia, unspecified which represented 17 percent of all outpatient SLP episodes. When this dysphagia diagnosis code is combined with the other two in the top 20 (787.22 – Dysphagia, oropharyngeal phase and 787.29 – Other dysphagia, this diagnosis group represents 24 percent of all outpatient SLP episodes. The top 100 principal claim ICD-9 codes represent 83 percent of all SLP episodes and 90 percent could be identified by the top 208 principal claim ICD-9 diagnosis codes reported.

<sup>54</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_ICD-9\_OT

**Table 24. Most common outpatient SLP episodes by principal claim ICD-9<sup>55</sup>**

Episode ICD-9	Number of Episodes	Mean Episode Days	SD Episode Days	Mean Episode Paid	SD Episode Paid	Mean Episode Claim Lines	SD Episode Claim Lines	Percent of Episodes	Cumulative Percent of Episodes
All	534,310	8.9	12.1	\$628	\$853	10.5	15.3	100.00%	100.00%
787.20	88,514	4.7	8.1	\$353	\$590	5.4	9.9	16.57%	16.57%
787.22	34,309	9.5	11.5	\$692	\$829	11.0	14.1	6.42%	22.99%
V57.3	30,695	7.0	10.4	\$447	\$616	7.5	11.5	5.74%	28.73%
331.0	15,670	11.0	12.0	\$764	\$853	13.0	15.6	2.93%	31.66%
787.21	14,442	8.7	9.9	\$632	\$701	10.0	12.1	2.70%	34.37%
V57.89	12,519	10.7	13.1	\$693	\$863	12.3	16.7	2.34%	36.71%
728.87	12,423	12.6	13.9	\$879	\$994	15.2	18.3	2.33%	39.04%
436	9,943	13.9	16.2	\$973	\$1,180	16.7	21.4	1.86%	40.90%
332.0	9,575	11.3	12.5	\$824	\$942	13.8	16.9	1.79%	42.69%
719.7	9,144	12.1	13.3	\$844	\$933	14.5	17.3	1.71%	44.40%
290.0	8,975	11.6	12.3	\$818	\$869	13.8	15.9	1.68%	46.08%
784.49	8,272	3.4	4.7	\$249	\$323	3.7	5.9	1.55%	47.63%
781.2	7,752	11.3	12.4	\$795	\$882	13.6	16.4	1.45%	49.08%
V57.1	7,192	9.3	12.2	\$571	\$710	10.0	13.5	1.35%	50.42%
486	7,022	9.8	11.9	\$730	\$877	11.5	14.9	1.31%	51.74%
401.9	6,374	12.8	14.4	\$924	\$1,076	15.9	19.8	1.19%	52.93%
428.0	6,245	10.5	11.9	\$754	\$891	12.7	16.0	1.17%	54.10%
294.8	6,230	10.2	11.9	\$710	\$826	12.1	15.5	1.17%	55.27%
784.5	5,432	7.9	11.6	\$530	\$739	9.1	13.9	1.02%	56.28%
787.29	5,424	4.5	7.6	\$333	\$527	5.1	8.8	1.02%	57.30%

***Trend Spotlight – Outpatient therapy episode changes by ICD-9 CY 2004-2008***

*Eighteen of the top 20 PT, 16 of the top 20 OT, and 14 of the top 20 SLP episode ICD-9 codes, are identical to those reported in CY 2006 suggesting stability in the reporting of outpatient therapy claim diagnoses over time. However, payment policy changes do appear to impact utilization variables within each diagnosis.*

*As Tables 25, 26 and 27 demonstrate, the trends for PT, OT, and SLP episodes suggests that the outpatient therapy caps as implemented in CY 2006 with the exceptions process did not appear to negatively impact initial access to such services as the number of episodes increased over time. However, the decline in mean and SD episode days, mean and SD episode paid, and mean and SD episode claim lines from CY 2004-2006 and the resulting rebound from CY 2006-2008 suggests that the therapy caps negatively impacted how much therapy was provided per episode in CY 2006. The ‘Manual Process Exceptions’ in CY 2006 may have discouraged billing above the cap because following its elimination episodes were billed with durations and costs similar to (for PT services) or higher than (for OT and SLP services) the uncapped year of CY 2004. These affects are most prevalent for ICD-9 codes that have higher than average treatment days, payments, and claim lines per episode.*

<sup>55</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_ICD-9\_SLP

**Table 25. PT episode changes CY 2004-2008**

PT	2004	2006	2008	Change 2006-2008	Change 2004-2008
Number of Episodes	4,315,218	4,477,757	4,603,770	2.8%	6.7%
Mean Episode Days	11.2	10.4	11.2	7.7%	0.0%
SD Episode Days	12.2	10.4	11.7	12.5%	-4.1%
Mean Episode Paid	\$748	\$682	\$760	11.4%	1.6%
SD Episode Paid	\$1,047	\$782	\$971	24.2%	-7.3%
Mean claim Lines	25.1	22.9	25.4	10.9%	1.2%
SD Claim Lines	33.9	26.8	31.5	17.5%	-7.1%
Percent of Therapy Episodes	75.5%	74.5%	73.6%	-1.2%	-2.5%

**Table 26. OT episode changes CY 2004-2008**

OT	2004	2006	2008	Change 2006-2008	Change 2004-2008
Number of Episodes	922,740	1,035,008	1,113,346	7.6%	20.7%
Mean Episode Days	11.0	10.5	11.8	12.4%	7.3%
SD Episode Days	12.5	11.4	13.3	16.7%	6.4%
Mean Episode Paid	\$777	\$722	\$833	15.4%	7.2%
SD Episode Paid	\$1,016	\$858	\$1,041	21.3%	2.5%
Mean claim Lines	21.7	20.7	24.7	19.3%	13.8%
SD Claim Lines	29.3	25.4	32.0	26.0%	9.2%
Percent of Therapy Episodes	16.1%	17.2%	17.8%	3.5%	10.6%

**Table 27. SLP episode changes CY 2004-2008**

SLP	2004	2006	2008	Change 2006-2008	Change 2004-2008
Number of Episodes	480,274	493,794	534,310	8.2%	11.3%
Mean Episode Days	7.5	7.5	8.9	18.7%	18.7%
SD Episode Days	10.6	10.2	12.1	18.6%	14.2%
Mean Episode Paid	\$572	\$548	\$628	14.6%	9.8%
SD Episode Paid	\$820	\$718	\$853	18.8%	4.0%
Mean claim Lines	9.1	8.6	10.5	22.1%	15.4%
SD Claim Lines	14.1	12.5	15.3	22.4%	8.5%
Percent of Therapy Episodes	8.4%	8.2%	8.5%	3.7%	1.2%

### 3.6.4 Episodes by CSC classification groups

As described in the previous sections, there are different treatment patterns observed with regard to the number of treatment days and payments per episode for each ICD-9 code. However, it is inefficient to describe such utilization patterns in an episode-based policy context when several thousand different 3-5 character ICD-9 codes are used. In the future, it may even become more complex when the 3-7 character ICD-10 codes are implemented for dates of service on or after October 1, 2013. Therefore, there is a need to consider mechanisms that consolidate outpatient therapy episodes into a meaningful number of clinical groups that can be compared.

In a prior CSC contracted study analyzing CY 2002 claims<sup>14</sup>, CSC demonstrated that by aggregating the 100 most frequent diagnosis codes into 21 distinct CSC Classification Groups,

reasonably good predictive power could be obtained through regression analysis<sup>56</sup>. A limitation of the initial modeling of the CSC Classification Groups was that only one model was used and was not specific to therapy type. Since the majority of outpatient therapy episodes are for PT services, the lumping of all three disciplines into a single classification model negatively affected the predictive power of the less common OT and SLP episodes. This suggests that any grouping of conditions into categories must be discipline specific in order to result in useful predictors.

In subsequent CSC contracted studies analyzing CY 2004 and CY 2006 claims, CSC refined the methodology to create separate classification groups by therapy type so that PT, OT, and SLP episodes were labeled using criteria based solely on the utilization data specific to their therapy type<sup>10, 57</sup>. In the three new discipline-specific PT, OT, and SLP CSC Classification Group models, 85-90 percent of all episodes within each discipline were identified and classified by the principal claim diagnosis codes. As a result, 24 PT classification groups were represented by 299 ICD-9 codes, 22 OT groups were represented by 300 ICD-9 codes, and 8 SLP groups were represented by 116 ICD-9 codes. The regression analysis of PT, OT, and SLP episodes using the discipline-specific CSC Classification Groups resulted in much improved predictive power for OT and SLP episodes in the CY 2004 and CY 2006 analysis while maintaining reasonably good predictive power for PT episodes.

In this analysis, for consistency purposes, we are using the identical CSC Classification Group model used in the prior CY 2004 and CY 2006 analyses for CY 2008 outpatient therapy claims (see Appendices D, E, and F for the respective PT, OT, and SLP CSC Classification Groups and their associated ICD-9 codes). The current CSC classification groups closely resemble the Body Structures and Functions components of the International Classification of Function, Disability and Health (ICF) adopted by the World Health Organization (WHO) in 2001.

### **3.6.5 PT episodes by CSC classification groups**

In CY 2008, 4.1 million PT episodes were sorted into 24 CSC PT Classification Groups using 299 individual ICD-9 codes as listed in Appendix D. This represents 89.7 percent of all PT episodes. The mean number of episode days for all PT classification group beneficiaries was 11 with a median of 8 days and a SD of 11 days. The mean episode payment for all PT classification group beneficiaries was \$763 with a mean of \$500 and a SD of \$955. The mean and SD for PT episode days and episode payments of the CSC classification group episodes is similar to that of all PT episodes identified by ICD-9 code in the prior section.

The PT episode utilization pattern by CSC Classification Group summarized in Table 28 indicates that the most common condition groups receiving PT services were; Lumbar/Sacral/Thoracic (18.7%), Shoulder/Upper Arm (10.6%), Knee/Leg (10.5%), and

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<sup>56</sup> The regression analysis considers multiple factors (variables) that contribute to the observed differences in Medicare payment per episode. Variables such as age, gender, condition, geography, and other factors can all be analyzed for their relative impact on therapy utilization. A key result of regression analysis is the explanatory power shown in Adjusted R-square. This indicates overall how effective the variables are in helping predict expenditures. The beta coefficients and associated confidence intervals for each factor are used to assess the relative importance and statistical significance of the variable in explaining the expenditure variation.

<sup>57</sup> Ciolek, D. E. and Hwang, W. *CY 2006 Outpatient Therapy Episode Tables*, April 14, 2008. Contract Number GS-35F-802H, Task Order Number HHSM-500-2007-00322G. Note: This report was not posted on the CMS website.

Mobility (10.4%). The PT classification groups with the highest mean episode payments were; Amputation (\$1,280), Neurologic (\$1,111), Mobility (\$979), Multiple Sites (\$977), and Cardiac/Vascular/Pulmonary (\$967). The PT classification groups with the highest mean treatment days per episode were; Amputation (19 days), Skin-Decubitus (17 days), Neurologic (16 days), and Swallowing (16 days).

**Table 28. Outpatient therapy episodes by CSC PT classification group<sup>58</sup>**

CSC Classification Group - PT	Number of Episodes	Percent of Episodes	Mean Episode Days	Median Episode Days	SD Episode Days	Mean Episode Paid	Median Episode Paid	SD Episode Paid
All	4,127,435	100.0%	11	8	11	\$763	\$500	\$955
Amputation	3,887	0.1%	19	12	22	\$1,280	\$777	\$1,619
Ankle/Foot	110,573	2.7%	8	6	9	\$554	\$336	\$737
Cardiac/Vascular/Pulmonary	83,226	2.0%	14	10	16	\$967	\$588	\$1,254
Cervical	254,160	6.2%	10	8	9	\$672	\$462	\$824
Cognitive/Mental	51,543	1.2%	14	11	14	\$896	\$611	\$994
Edema	26,935	0.7%	8	5	11	\$610	\$286	\$955
Elbow/Forearm	12,752	0.3%	9	7	8	\$602	\$428	\$675
Hip/Pelvis/Thigh	193,645	4.7%	11	9	11	\$794	\$546	\$904
Incontinence	6,482	0.2%	6	4	7	\$347	\$164	\$664
Knee/Leg	432,908	10.5%	12	10	11	\$854	\$616	\$938
Lumbar/Sacral/Thoracic	769,922	18.7%	10	8	10	\$701	\$475	\$924
Metabolic	22,475	0.5%	14	9	17	\$937	\$522	\$1,455
Mobility	428,265	10.4%	14	10	13	\$979	\$676	\$1,104
Multiple Sites	192,878	4.7%	14	10	14	\$977	\$663	\$1,123
Neurologic	105,905	2.6%	16	11	17	\$1,111	\$722	\$1,337
Neuromusculoskeletal-Other	193,590	4.7%	10	7	12	\$700	\$410	\$1,177
Shoulder/Upper Arm	439,507	10.6%	12	9	11	\$817	\$574	\$883
Skin-Decubitus	4,738	0.1%	17	8	25	\$838	\$338	\$1,350
Skin-Not Decubitus	8,817	0.2%	11	5	17	\$607	\$224	\$1,045
Spinal Cord	2,240	0.1%	12	4	19	\$911	\$300	\$2,217
Spine	11,322	0.3%	10	8	9	\$641	\$448	\$750
Swallowing	8,974	0.2%	16	12	16	\$995	\$653	\$1,115
Wrist/Hand	42,559	1.0%	9	7	10	\$639	\$402	\$817
Other PT	720,132	17.4%	10	7	10	\$556	\$364	\$674

### 3.6.6 OT episodes by CSC classification groups

In CY 2008, 951 thousand OT episodes were sorted into 22 CSC OT Classification Groups using 300 individual ICD-9 codes as listed in Appendix E. This represents 85.4 percent of all OT episodes. The mean number of episode days for all OT classification group beneficiaries was 12 with a median of 8 days and a SD of 13 days. The mean episode payment for all OT classification group beneficiaries was \$844 with a mean of \$504 and a SD of \$1,037. The mean and SD for OT episode days and episode payments of the CSC classification group episodes is similar to that of all OT episodes identified by ICD-9 code in the prior section.

The OT episode utilization pattern by CSC Classification Group summarized in Table 29 indicates that the most common condition groups receiving OT services were;

<sup>58</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_CSC Classification

Neuromusculoskeletal-other (14.8%), Mobility (12.5%), Neurologic (8.9%), and Wrist/Hand (7.1%). The OT classification groups with the highest mean episode payments were; Knee/Leg (\$1,233), Amputation (\$1,232), Ankle/Foot (\$1,183), and Cervical (\$1,142). The OT classification groups with the highest mean treatment days per episode were; Amputation (18 days), Multiple Sites (15 days), Mobility (14 days), and Neurologic (14 days).

**Table 29. Outpatient therapy episodes by CSC OT classification group**<sup>59</sup>

CSC Classification Group - OT	Number of Episodes	Percent of Episodes	Mean Episode Days	Median Episode Days	SD Episode Days	Mean Episode Paid	Median Episode Paid	SD Episode Paid
All	950,998	100.0%	12	8	13	\$844	\$504	\$1,037
Amputation	1,050	0.1%	18	12	21	\$1,232	\$727	\$1,640
Ankle/Foot	2,783	0.3%	13	13	11	\$1,183	\$1,224	\$1,093
Cardiac/Vascular/Pulmonary	61,094	6.4%	14	10	15	\$994	\$624	\$1,178
Cervical	11,747	1.2%	11	12	9	\$1,142	\$1,219	\$966
Cognitive/Mental	53,211	5.6%	13	9	14	\$850	\$527	\$999
Edema	11,104	1.2%	8	5	10	\$683	\$380	\$918
Elbow/Forearm	26,417	2.8%	9	7	10	\$604	\$378	\$739
Hip/Pelvis/Thigh	18,274	1.9%	14	11	14	\$1,085	\$764	\$1,208
Knee/Leg	18,772	2.0%	12	13	10	\$1,233	\$1,343	\$1,076
Lumbar/Sacral/Thoracic	36,494	3.8%	12	11	11	\$1,054	\$878	\$1,094
Metabolic	21,136	2.2%	14	10	16	\$973	\$577	\$1,229
Mobility	119,332	12.5%	14	10	14	\$1,002	\$664	\$1,105
Multiple Sites	22,766	2.4%	15	12	14	\$1,113	\$784	\$1,186
Neurologic	84,231	8.9%	14	10	16	\$1,004	\$608	\$1,222
Neuromusculoskeletal-Other	140,683	14.8%	13	9	14	\$878	\$545	\$1,056
Shoulder/Upper Arm	48,916	5.1%	12	10	11	\$873	\$610	\$946
Skin	3,942	0.4%	14	9	17	\$918	\$506	\$1,241
Spinal Cord	920	0.1%	11	4	16	\$722	\$289	\$1,134
Swallowing	9,829	1.0%	14	10	15	\$894	\$541	\$1,092
Vision	6,760	0.7%	3	1	4	\$265	\$143	\$364
Wrist/Hand	67,301	7.1%	8	5	9	\$491	\$275	\$644
Other OT	184,236	19.4%	9	5	12	\$596	\$312	\$834

### 3.6.7 SLP episodes by CSC classification groups

In CY 2008, 450 thousand SLP episodes were sorted into 8 CSC SLP Classification Groups using 116 individual ICD-9 codes as listed in Appendix F. This represents 84.2 percent of all SLP episodes. The mean number of episode days for beneficiaries in SLP classification groups was 9 with a median of 5 days and a SD of 12 days. The mean episode payment for beneficiaries in SLP classification group beneficiaries was \$628 with a mean of \$334 and a SD of \$850. The mean and SD for SLP episode days and episode payments of the CSC classification group episodes is similar to that of all SLP episodes identified by ICD-9 code in the prior section.

The SLP episode utilization pattern by CSC Classification Group summarized in Table 30 indicates that the most common condition groups receiving SLP services were; Swallowing (36.3%), Neurologic-Central (10.1%), and Cognitive (10.1%). The SLP classification groups with the highest mean episode payments were; Communication (\$934), Neurologic-Central

<sup>59</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_CSC Classification

(\$862), and Cognitive (\$789). The SLP classification groups with the highest mean treatment days per episode were; Communication (15 days), Neurologic-Central (12 days), and Cognitive (11 days).

**Table 30. Outpatient therapy episodes by CSC SLP classification group** <sup>60</sup>

CSC Classification Group - SLP	Number of Episodes	Percent of Episodes	Mean Episode Days	Median Episode Days	SD Episode Days	Mean Episode Paid	Median Episode Paid	SD Episode Paid
All	449,637	100.0%	9	5	12	\$628	\$334	\$850
Cognitive	45,354	10.1%	11	8	13	\$789	\$549	\$890
Communication	10,463	2.3%	15	11	15	\$934	\$643	\$1,006
Hearing	1,305	0.3%	3	1	7	\$238	\$120	\$351
Neurologic - Central	45,449	10.1%	12	8	15	\$862	\$523	\$1,075
Speech	6,373	1.4%	8	3	12	\$527	\$251	\$735
Swallowing	163,010	36.3%	6	2	10	\$479	\$180	\$703
Voice	12,271	2.7%	3	1	5	\$253	\$138	\$344
Others	165,412	36.8%	10	6	13	\$683	\$398	\$885

***Trend Spotlight – Outpatient therapy episode changes by CSC Classification Groups CY 2004-2008***

*The overall episode utilization patterns for the CSC PT, OT, and SLP classification groups remained relatively stable compared with prior CY 2004 and 2006 results. Episode groups with higher mean episode days and payments remained in the higher groups and the relative proportion of each classification group among all episodes remained consistent. Mean episode payments, mean episode days, and the SD for episode payments and days demonstrated drops in CY 2006 consistent to that described in the prior episodes by principal claim ICD-9 section. Therefore, this classification scheme appears to successfully represent distinct outpatient therapy clinical groups by using only a modest number of groupings to aggregate thousands of different ICD-9 diagnosis codes.*

**3.6.8 Episode regression results for CSC classification groups**

**Purpose of Regression Analysis**

Health-based payment models have used the diagnostic information generated during patient encounters to infer which medical problems are present and the level of a patient’s burden of illness. These payment models typically include demographic and diagnosis profiling methods to account for the variation in health care expenditures for a defined population. Generally referred to as risk adjustment systems, these models consist of two processes: 1) to risk assess and classify an individual’s health status based on demographic and diagnostic information, and 2) to assess the relative risk for incurring health care expenditures across subgroups of patients (or patient classifications). One application of such modeling technique is used to better align the health care resources with actual health care needs of the patient population. The ultimate goal of modeling is to be better able to match expenditures with the health care needs of beneficiaries. Regression analysis presumes that the services furnished were medically necessary.

<sup>60</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_CSC Classification

Regression analysis provides an analysis of how well the model(s) perform. The regression analysis creates a single summary performance measure number, or Adjusted R-Square, for risk-adjustment. With a range of between 0 and 1, the Adjusted R-Square is the proportion of variation in expenditures that the model explains. The higher the R-Square value is, the better the model is at predicting expenditures.

For reference, Ash, et al. report that demographic payment models for Medicare populations that use demographic information only often have Adjusted R-Square values of less than two percent. However, when using a Diagnosis Cost Group (DCG) model that includes age, gender, and diagnosis, Ash, et al. demonstrated that using data analysis and clinical judgment to identify variables that create more homogenous clinical groups, the Medicare population R-Square value improved to nearly nine percent<sup>61</sup>. Following is a discussion of the variables included in this analysis tailored to predict expenditures for episodes of outpatient therapy services.

When constructing this and the prior CSC studies related to outpatient therapy episode utilization during CY 2002<sup>14</sup>, 2004<sup>10</sup>, and 2006<sup>52</sup> we considered many factors that could explain the variation of therapy expenditures. However, purposeful decisions were made to construct these models with the intent to inform CMS in devising payment policies and not for academic exercise. Therefore, some factors that potentially could be used to predict Medicare therapy expenditures were considered, but were excluded from the models. For example, beneficiaries' race/ethnicity background has been shown in a prior study to have significant association with higher or lower Medicare therapy expenditures<sup>16</sup>; however, it is not appropriate that a payment system be partially based on beneficiary's racial/ethnicity characteristics.

The episode time frame is another significant consideration. In the absence of clearly defined outpatient therapy episodes in the CMS claims data, we have opted to construct a data-driven operational definition of an "outpatient therapy episode" to permit regression analysis. Section 2.3 of this report provides details of how episodes were constructed for this report. The impact of prior use of other health care services, including inpatient therapy services, cannot be underestimated when considering the predicted expenditures associated with outpatient therapy services. However, logistic limitations, including the absence of medical review, prevented the inclusion of such analysis in this and the prior CSC studies.

Another way to study the influence of certain variables on therapy services is to look at the outcomes, rather than expenditures. Unlike some Part A payment systems (e.g. SNF, home health, IRF), the current Medicare Part B data system does not have any mechanism to measure each beneficiary's functional ability, restoration potential, or functional outcome<sup>62</sup>. In recent years there has been an increase in activity from the therapy professional associations and private industry to develop national outpatient therapy outcomes databases that may contribute to a better understanding of appropriate outcomes. In addition, the currently ongoing CMS DOTPA study is developing and testing an outpatient therapy outcomes measurement tool that could

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<sup>61</sup> Ash, A., et al. *Health Care Financing Review* 2000; 21:7-28.

<sup>62</sup> Even the Part A payment system functional measurements are extremely limited and are not specific to therapy services. They generally serve only to identify and classify beneficiaries for resource needs of all inpatient (or home health services) and are not tailored to identify specific therapy resource needs or functional outcomes.

potentially generate clinical data that would be useful in future outpatient therapy episode predictive modeling.

A new payment method based on such requirement is not feasible, at least in the short term.

In addition, based on current payment policies, we decided to separate PT, OT, and SLP services when defining therapy episodes. As a result, each PT episode includes only PT services and associated payments - although it is possible that a beneficiary may have other OT or SLP services during the same period of time. Multiple therapy types during a specific episode may be statistically indicative for the treatment needed for a patient, but inclusion of such a variable would contradict the construction of the dependent variable (Medicare paid amount) that is based solely on only type of therapy service. Moreover, including such a variable in a payment model may generate unintended financial incentives for providers to provide unnecessary multiple types of therapy for payment optimization purposes.

Our regression models do not require Medicare to collect additional information. Factors such as Medicare payment amount, beneficiaries' age, gender, geographic, diagnosis, and types of provider/professional specialty can be extracted from current Medicare data. The regression model is that the Medicare therapy payment per episode (dependent variable) is a function of beneficiaries' age, gender, state of residence, provider setting/professional specialty and ICD-9 diagnosis code (independent variables). The general form of a prediction equation can be expressed as:

$$Y = \alpha + (\beta_1 * X_1) + (\beta_2 * X_2) + (\beta_3 * X_3) + (\beta_4 * X_4) + (\beta_5 * X_5) + \epsilon$$

Where

Y = Medicare paid amount for the therapy episode

X<sub>1</sub> = age

X<sub>2</sub> = gender

X<sub>3</sub> = state

X<sub>4</sub> = provider setting/professional specialty

X<sub>5</sub> = ICD-9 principal claim episode diagnosis

α = Y intercept

β<sub>1</sub> to β<sub>5</sub> = regression coefficients

Because there is more than one explanatory variable (e.g., age, gender, state), each parameter is interpreted as a partial derivative, holding all other variables constant. The regression coefficients are the weights given to each variable. To facilitate the interpretation of regression results, we created a series of dichotomous variables (1 or 0) for each explanatory variable on the right hand side of the equation<sup>63</sup>.

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<sup>63</sup> If, for example, a beneficiary's age is 73, a series of age group variables were created as the following:

Age group 1 (< 65 years old) = 0

Age group 2 (65 – 69 years old) = 0

Age group 3 (70 – 74 years old) = 1

The same techniques are applied to gender, state, setting and ICD-9 diagnostic classification. The reference groups used in the regression models varies per therapy type.

Ordinary least squares (OLS) linear regression is the standard model most commonly applied to continuous outcome data. However, when used for cost data (whose distribution usually is very skewed), assumptions of the method are unlikely to be met. In particular, cost data are likely to be non-normal and heteroscedastic (i.e., not of constant variance) and relationships may not be truly linear. Violation of OLS model assumptions may mean that properties of normality and efficiency of estimators are not achieved; therefore, for cost data, this approach may not provide the best estimates of the average effects in the population. To provide better fits, we therefore transform the cost data (based on natural logarithm) and then apply OLS analysis<sup>64</sup>.

In this, and the prior CSC analyses, we constructed models with independent variables of age, gender, state of residence, provider setting/professional specialty, and clinical classification group. The dependent variable was measured in both raw dollars and on a transformed scale using a natural logarithm of dollars. But to interpret the results, we focus on the models with dependent variable measured in raw dollars. The coefficients for each variable (parameter estimate) represent “real dollars” and are more intuitive for policy analysis purposes.

#### **Four Regression Models**

For this analysis we have constructed four sub-models to test that were identical to those in our prior reports. Model 1: All episodes, includes all outpatient therapy episodes for each outpatient therapy discipline that were placed in the identified CSC Classification Groups for that discipline. Model 2: One-day episodes excluded, is used to truncate the left tail of the distribution to minimize any skewing related to evaluation-only visits that do not result in the development of a follow-on POC. Model 3: Episodes with Medicare payment  $\geq$  99<sup>th</sup> percentile paid excluded, is used to truncate the right tail of the distribution to minimize any skewing related to extremely high-cost episodes. Model 4: One-day episodes and  $\geq$  99<sup>th</sup> percentile paid excluded, is used to truncate both the right and left tails of the distribution to minimize variance due to these outliers.

#### **Results**

Overall, the results indicate that two of the CSC Classification Group models are more effective at predicting Medicare expenditures than the other two models. As demonstrated in Table 31, the strongest results obtained from the four different regression models tested for CY 2008 data are samples that exclude the top one percent cost beneficiary episodes (Model 3); however, the results are only slightly better than the model that includes all episodes (Model 1). The weakest regression results were for the model with samples that excluded one-day episodes (Model 2),

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Age group 4 (75 – 79 years old) = 0

Age group 5 (80 – 84 years old) = 0

Age group 6 (85 – 89 years old) = 0

Age group 7 (90 + ) = 0

One age group is chosen as the reference group and omitted from the right hand side of equation.

<sup>64</sup> For reference, see Briggs, A., Gray, A.. “The distribution of health care costs and their statistical analysis for economic evaluation.” *Journal of Health Services Research and Policy* 1998; 3:233-245.

and the model that excluded one-day episodes and top one percent cost beneficiary episodes (Model 4).

**Table 31. Summary of regression analysis of CSC classification groups for CY 2008<sup>65</sup>**

Multivariate Results (Adjusted R-Square)	PT	OT	SLP
Model 1: All episodes	11.6%	18.6%	24.2%
Model 2: One-day episodes excluded	8.4%	13.6%	9.8%
Model 3: Episodes with Medicare payment >= 99 <sup>th</sup> percentile paid excluded	11.7%	18.7%	24.4%
Model 4: One-day episodes and >= 99 <sup>th</sup> percentile paid excluded	10.3%	13.9%	9.9%

***Trend Spotlight – Change in predictive power of CSC Classification Groups CY 2004-2008***

*The grouping of PT, OT, and SLP episode ICD-9 principal claim diagnoses into a reasonably small number of discipline-specific body structure and function related CSC Classification Groups has resulted in relatively stable utilization results over a span of multiple years. The statistical power of using existing administrative claims data within these CSC Classification Groups to predict outpatient therapy episode expenditures has also remained relatively stable over time. This strongly suggests that this classification scheme could be used as a benchmark to compare the effectiveness of outpatient therapy outcomes tools at predicting episode expenditures.*

*The strongest results obtained from four different regression models over several studies are consistently from samples that exclude the top 1 percent cost beneficiary episodes. For example, the adjusted R-Square for the 24 PT CSC Classification Groups sample that excludes top 1 percent cost episodes in CY 2008 (Model 3) was 11.2 percent, compared to 11.2 percent in CY 2006 and 13.1 percent in CY 2004. The adjusted R-Square for 22 OT CSC Classification Groups Model 3 was 18.7 percent, compared to 17.2 percent in CY 2006 and 18.1 percent in CY 2004. The adjusted R-Square for 8 SLP CSC Classification Group Model 3 was 24.2 percent, compared to 21.8 percent in CY 2006 and 21.8 percent in CY 2004.*

*However the results are consistently only slightly better than the model that includes all episodes (Model 1). The weakest regression results are consistently for samples that exclude single-day episodes (Model 2) and those that exclude single day and top 1 percent cost episodes (Model 4).*

*It is notable that the statistical power of using the existing administrative claims demographic data along with the discipline specific body structure and function related CSC Classification Groups to predict outpatient therapy episode expenditures for the CSC Classification Groups sample that excludes top 1 percent cost episodes in CY 2008 (Model 3) and the CSC Classification Groups sample that includes all episodes (Model 1) is notably stronger than the Medicare population R-Square value of nearly nine percent observed by Ash, et al.<sup>61</sup> when using a Diagnosis Cost Group (DCG) model that includes age, gender, and diagnosis.*

*The consistent outpatient therapy episode paid amount regression results over time using the CSC Classification Group model to aggregate similar episode ICD-9 diagnosis codes, and other*

<sup>65</sup> Appendix C: STATS Excel file – CY 2008\_Episode\_Regression\_OT, CY 2008\_Episode\_Regression\_PT, and CY 2008\_Episode\_Regression\_SLP

*data such as beneficiary age, gender, state, and provider setting/professional office where services are furnished, demonstrate that patient classification and existing administrative claims data could be an important component in the development of a long-term payment model. Further study could add results from functional measurement tools to these administrative data to improve the ability of the classification model to predict outpatient therapy expenditures, which would be necessary for the development of a long-term episode-based payment option.*

## 4 - Outpatient Therapy Cap Impact

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. Since CY 1999, the therapy caps have been under various moratoria, or have been enforced in various formats. In 2004, a moratorium prevented caps from being applied. Since January 2006, the therapy caps have been enforced as originally enacted, with the addition of an exceptions process that CMS was instructed to establish. This process permitted beneficiaries who receive outpatient therapy services in non-hospital settings (SNF, CORF, ORF, or HHA) or from office-based professionals (PTPP, OTPP, SLPP, physician, or NPP) to be able to receive medically necessary services beyond the cap threshold limits. Since outpatient therapy services provided by hospital providers are exempt from the caps, the exceptions process does not apply to hospital furnished outpatient therapy services.

The amount of the PT/SLP combined cap and separate OT cap is adjusted annually based upon the congressionally mandated Medicare Economic Index. During CY 2008, the cap threshold was established at \$1,810 allowed amount, which results in a Medicare paid amount (after any deductibles and 20% coinsurance) of approximately \$1,448 for the PT/SLP combined and separate OT cap limits. The outpatient therapy cap limits are tracked through the Medicare Common Working File (CWF). The CWF is programmed to flag and deny further payments for outpatient therapy services (except for hospital claims) once their annual PT/SLP combined services, or OT services surpass the cap threshold limits established for each individual beneficiary each calendar year.

Without the outpatient therapy cap exceptions process, the only way an individual beneficiary could receive medically necessary services beyond the annual cap threshold amount was to receive services from an outpatient hospital therapy department<sup>66</sup>. However, since the exceptions process applied in CY 2008, beneficiaries who received services from non-hospital provider settings and professional offices could receive outpatient therapy services beyond the cap threshold amounts if the treating clinician determined that additional services were medically necessary per Medicare guidelines. In such situations the non-hospital provider or professional office would append a KX modifier to all services furnished at or above the cap limits for that calendar year<sup>67</sup>. The KX modifier serves as an attestation that the beneficiary's clinical record contains documentation supporting the medical necessity of the services furnished beyond the cap limits. When outpatient therapy claims containing the KX modifier are processed in the

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<sup>66</sup> With the exception of beneficiaries residing in the Medicare certified portion of a SNF, as the SNF consolidated billing requirements prohibit hospitals from receiving payment for outpatient therapy services for such beneficiaries.

<sup>67</sup> As described in Medlearn Matters article #SE0637 – *Use of the KX modifier on Claims Submitted to the Fiscal Intermediary When Some Services Exceed the Therapy Caps*, due to CMS systems limitations, some services under the cap limits in cap-affected provider setting claims (SNF, CORF, ORF, and HHA) may also have the KX modifier appended to the claim line if the cap limit were surpassed at any time during the span of dates of service on the claim. Policy located in Medicare Claims Processing Manual, Chapter 5, Section 10.2.C.6 – *Use of the KX Modifier for Therapy Cap Exceptions*.

CWF, outpatient therapy claim lines containing the KX modifier are paid, even if the beneficiary has already surpassed the annual outpatient therapy cap threshold limit.

As a result of the outpatient therapy cap exceptions process, many beneficiaries in CY 2008 received outpatient therapy services above the cap limit threshold of \$1,810 allowed for PT/SLP services combined or for OT services separate. This section provides an estimate of the impact of the cap exceptions process in terms of how many beneficiaries benefitted from the cap exceptions process, and the dollar impact of the exceptions process. This analysis has particular importance as the outpatient therapy cap exceptions process is due to expire on December 31, 2010. Without further Congressional action, it is likely that the beneficiaries, providers, and professionals that benefitted from the exceptions process will be significantly impacted by the full enforcement of the outpatient therapy caps in CY 2011 and beyond. This section provides information related to the estimated impact overall, by therapy type, by demographic factors (gender, age, and state), by principal claim ICD-9, and by the provider setting or professional office specialty to reveal the beneficiary characteristics most likely to be impacted by the therapy caps if they were fully enforced without the exceptions process.

In the tables below, the total users of therapy services includes users of hospital services. Calculations of therapy users and payments that exceed therapy caps exclude services billed by outpatient hospitals because they were excepted from therapy caps.

## 4.1 Overall Cap Impact

### 4.1.1 PT/SLP combined cap

As presented in Table 32, during CY 2008, 4.2 million beneficiaries received outpatient PT and/or SLP services from all settings, including hospital, accounting for \$3.8 billion in payments. This represents 93.1 percent of all outpatient therapy users and 80.5 percent of all outpatient therapy payments. 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, represent 22.8 percent of all outpatient PT/SLP payments in CY 2008.

**Table 32. Estimated cap impact by therapy type<sup>68</sup>**

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

<sup>68</sup> Appendix C: STATS Excel file – CY 2008\_Cap\_Demographics

#### 4.1.2 OT separate cap

During CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital, accounting for \$928 million in payments. This represents 21.6 percent of all outpatient therapy users and 19.5 percent of all outpatient therapy payments. 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, represent 27.9 percent of all outpatient OT payments in CY 2008.

#### 4.1.3 PT separate (hypothetical cap)

During CY 2008, 4.0 million beneficiaries received outpatient PT services from all settings, including hospital, accounting for \$3.5 billion in payments. This represents 87.8 percent of all outpatient therapy users and 73.4 percent of all outpatient therapy payments. Of these PT users, 578,244 beneficiaries, or 14.6 percent, would have benefitted from the exceptions process and received services beyond the therapy cap threshold of \$1,810 allowed amount (~\$1,448 paid), if there was a separate PT cap. The net payments beyond the hypothetical PT cap threshold, totaling \$726 million, represent 20.8 percent of all outpatient PT payments in CY 2008.

#### 4.1.4 SLP separate (hypothetical cap)

During CY 2008, 478 thousand beneficiaries received outpatient SLP services from all settings, including hospital, accounting for \$336 million in payments. This represents 10.6 percent of all outpatient therapy users and 7.1 percent of all outpatient therapy payments. Of these SLP users, 55,765 beneficiaries, or 11.7 percent would have benefitted from the exceptions process and received services beyond the therapy cap threshold of \$1,810 allowed amount (~\$1,448 paid), if there was a separate SLP cap. The net payments beyond the hypothetical SLP cap threshold, totaling \$66 million, represent 19.7 percent of all outpatient SLP payments in CY 2008.

#### 4.1.5 Estimated impact of separating PT/SLP cap

During CY 2008, 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 \$1.132 billion (Table 33). This means that 23.8 percent of all outpatient therapy payments during CY 2008 were for services furnished above the therapy cap threshold limits. If Congress were to separate the PT/SLP combined cap into separate PT and SLP caps, the estimated net payments above the cap threshold limits would have been \$1.051 billion, or 22.1 percent of total outpatient therapy payments. Although beneficiaries who receive both PT and SLP services would benefit from separating the PT/SLP cap, the estimated difference in payments above the cap limits is only 1.7 percent of total outpatient therapy payments, or \$81 million.

**Table 33. Estimated impact of caps on overall payments<sup>68</sup>**

2008 Estimated Impact of Outpatient Therapy Caps on Overall Payments if Enforced Without Exceptions	Total Net Paid Above Cap Threshold	Percent of Total Payments Paid Above Cap Threshold
Total 3 Caps (PT, OT, SLP)	\$1,051,192,288	22.1%
Total 2 Caps (PT/SLP and OT)	\$1,132,267,820	23.8%
Impact of Separating PT/SLP into separate caps	\$81,075,532	1.7%

***Trend Spotlight – Change in the estimated number of beneficiaries affected by therapy caps CY 2006-2008***

As demonstrated in Table 34, there was a notable increase in the number of individuals that benefitted from the therapy cap exceptions process from CY 2006 to CY 2008. For the Combined PT/SLP cap, the number of therapy users that received services beyond the cap limits increased from 518,443 to 640,937, which represents a 23.6 percent increase over the two-year span. For the separate OT cap, the number of therapy users that received services beyond the cap limits increased from 140,106 to 185,428, which represents a 32.3 increase over the two-year span. Similar increases in the percent increase in beneficiaries benefitting from the cap exceptions process are estimated for the hypothetical PT cap (24.5%) and the hypothetical SLP cap (41.5%).

**Table 34. Change in estimated number of beneficiaries affected by caps CY 2006-2008**

Therapy Type	Number of Therapy Users Over Cap 2006	Number of Therapy Users Over Cap 2008	Percent Change 2006-2008
PT	464,285	578,244	24.5%
OT	140,106	185,428	32.3%
SLP	39,401	55,765	41.5%
PT/SLP	518,443	640,937	23.6%

***Trend Spotlight – Change in the estimated impact of therapy caps on overall payments CY 2006–2008***

As demonstrated in Table 35, there was a sizeable increase in the total net payments of above the outpatient therapy cap threshold limits CY 2006 to CY 2008. For the combined PT/SLP cap, the total net payments above the PT/SLP cap limits that the therapy cap exceptions process permitted increased from \$560 million in CY 2006 to \$874 million in CY 2008. This represents a 55.9 percent increase in total net PT/SLP payments beyond the cap limits during this two-year span. For the separate OT cap, the total net payments above the OT cap limits that the therapy cap exceptions process permitted increased from \$156 million in CY 2006 to \$259 million in CY 2008. This represents a 65.8 percent increase in total net OT payments beyond the cap limits during this two-year span. Similar increases in the total net payments above the outpatient therapy cap limits are estimated for the hypothetical PT cap (54.3%) and the hypothetical SLP cap (70.3%).

**Table 35. Change in estimated impact of caps on overall payments CY 2006-2008**

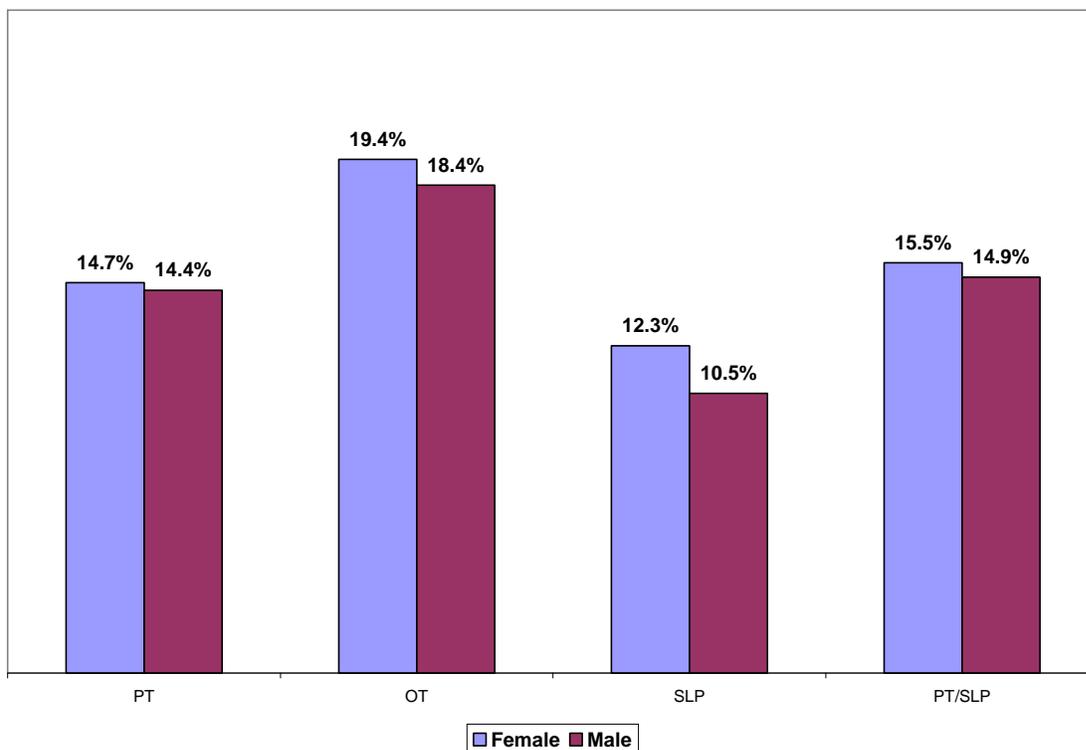
Therapy Type	Total Net Paid Above Cap Threshold 2006	Total Net Paid Above Cap Threshold 2008	Percent Change 2006-2008
PT	\$470,752,490	\$726,384,330	54.3%
OT	\$156,015,036	\$258,709,146	65.8%
SLP	\$38,810,773	\$66,098,812	70.3%
PT/SLP	\$560,286,535	\$873,558,675	55.9%
Total 3 Caps (PT, OT, SLP)	\$665,578,299	\$1,051,192,288	57.9%
Total 2 Caps (PT/SLP and OT)	\$716,301,571	\$1,132,267,820	58.1%
Impact of Separating PT/SLP into separate caps	\$50,723,272	\$81,075,532	59.8%

The primary driver of these increases was the increase in the number of treatment days per episode in CY 2008, which returned to the levels observed prior to the caps being implemented for PT services, and increased beyond the levels observed prior to the caps for OT and SLP services (see Section 3.6). With episodes of longer duration, more beneficiaries surpassed the cap limits, and by a larger dollar amount.

## 4.2 Cap Impact by Gender

As demonstrated in Figure 10, there was a nominal difference in the likelihood of females or males surpassing the outpatient therapy cap threshold limits in CY 2008. For the PT/SLP services combined cap, females surpassed the cap at a rate of 15.5 percent compared to 14.9 percent for males. For OT services the female rate of 19.4 percent was slightly higher than males at 18.4 percent.

**Figure 10. Estimated therapy users within gender surpassing cap threshold in CY 2008<sup>68</sup>**



For the hypothetical PT cap, 14.7 percent of females and 14.4 percent of males surpassed the cap. For the hypothetical SLP cap, 12.3 percent of females and 10.5 percent of males surpassed the cap.

### 4.2.1 PT/SLP combined cap

As presented in Table 36, 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). Females represent 64.7 percent of all PT/SLP users and a similar 65.5 percent of all PT/SLP users that surpassed

the cap limits. The net paid above the cap limits for each female that surpassed the caps was \$1,328, which resulted in a net payment above the CY 2008 PT/SLP cap limits of \$558 million. Males represent 35.3 percent of all PT/SLP users and a similar 34.5 percent of all PT/SLP users that surpassed the cap limits. The net paid above the cap limits for each male that surpassed the caps was \$1,429, which resulted in a net payment above the CY 2008 PT/SLP cap limits of \$316 million.

**Table 36. Estimated cap impact by gender PT/SLP<sup>68</sup>**

Gender	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Gender 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
All	4,194,265	100.0%	640,937	100.0%	15.3%	\$2,811	\$1,363	\$1,801,634,899	\$873,558,675
Female	2,713,077	64.7%	419,857	65.5%	15.5%	\$2,776	\$1,328	\$1,165,573,279	\$557,620,479
Male	1,481,188	35.3%	221,080	34.5%	14.9%	\$2,877	\$1,429	\$636,061,620	\$315,938,796

In general, full enforcement of the outpatient therapy caps without exceptions does not appear to have a disproportionate impact on the likelihood of either gender surpassing the cap limits, as 15.5% of females and 14.9% of males received services above the PT/SLP limits in CY 2008. However, the financial impact is slightly higher in males that do surpass the cap limits, as the mean paid for males that surpassed the PT/SLP cap limits was \$101 greater than that paid for females.

#### 4.2.2 OT separate cap

As presented in Table 37, during CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital. 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). Females represent 67.1 percent of all OT users and a similar 68.2 percent of all OT users that surpassed the cap limits. The net paid above the cap limits for each female that surpassed the caps was \$1,371, which resulted in a net payment above the CY 2008 OT cap limits of \$173 million. Males represent 32.9 percent of all OT users and a similar 31.8 percent of all OT users that surpassed the cap limits. The net paid above the cap limits for each male that surpassed the caps was \$1,447, which resulted in a net payment above the CY 2008 OT cap limits of \$85 million.

**Table 37. Estimated cap impact by gender OT<sup>68</sup>**

Gender	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Gender 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
All	973,222	100.0%	185,428	100.0%	19.1%	\$2,843	\$1,395	\$527,209,067	\$258,709,146
Female	652,979	67.1%	126,503	68.2%	19.4%	\$2,819	\$1,371	\$356,614,540	\$173,438,143
Male	320,243	32.9%	58,925	31.8%	18.4%	\$2,895	\$1,447	\$170,594,527	\$85,270,957

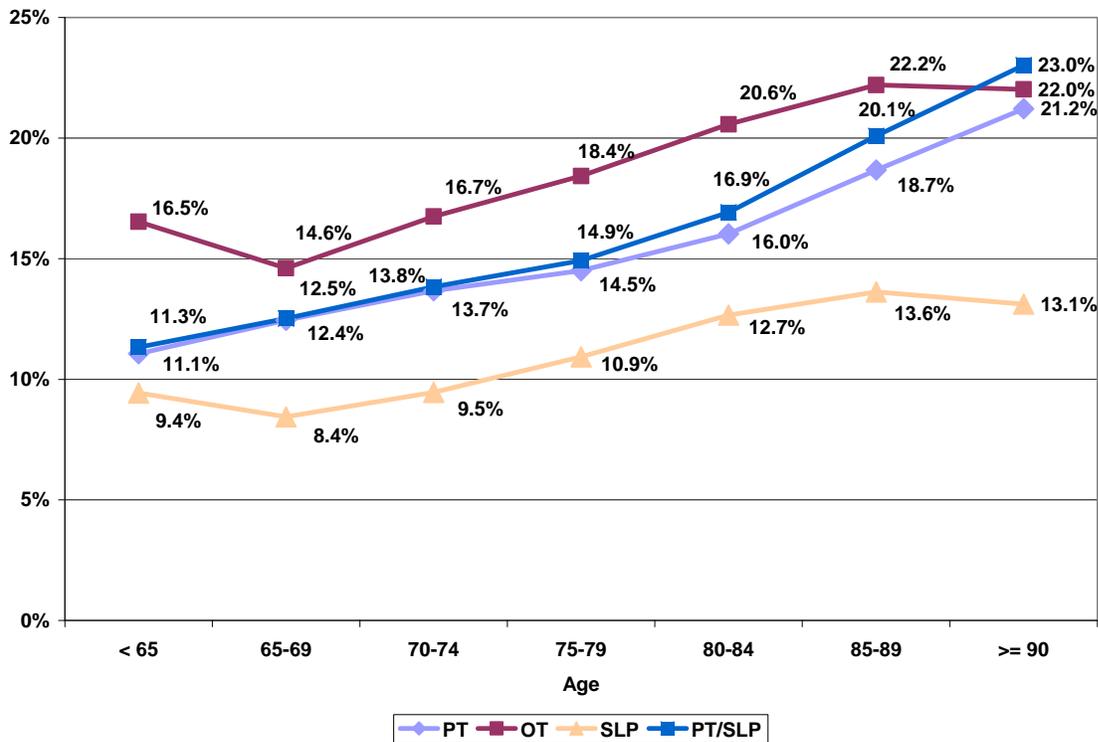
In general, full enforcement of the outpatient therapy caps without exceptions does not appear to have a disproportionate impact on the likelihood of either gender surpassing the cap limits, as 19.4 percent of females and 18.4 percent of males received services above the OT limits in CY 2008. However, the financial impact is slightly higher in males that do surpass the cap limits, as the mean paid for males that surpassed the OT cap limits was \$76 greater than that paid for females.

**Trend Spotlight – Change in the estimated impact of therapy caps by gender CY 2006–2008**  
*Beneficiary gender continues to be a nominal factor in whether a beneficiary would be impacted by the outpatient therapy caps, regardless of therapy type.*

### 4.3 Cap Impact by Age

During CY 2008, the beneficiary’s age appeared to be an important variable in the likelihood that an individual benefitted from the exceptions process and received services beyond the therapy cap threshold. As demonstrated in Figure 11, the age effect pattern was generally consistent across all therapy types as the percentage of beneficiaries within each age group surpassing the cap threshold generally increased with age. Beneficiaries receiving PT/SLP services in the under 65 age group were least likely to surpass the cap limits at 11.3 percent while those in the age 90 or above age group were most likely at 23.0 percent. For OT services, beneficiaries aged 65-69 were least likely to surpass the caps at 14.6 percent, while those aged 85-89 were most likely at 22.2 percent.

**Figure 11. Estimated therapy users within age group over cap threshold in CY 2008<sup>68</sup>**



For the hypothetical PT cap, beneficiaries aged under 65 were least likely to surpass the cap at 11.1 percent while those aged 90 and above were most likely at 21.2 percent. For the hypothetical SLP cap, beneficiaries aged 65-69 were least likely to surpass the cap at 8.4 percent while those aged 85-89 and above were most likely at 13.6 percent.

### 4.3.1 PT/SLP combined cap

As presented in Table 38, 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 PT/SLP cap threshold of \$1,810 allowed amount (~\$1,448 paid).

**Table 38. Estimated PT/SLP cap impact by age in 2008<sup>68</sup>**

Age	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Age 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
All	4,194,265	100.0%	640,937	100.0%	15.3%	\$2,811	\$1,363	\$1,801,634,899	\$873,558,675
< 65	565,964	13.5%	64,104	10.0%	11.3%	\$3,136	\$1,688	\$201,046,740	\$108,224,219
65-69	740,141	17.6%	92,690	14.5%	12.5%	\$2,639	\$1,191	\$244,598,490	\$110,383,594
70-74	763,272	18.2%	105,626	16.5%	13.8%	\$2,703	\$1,255	\$285,534,949	\$132,588,093
75-79	711,546	17.0%	106,165	16.6%	14.9%	\$2,754	\$1,306	\$292,381,293	\$138,654,675
80-84	646,279	15.4%	109,377	17.1%	16.9%	\$2,825	\$1,377	\$308,996,991	\$150,618,692
85-89	464,069	11.1%	93,227	14.5%	20.1%	\$2,886	\$1,438	\$269,066,108	\$134,073,478
>= 90	302,994	7.2%	69,748	10.9%	23.0%	\$2,868	\$1,420	\$200,010,328	\$99,014,958

The age group with the greatest number of beneficiaries surpassing the PT/SLP cap limit in CY 2008 was those aged 80-84, with 109,377, or 17.1 percent. In contrast, only 64,104, or 10.0 percent of beneficiaries who used PT/SLP under age 65 surpassed the PT/SLP cap limit. The distribution of the number of PT/SLP users over the cap limit was a relatively normal distribution, peaking at age 80-84, with the fewest surpassing the caps in the youngest and oldest age groups. However, the percentage of beneficiaries within each age group surpassing the PT/SLP cap demonstrated an increase in each age group from a low of 11.3 percent for those under age 65 to a high of 23.0 percent for those aged 90 and above. This pattern indicates that older beneficiaries are disproportionately more likely to surpass the PT/SLP caps than younger beneficiaries.

In addition, the financial impact of discontinuing the cap exceptions process will be disproportionate depending on beneficiary age. For example, there is a \$497 difference in net paid amounts above the cap limits between beneficiaries who used PT/SLP in the under 65 and the 65-69 age groups that surpassed the cap limits in CY 2008 (\$1,688 paid above cap vs. \$1,191).

### 4.3.2 OT separate cap

As presented in Table 39, during CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital. Of these OT users, 185,428 beneficiaries, or 19.1

percent, benefitted from the exceptions process and received services beyond the OT cap threshold of \$1,810 allowed amount (~\$1,448 paid).

**Table 39. Estimated OT cap impact by age in 2008<sup>68</sup>**

Age	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Age 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
All	973,222	100.0%	185,428	100.0%	19.1%	\$2,843	\$1,395	\$527,209,067	\$258,709,146
< 65	125,198	12.9%	20,701	11.2%	16.5%	\$3,103	\$1,655	\$64,232,469	\$34,257,464
65-69	112,783	11.6%	16,475	8.9%	14.6%	\$2,941	\$1,493	\$48,449,862	\$24,594,045
70-74	124,446	12.8%	20,840	11.2%	16.7%	\$2,955	\$1,507	\$61,581,635	\$31,405,255
75-79	138,310	14.2%	25,491	13.7%	18.4%	\$2,868	\$1,420	\$73,108,645	\$36,197,730
80-84	166,326	17.1%	34,211	18.4%	20.6%	\$2,812	\$1,364	\$96,195,967	\$46,658,330
85-89	162,661	16.7%	36,114	19.5%	22.2%	\$2,745	\$1,297	\$99,118,072	\$46,825,051
>= 90	143,498	14.7%	31,596	17.0%	22.0%	\$2,675	\$1,227	\$84,522,416	\$38,771,452

The age group with the greatest number of beneficiaries surpassing the OT cap limit in CY 2008 was those aged 85-89, with 36,114, or 19.5 percent. In contrast, only 16,475 or 8.9 percent of beneficiaries who used OT aged 65-69 surpassed the OT cap limit. From age 65-69 to age 85-89 the number of users over the OT cap limit increased. Similarly, the percentage of beneficiaries within each age group surpassing the OT cap demonstrated an increase in age, from age 65-69 with a low of 14.6 percent over the cap limit, to a high of 22.2 percent for those aged 85-89. This pattern indicates that older beneficiaries are disproportionately more likely to surpass the OT caps than younger beneficiaries.

In addition, the financial impact of discontinuing the cap exceptions process is disproportionate depending on beneficiary age. For example, there is a \$428 difference in net paid amounts above the cap limits between the beneficiaries who used OT in the under 65 and the age 90 and above age groups that surpassed the cap limits in CY 2008 (\$1,655 paid above cap vs. \$1,227).

***Trend Spotlight – Change in the estimated impact of therapy caps by age CY 2006–2008***

*Older beneficiaries continue to be more likely to be impacted by the outpatient therapy caps as they are more likely to surpass the cap benefit threshold, and when they do, they require more costly services than younger beneficiaries. This pattern is consistent across all three outpatient therapy disciplines and over time.*

**4.4 Cap Impact by State**

During CY 2008, the beneficiary’s state appeared to be an important variable in the likelihood that the individual benefitted from the exceptions process and received services beyond the outpatient therapy cap limits. The state effect pattern was not consistent across all therapy types.

**4.4.1 PT/SLP combined cap**

As presented in Table 40, 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 PT/SLP cap threshold of \$1,810 allowed amount (~\$1,448 paid).

**Table 40. Estimated PT/SLP cap impact by state in 2008 - Ranked by percent of all users across country over cap<sup>68</sup>**

State	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Users in State 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
All	4,194,265	100.0%	640,937	100.0%	15.3%	\$2,811	\$1,363	\$1,801,634,899	\$873,558,675
FL	359,871	8.6%	85,697	13.4%	23.8%	\$2,898	\$1,450	\$248,387,496	\$124,298,357
NY	299,282	7.1%	66,816	10.4%	22.3%	\$2,966	\$1,518	\$198,199,809	\$101,450,074
CA	363,191	8.7%	66,792	10.4%	18.4%	\$2,786	\$1,338	\$186,107,929	\$89,393,077
NJ	155,477	3.7%	35,280	5.5%	22.7%	\$2,708	\$1,260	\$95,538,347	\$44,452,800
PA	188,890	4.5%	34,489	5.4%	18.3%	\$2,676	\$1,228	\$92,288,334	\$42,348,353
DC	7,462	0.2%	1,053	0.2%	14.1%	\$3,040	\$1,592	\$3,200,811	\$1,676,071
WY	8,877	0.2%	937	0.1%	10.6%	\$2,613	\$1,165	\$2,448,040	\$1,091,268
SD	13,271	0.3%	931	0.1%	7.0%	\$2,613	\$1,165	\$2,432,432	\$1,084,345
ND	11,774	0.3%	382	0.1%	3.2%	\$2,205	\$757	\$842,433	\$289,296
AK	5,960	0.1%	333	0.1%	5.6%	\$2,253	\$805	\$750,288	\$268,105

Among 50 states and the District of Columbia, the state of Florida had the greatest number of PT and/or SLP users that surpassed the PT/SLP cap limit in CY 2008. These 86 thousand beneficiaries represent 13.4 percent of all PT/SLP users over the cap threshold. Florida and the other four states with the greatest number of beneficiaries who surpassed the PT/SLP cap limits (New York, California, New Jersey, and Pennsylvania) represent 45.1 percent of all beneficiaries who surpassed the PT/SLP cap limits in CY 2008. In addition, the net \$402 million paid above the PT/SLP cap limits in these five states represent 46.0 percent of all net payments above the PT/SLP cap limits. In contrast, Alaska had the fewest number of beneficiaries surpass the PT/SLP caps, at 333 (0.1%) followed by North Dakota, South Dakota, Wyoming, and the District of Columbia. The net payments above the PT/SLP cap limits in these five states of \$4 million represents only 0.5% of all net payments above the PT/SLP cap limits.

As presented in Table 41, during CY 2008, beneficiaries in certain states, regardless of size, were more likely to surpass the PT/SLP cap limits than beneficiaries in other states. The five states with beneficiaries most likely to surpass the PT/SLP cap payment threshold were; Florida (23.8%), New Jersey (22.7%), New York (22.3%), Louisiana (20.5%), and Delaware (20.0%). The states least likely to have beneficiaries surpass the PT/SLP cap limits were North Dakota (3.2%), Iowa (4.8%), Minnesota (5.0%), Oregon (5.1%), and Alaska (5.6%).

**Table 41. Estimated PT/SLP cap impact by state in 2008 - Ranked by percent of users within state over cap<sup>68</sup>**

State	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Users in State 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
All	4,194,265	100.0%	640,937	100.0%	15.3%	\$2,811	\$1,363	\$1,801,634,899	\$873,558,675
FL	359,871	8.6%	85,697	13.4%	23.8%	\$2,898	\$1,450	\$248,387,496	\$124,298,357
NJ	155,477	3.7%	35,280	5.5%	22.7%	\$2,708	\$1,260	\$95,538,347	\$44,452,800
NY	299,282	7.1%	66,816	10.4%	22.3%	\$2,966	\$1,518	\$198,199,809	\$101,450,074
LA	47,736	1.1%	9,778	1.5%	20.5%	\$3,000	\$1,552	\$29,334,222	\$15,175,652
DE	19,314	0.5%	3,865	0.6%	20.0%	\$2,417	\$969	\$9,340,589	\$3,744,064
AK	5,960	0.1%	333	0.1%	5.6%	\$2,253	\$805	\$750,288	\$268,105
OR	37,254	0.9%	1,916	0.3%	5.1%	\$2,373	\$925	\$4,546,846	\$1,772,472
MN	67,554	1.6%	3,371	0.5%	5.0%	\$2,390	\$942	\$8,057,930	\$3,176,729
IA	50,384	1.2%	2,420	0.4%	4.8%	\$2,215	\$767	\$5,360,267	\$1,856,116
ND	11,774	0.3%	382	0.1%	3.2%	\$2,205	\$757	\$842,433	\$289,296

In addition, although not presented here in table format, the financial impact of discontinuing the cap exceptions process is disproportionate depending on beneficiary state. For example, there is a \$1,226 difference in net paid amounts above the cap limits between the PT/SLP beneficiaries in Texas that surpassed the cap limits in CY 2008 (\$1,983) and the net paid above the cap limits in North Dakota (\$757)<sup>77</sup>. Other top five states with the highest per beneficiary PT/SLP payments when the PT/SLP caps were surpassed were; Mississippi, District of Columbia, Indiana, and Louisiana. Other bottom five states with the lowest per beneficiary payments when the PT/SLP caps were surpassed were; Iowa, Alaska, Montana, and Oregon.

#### 4.4.2 OT separate cap

As presented in Table 42, during CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital. Of these OT users, 185,428 beneficiaries, or 19.1 percent, benefitted from the exceptions process and received services beyond the OT cap threshold of \$1,810 allowed amount (~\$1,448 paid).

Among 50 states and the District of Columbia, the state of Florida had the greatest number of OT users that surpassed the OT cap limit in CY 2008. These 41 thousand beneficiaries represent 22.3 percent of all OT users over the cap threshold. Florida and the other four states with the greatest number of beneficiaries who surpassed the OT cap limits; Texas, California, Ohio, and Pennsylvania, represent 46.6 percent of all beneficiaries who surpassed the OT cap limits in CY 2008. In addition, the net \$129 million paid above the OT cap limits in these five states represent 49.7 percent of all net payments above the OT cap limits. In contrast, Alaska had the fewest number of beneficiaries surpass the OT caps, at 38 (0.02%) followed by North Dakota, Montana, Vermont, and Hawaii. The \$1 million net payments above the OT cap limits in these five states represents only 0.4% of all net payments above the OT cap limits.

**Table 42. Estimated OT cap impact by state in 2008 - Ranked by percent of all users across country over cap<sup>68</sup>**

State	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Users in State 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
All	973,222	100.0%	185,428	100.0%	19.1%	\$2,843	\$1,395	\$527,209,067	\$258,709,146
FL	105,188	10.8%	41,361	22.3%	39.3%	\$3,065	\$1,617	\$126,754,346	\$66,863,779
TX	58,557	6.0%	14,604	7.9%	24.9%	\$2,988	\$1,540	\$43,637,044	\$22,490,452
CA	59,686	6.1%	10,328	5.6%	17.3%	\$2,719	\$1,271	\$28,080,811	\$13,125,855
OH	52,311	5.4%	10,139	5.5%	19.4%	\$2,897	\$1,449	\$29,375,961	\$14,694,655
PA	57,537	5.9%	9,950	5.4%	17.3%	\$2,602	\$1,154	\$25,892,992	\$11,485,385
HI	1,615	0.2%	234	0.1%	14.5%	\$3,454	\$2,006	\$808,349	\$469,516
VT	2,520	0.3%	199	0.1%	7.9%	\$2,137	\$689	\$425,208	\$137,055
MT	2,736	0.3%	184	0.1%	6.7%	\$2,666	\$1,218	\$490,495	\$224,062
ND	3,608	0.4%	113	0.1%	3.1%	\$2,324	\$876	\$262,600	\$98,976
AK	829	0.1%	38	0.0%	4.6%	\$3,258	\$1,810	\$123,820	\$68,765

As presented in Table 43, during CY 2008, beneficiaries in certain states, regardless of size, were more likely to surpass the OT cap limits than other states. The five states with beneficiaries most likely to surpass the OT cap payment threshold were; Florida (39.3%), Louisiana (28.8%), Mississippi (26.5%), Texas (24.9%), and West Virginia (23.2%). The states least likely to have beneficiaries surpass the OT cap limits were; North Dakota (3.1%), Iowa (3.6%), Alaska (4.6%), Oregon (5.0%), and Minnesota (6.2%).

**Table 43. Estimated OT cap impact by state in 2008 - Ranked by percent of users within state over cap<sup>68</sup>**

State	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of Users in State 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
All	973,222	100.0%	185,428	100.0%	19.1%	\$2,843	\$1,395	\$527,209,067	\$258,709,146
FL	105,188	10.8%	41,361	22.3%	39.3%	\$3,065	\$1,617	\$126,754,346	\$66,863,779
LA	14,430	1.5%	4,161	2.2%	28.8%	\$2,749	\$1,301	\$11,439,323	\$5,414,210
MS	11,046	1.1%	2,924	1.6%	26.5%	\$3,318	\$1,870	\$9,701,477	\$5,467,529
TX	58,557	6.0%	14,604	7.9%	24.9%	\$2,988	\$1,540	\$43,637,044	\$22,490,452
WV	6,150	0.6%	1,426	0.8%	23.2%	\$2,914	\$1,466	\$4,155,198	\$2,090,345
MN	19,105	2.0%	1,176	0.6%	6.2%	\$2,422	\$974	\$2,848,719	\$1,145,871
OR	6,102	0.6%	305	0.2%	5.0%	\$2,670	\$1,222	\$814,390	\$372,750
AK	829	0.1%	38	0.0%	4.6%	\$3,258	\$1,810	\$123,820	\$68,796
IA	14,166	1.5%	504	0.3%	3.6%	\$2,313	\$865	\$1,165,732	\$435,940
ND	3,608	0.4%	113	0.1%	3.1%	\$2,324	\$876	\$262,600	\$98,976

In addition, although not presented here in table format, the financial impact of discontinuing the cap exceptions process is disproportionate depending on beneficiary state. For example, there is a \$1,317 difference in net paid amounts above the cap limits between the beneficiaries who used OT in Hawaii that surpassed the cap limits in CY 2008 from the net paid above the cap limits in Vermont (\$2,006 net paid above cap vs. \$689)<sup>77</sup>. Other top five states with the highest per beneficiary OT payments when the OT caps were surpassed were; Mississippi, Alaska, Florida, and Texas. Other bottom five states with the lowest per beneficiary payments when the OT caps were surpassed were; Iowa, North Dakota, Minnesota, and Connecticut.

***Trend Spotlight – Change in the estimated impact of therapy caps by state CY 2006–2008***

*There continues to be a wide disparity between states in the likelihood that a beneficiary will benefit from the cap exceptions process, and how much is paid above the cap limits with the exceptions process. States that had higher or lower relative accessibility and costs in CY 2008 had similar placements in prior years. However, this pattern is not consistent among therapy types as different states have different proportions of the three therapy disciplines represented, which suggests regional differences in clinical practice and/or patient accessibility to different outpatient therapy providers and professionals.*

**4.5 Cap Impact by Diagnosis**

During CY 2008, the beneficiary's principal claim diagnosis (ICD-9) appeared to be an important variable in the likelihood that the individual benefitted from the exceptions process and received services beyond the therapy cap limit. The pattern of diagnoses used most frequently was not consistent across therapy types.

**4.5.1 PT/SLP combined cap**

As presented in Table 44, during CY 2008, 4.2 million beneficiaries received outpatient PT and/or SLP services from all settings, including hospital. Of these PT/SLP users, 640,937 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).

There were 4,376 different principal claim diagnoses attributed to beneficiaries who received PT and/or SLP services in CY 2008 and that received services beyond the PT/SLP cap limit. However, a limited number of principal claim ICD-9 codes describe the majority of diagnoses of beneficiaries who received outpatient PT/SLP services beyond the PT/SLP cap limits.

**Table 44. Cap impact 2008 by ICD-9 - Ranked by estimated number of users over PT/SLP cap<sup>69</sup>**

Rank	First Diagnosis ICD-9	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of ICD-9 Over Cap	Mean Paid for Users that Surpassed Caps	Net Paid Above Cap Limits for Users That Surpassed Cap	Net Paid Above Cap Limits
All	All	4,194,265	100.0%	640,937	100.0%	15.3%	\$2,811	\$1,363	\$873,558,675
1	781.2	179,957	4.3%	41,270	6.4%	22.9%	\$2,857	\$1,409	\$58,141,176
2	724.2	304,404	7.3%	33,238	5.2%	10.9%	\$2,637	\$1,189	\$39,522,309
3	719.7	119,333	2.8%	32,804	5.1%	27.5%	\$2,841	\$1,393	\$45,698,924
4	728.87	86,716	2.1%	22,651	3.5%	26.1%	\$2,938	\$1,490	\$33,757,012
5	719.41	145,839	3.5%	17,890	2.8%	12.3%	\$2,364	\$916	\$16,382,946
6	719.46	134,787	3.2%	17,456	2.7%	13.0%	\$2,380	\$932	\$16,271,261
7	715.16	70,763	1.7%	17,068	2.7%	24.1%	\$2,690	\$1,242	\$21,201,699
8	724.4	55,643	1.3%	12,664	2.0%	22.8%	\$2,925	\$1,477	\$18,703,334
9	726.10	60,515	1.4%	12,239	1.9%	20.2%	\$2,597	\$1,149	\$14,064,814
10	723.1	123,480	2.9%	11,960	1.9%	9.7%	\$2,556	\$1,108	\$13,246,537
11	724.02	60,985	1.5%	11,151	1.7%	18.3%	\$2,613	\$1,165	\$12,995,041
12	715.09	31,126	0.7%	10,976	1.7%	35.3%	\$3,083	\$1,635	\$17,945,650
13	V43.65	37,913	0.9%	10,674	1.7%	28.2%	\$2,493	\$1,045	\$11,150,381
14	781.3	28,442	0.7%	9,402	1.5%	33.1%	\$3,057	\$1,609	\$15,128,100
15	715.96	43,223	1.0%	9,297	1.5%	21.5%	\$2,770	\$1,322	\$12,294,167
16	332.0	24,038	0.6%	7,762	1.2%	32.3%	\$3,271	\$1,823	\$14,152,299
17	V57.1	476,399	11.4%	7,200	1.1%	1.5%	\$2,532	\$1,084	\$7,806,672
18	719.45	66,351	1.6%	6,745	1.1%	10.2%	\$2,351	\$903	\$6,090,870
19	436	21,386	0.5%	6,647	1.0%	31.1%	\$3,445	\$1,997	\$13,276,851
20	331.0	24,036	0.6%	6,642	1.0%	27.6%	\$2,922	\$1,474	\$9,791,171

The top 20 PT/SLP principal claim diagnosis codes represent 50.0 percent of the beneficiaries receiving outpatient PT/SLP services and 47.7 percent of all users over the PT/SLP cap limits, and 45.6 percent of total net payments above the PT/SLP cap limits. These top 20 PT/SLP principal claim diagnosis codes for beneficiaries surpassing the PT/SLP cap limits were:

- 781.2 – Abnormality of gait
- 724.2 – Lumbago (low back pain/syndrome)
- 719.7 – Difficulty in walking
- 728.87 – Muscle weakness (generalized)
- 719.41 – Pain in joint (shoulder region)
- 719.46 – Pain in joint (lower leg)
- 715.16 – Osteoarthritis, localized, primary (lower leg)
- 724.4 – Thoracic or lumbosacral neuritis or radiculitis (upper or lower back)
- 726.10 – Rotator cuff syndrome (shoulder)
- 723.1 – Cervicalgia (pain in neck)
- 724.02 – Spinal stenosis (lumbar/lower back region)

<sup>69</sup> Appendix C: STATS Excel file – CY 2008\_Cap\_ICD-9\_PT-SLP

- 715.09 – Osteoarthritis, generalized (multiple sites)
- V43.65 – Joint replacement (knee)
- 781.3 – Lack of coordination
- 715.96 – Osteoarthritis, unspecified (lower leg)
- 332.0 – Parkinson’s disease (paralysis agitans)
- V57.1 – Care involving the use of rehabilitation procedures (physical therapy)
- 719.45 – Pain in joint (pelvic region and thigh)
- 436 – Acute cerebrovascular disease (stroke)
- 331.0 – Alzheimer’s disease

Twenty-three principal claim ICD-9 codes describe 50 percent of beneficiaries who received services beyond the PT/SLP cap limit, and 79 ICD-9 codes represent 75 percent of those that received services beyond the PT/SLP cap limit. Since 9.3 percent of beneficiaries use PT services and only 1.1 percent use SLP services, the great majority of the top diagnosis codes representing beneficiaries receiving services beyond the PT/SLP cap limit are dominated by PT diagnosis codes.

However, among the most commonly observed principal claim ICD-9 codes for PT/SLP users that surpassed the PT/SLP cap limit, there were differences in the likelihood that an individual with a specific diagnosis code would receive services beyond the PT/SLP cap limits. In other words, some beneficiaries with less commonly observed diagnoses are more likely to surpass the PT/SLP cap limits. For example, among the 79 diagnosis codes that represent 75 percent of beneficiaries receiving services beyond the PT/SLP cap limits, the following ten ICD-9 codes represent the diagnoses that have a higher probability of beneficiaries surpassing the PT/SLP cap limits than other more commonly observed diagnoses. They are:

- 726.64 – Patellar tendinitis [48.4% over PT/SLP cap]
- 438.0 – Late effects cerebrovascular disease (stroke) with cognitive deficits [39.5% over PT/SLP cap]
- 438.22 – Late effects cerebrovascular disease (stroke), Hemiplegia affecting nondominant side [37.4% over PT/SLP cap]
- 438.21 – Late effects cerebrovascular disease (stroke), Hemiplegia affecting dominant side [36.5% over PT/SLP cap]
- 410.9 – Acute myocardial infarction (heart attack) (unspecified) [35.5% over PT/SLP cap]
- 715.09 – Osteoarthritis, generalized (multiple sites) [35.3% over PT/SLP cap]
- 250.00 – Diabetes mellitus (type II or unspecified) [34.7% over PT/SLP cap]
- 438.9 – Late effects cerebrovascular disease (stroke), unspecified effects [34.5% over PT/SLP cap]
- 781.3 – Lack of coordination [33.1% over PT/SLP cap]
- 332.0 – Parkinson’s disease (paralysis agitans) [32.3% over PT/SLP cap]

Other less commonly occurring ICD-9 codes have even higher rates of beneficiaries surpassing the PT/SLP cap limits and the financial impact of discontinuing the cap exceptions process would also be disproportionate for these individuals as well<sup>69</sup>.

#### 4.5.2 OT separate cap

As presented in Table 45, during CY 2008, 973 thousand beneficiaries received outpatient OT services from all settings, including hospital. 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).

There were 3,350 different principal claim diagnoses attributed to beneficiaries who received OT services in CY 2008 beyond the OT cap limit. However, a limited number of principal claim ICD-9 codes describe the majority of diagnoses of beneficiaries who received outpatient OT services beyond the OT cap limits.

**Table 45. Cap impact 2008 by ICD-9 -Ranked by estimated number of users over OT cap**<sup>70</sup>

Rank	First Diagnosis ICD-9	Total Users	Percent of 'Total Users'	Users Over Cap	Percent of 'Users Over Cap'	Percent of ICD-9 Over Cap	Mean Paid for Users that Surpassed Caps	Net Paid Above Cap Limits for Users That Surpassed Cap	Net Paid Above Cap Limits
All	All	973,222	100.0%	185,428	100.0%	19.1%	\$2,843	\$1,395	\$258,709,146
1	728.87	46,544	4.8%	12,326	6.6%	26.5%	\$2,776	\$1,328	\$16,374,105
2	719.7	32,655	3.4%	9,170	4.9%	28.1%	\$2,814	\$1,366	\$12,525,486
3	781.2	34,288	3.5%	8,711	4.7%	25.4%	\$2,815	\$1,367	\$11,907,240
4	781.3	15,673	1.6%	5,125	2.8%	32.7%	\$2,883	\$1,435	\$7,356,835
5	715.09	10,560	1.1%	3,799	2.0%	36.0%	\$3,021	\$1,573	\$5,977,005
6	332.0	11,486	1.2%	3,382	1.8%	29.4%	\$2,889	\$1,441	\$4,874,138
7	728.2	11,198	1.2%	3,326	1.8%	29.7%	\$2,888	\$1,440	\$4,788,043
8	401.9	10,403	1.1%	3,315	1.8%	31.9%	\$2,920	\$1,472	\$4,880,641
9	331.0	15,654	1.6%	3,296	1.8%	21.1%	\$2,663	\$1,215	\$4,005,728
10	436	12,389	1.3%	3,203	1.7%	25.9%	\$3,037	\$1,589	\$5,088,382
11	428.0	11,438	1.2%	3,084	1.7%	27.0%	\$2,833	\$1,385	\$4,271,494
12	724.4	5,186	0.5%	2,889	1.6%	55.7%	\$3,428	\$1,980	\$5,721,144
13	724.2	12,060	1.2%	2,720	1.5%	22.6%	\$2,875	\$1,427	\$3,882,664
14	715.90	8,982	0.9%	2,307	1.2%	25.7%	\$2,765	\$1,317	\$3,037,419
15	781.92	12,157	1.2%	2,188	1.2%	18.0%	\$2,693	\$1,245	\$2,723,360
16	799.3	9,481	1.0%	2,108	1.1%	22.2%	\$2,724	\$1,276	\$2,690,461
17	290.0	8,374	0.9%	2,046	1.1%	24.4%	\$2,768	\$1,320	\$2,700,106
18	V57.89	22,098	2.3%	2,010	1.1%	9.1%	\$2,647	\$1,199	\$2,409,488
19	250.00	6,368	0.7%	1,976	1.1%	31.0%	\$2,978	\$1,530	\$3,022,608
20	496	7,849	0.8%	1,945	1.0%	24.8%	\$2,793	\$1,345	\$2,616,083

The top 20 OT principal claim diagnosis codes represents 31.3 percent of all beneficiaries receiving outpatient OT services, 42.6 percent of all users over the OT cap limits, and 42.8 percent of total net payments above the OT cap limits. These top 20 OT principal claim diagnosis codes for beneficiaries surpassing the OT cap limits were:

- 728.87 – Muscle weakness (generalized)

<sup>70</sup> Appendix C: STATS Excel file – CY 2008\_Cap\_ICD-9\_OT

- 719.7 – Difficulty in walking
- 781.2 – Abnormality of gait
- 781.3 – Lack of coordination
- 715.09 – Osteoarthritis, generalized (multiple sites)
- 332.0 – Parkinson’s disease
- 728.2 – Muscular wasting and disuse atrophy
- 401.9 – Essential hypertension (unspecified)
- 331.0 – Alzheimer’s disease
- 436 – Acute cerebrovascular disease (stroke)
- 428.0 – Congestive heart failure (unspecified)
- 724.4 – Thoracic or lumbosacral neuritis or radiculitis (upper or lower back)
- 724.2 – Lumbago (low back pain/syndrome)
- 715.90 – Osteoarthritis, unspecified
- 781.92 – Abnormal posture
- 799.3 – Debility, unspecified
- 290.0 – Senile dementia (uncomplicated)
- V57.89 – Care involving the use of rehabilitation procedures (multiple therapies)
- 250.00 – Diabetes mellitus, type II or unspecified
- 496 – Nonspecific lung disease

Twenty-nine principal claim ICD-9 codes describe 50 percent of beneficiaries who received services beyond the OT cap limit, and 103 ICD-9 codes represent 75 percent of those that received services beyond the OT cap limit. Some of these diagnoses are also frequently associated with PT users who exceeded caps.

However, among the most commonly observed principal claim ICD-9 codes for OT users that surpassed the OT cap limit, there were differences in the likelihood that an individual with a specific diagnosis code would receive services beyond the OT cap limits. In other words, some beneficiaries with less commonly observed diagnoses are more likely to surpass the OT cap limits. For example, among the 103 diagnosis codes that represent 75 percent of beneficiaries receiving services beyond the OT cap limits, the following ten ICD-9 codes represent the diagnoses that have a higher probability of beneficiaries surpassing the OT cap limits than other more commonly observed diagnoses. They are:

- 726.64 – Patellar tendinitis [79.2% over OT cap]
- 727.06 – Tenosynovitis of foot and ankle [76.7% over OT cap]
- 846.0 – Sprains and strains of lumbosacral joint/ligament [71.2% over OT cap]
- 726.60 – Enthesopathy of knee, unspecified (bursitis) [69.9% over OT cap]
- 843.9 – Sprains and strains of hip and thigh (unspecified) [69.8% over OT cap]
- 844.9 – Sprains and strains of knee and leg (unspecified) [68.6% over OT cap]
- 727.09 – Synovitis and tenosynovitis (other) 65.3% over OT cap]
- 845.00 – Sprains and strains of ankle (unspecified) [63.5% over OT cap]
- 724.4 – Thoracic or lumbosacral neuritis or radiculitis (upper or lower back) [55.7% over cap]
- 723.4 – Brachia neuritis or radiculitis (neck) [49.3% over OT cap]

Other less commonly occurring ICD-9 codes have even higher rates of beneficiaries surpassing the OT cap limits and the financial impact of discontinuing the cap exceptions process would also be disproportionate for these individuals as well<sup>70</sup>.

### ***Trend Spotlight – Change in the estimated impact of therapy caps by principal claim ICD-9 CY 2006–2008***

*Despite the large number of observed ICD-9 principal claim diagnosis codes submitted on outpatient therapy claims, there are only a limited number that represent most outpatient therapy episodes. In addition, the episode ICD-9 code plays a large role in indicating whether a beneficiary will benefit from the cap exceptions process. This pattern is consistent over time and across all three outpatient therapy disciplines.*

## **4.6 Cap Impact – Percentiles by Therapy Type**

Since the outpatient therapy caps were first implemented in CY 1999, there has been much discussion regarding the disproportionate impact of the cap limits on beneficiaries depending on differences in the patient characteristics. As the prior cap analysis sections have identified, when the exceptions process is in place, there are clear differences in the number of beneficiaries who have received outpatient therapy services above the PT/SLP and OT cap limits, and net payments above the cap limits, based upon various beneficiary characteristics including; the patient demographics (gender, age, state), therapy type (PT, OT, or SLP services), and the type of provider setting (hospital, SNF, CORF, ORF, or HHA) or professional office specialty (PTPP, OTTP, physician, or NPP) the beneficiary receives outpatient therapy from.

Until CMS is able to obtain better information about patient characteristics that can better predict therapy need and outcomes, it has been proposed that Congress and CMS consider providing alternative variations of the therapy caps. These variations include; merging the caps into a single cap, separating the PT/SLP combined cap into separate cap limits, or establishing separate cap limits depending on the provider setting or professional office specialty where the beneficiary receives outpatient therapy services. In order to consider such alternative variations of the therapy cap limits, Congress and CMS will need information indicating the likelihood that an individual would surpass the cap limits at specific dollar levels.

The following table extracts provide information regarding average annual per-beneficiary expenditures (allowed and Medicare paid dollars) during CY 2008 for services that the cap limits applied to. Since hospital outpatient therapy payments are not counted against the beneficiary cap limits, per-beneficiary hospital payments are not included in these tables. The per-beneficiary expenditures are reported as the annual allowed and paid dollar threshold amount for beneficiaries as a percentile of the total number of beneficiaries who received outpatient therapy services in that particular provider setting or from that particular professional office specialty. For CY 2008, the cap allowed amount for both the PT/SLP combined cap and the separate OT cap was \$1,810, which is equivalent to \$1,448 paid (Allowed = Paid + any deductibles and 20% coinsurance).

### **4.6.1 Cap percentiles by therapy type across all settings**

As Table 46 reveals, when outpatient therapy services across all provider settings and professional office specialties are combined, there are differences in the amount of Medicare

payments for beneficiaries depending on therapy type. While the PT/SLP cap and OT cap are currently established at a fixed dollar amount, the percentage of beneficiaries in CY 2008 that received services beyond the cap limits was 15.3 percent for PT/SLP and 19.1 percent for OT respectively. If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile so that only about 5 percent of beneficiaries would be impacted by the cap limits, the cap limits would need to be increased to the following allowed dollar thresholds; PT only = \$3,341, OT only = \$4,103, SLP only = \$2,939, and PT/SLP combined = \$3,535. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008.

**Table 46. Estimated cap paid percentile of outpatient therapy users in all settings<sup>71</sup>**

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$68,567	\$85,843	\$68,567	\$85,843	\$25,677	\$32,096	\$23,911	\$29,888	\$68,567	\$85,843
99th	\$7,829	\$9,797	\$5,149	\$6,455	\$5,909	\$7,388	\$4,480	\$5,600	\$5,590	\$7,008
98th	\$5,801	\$7,261	\$4,011	\$5,033	\$4,721	\$5,902	\$3,500	\$4,375	\$4,307	\$5,398
97th	\$4,704	\$5,892	\$3,369	\$4,229	\$4,120	\$5,152	\$2,966	\$3,708	\$3,610	\$4,527
96th	\$3,986	\$4,995	\$2,963	\$3,718	\$3,637	\$4,548	\$2,609	\$3,261	\$3,147	\$3,947
95th	\$3,477	\$4,358	\$2,661	\$3,341	\$3,282	\$4,103	\$2,351	\$2,939	\$2,816	\$3,535
94th	\$3,098	\$3,886	\$2,416	\$3,036	\$3,017	\$3,772	\$2,139	\$2,673	\$2,553	\$3,205
93rd	\$2,835	\$3,556	\$2,217	\$2,785	\$2,802	\$3,504	\$1,967	\$2,459	\$2,334	\$2,933
92nd	\$2,596	\$3,258	\$2,049	\$2,576	\$2,606	\$3,259	\$1,824	\$2,280	\$2,153	\$2,705
91st	\$2,388	\$2,998	\$1,908	\$2,401	\$2,417	\$3,022	\$1,697	\$2,122	\$1,999	\$2,513
90th	\$2,206	\$2,771	\$1,786	\$2,248	\$2,253	\$2,819	\$1,588	\$1,985	\$1,867	\$2,347
89th	\$2,050	\$2,576	\$1,680	\$2,116	\$2,113	\$2,642	\$1,495	\$1,869	\$1,750	\$2,201
88th	\$1,913	\$2,405	\$1,586	\$1,998	\$1,985	\$2,484	\$1,422	\$1,778	\$1,647	\$2,074
87th	\$1,791	\$2,253	\$1,506	\$1,898	\$1,872	\$2,342	\$1,355	\$1,693	\$1,556	\$1,961
86th	\$1,683	\$2,118	\$1,450	\$1,822	\$1,771	\$2,216	\$1,292	\$1,615	\$1,482	\$1,866
85th	\$1,586	\$1,997	\$1,436	\$1,810	\$1,682	\$2,104	\$1,236	\$1,545	\$1,448	\$1,810
84th	\$1,503	\$1,893	\$1,386	\$1,750	\$1,599	\$2,001	\$1,179	\$1,474	\$1,418	\$1,792
83rd	\$1,448	\$1,810	\$1,339	\$1,687	\$1,524	\$1,907	\$1,124	\$1,405	\$1,368	\$1,727
82nd	\$1,416	\$1,790	\$1,288	\$1,624	\$1,471	\$1,841	\$1,074	\$1,343	\$1,319	\$1,662
81st	\$1,361	\$1,719	\$1,240	\$1,563	\$1,448	\$1,810	\$1,025	\$1,281	\$1,269	\$1,599
80th	\$1,309	\$1,650	\$1,193	\$1,505	\$1,406	\$1,760	\$981	\$1,227	\$1,220	\$1,538
75th	\$1,065	\$1,345	\$992	\$1,253	\$1,155	\$1,446	\$791	\$989	\$1,008	\$1,273
50th	\$370	\$475	\$375	\$481	\$368	\$463	\$211	\$265	\$369	\$473
25th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

***Trend Spotlight – Change in the therapy caps per-beneficiary paid percentile thresholds by therapy type CY 2006–2008***

*Beneficiaries requiring OT services are more likely to benefit from the cap exceptions process than those that require PT and/or SLP services, regardless of what dollar limit the caps are set at. Splitting the PT/SLP combined cap into separate PT and SLP caps would have only a nominal impact on beneficiaries requiring PT services, however, splitting the PT/SLP cap would permit a higher percentage SLP users to obtain services before reaching the cap limit. This pattern is consistent with prior years.*

<sup>71</sup> Appendix C: STATS Excel file – CY 2008\_Cap\_Percentile

## 4.7 Cap Impact – Percentiles by Provider Setting and Professional Specialty

### 4.7.1 Hospital accessed

Outpatient services billed by hospitals are exempted from therapy caps. As Table 47 reveals, when beneficiaries who were able to obtain outpatient therapy services from outpatient hospitals at least some time during the year, they were less likely than average to receive services that surpassed the cap limits, since the services furnished by the hospital did not count against the cap limits. The dollars presented on this table reflect only those services that were furnished by another provider setting or professional office specialty during the same year that the beneficiary also accessed the hospital outpatient therapy department.

**Table 47. Estimated cap paid percentile when hospital accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$47,240	\$59,051	\$34,921	\$43,785	\$14,723	\$18,404	\$18,808	\$23,510	\$34,921	\$43,785
99th	\$3,663	\$4,589	\$2,446	\$3,069	\$2,000	\$2,502	\$2,475	\$3,094	\$2,870	\$3,599
98th	\$2,377	\$2,982	\$1,672	\$2,104	\$1,230	\$1,539	\$1,554	\$1,942	\$1,936	\$2,431
97th	\$1,740	\$2,186	\$1,374	\$1,732	\$803	\$1,005	\$1,126	\$1,408	\$1,470	\$1,847
96th	\$1,422	\$1,793	\$1,123	\$1,413	\$505	\$633	\$827	\$1,034	\$1,269	\$1,597
95th	\$1,176	\$1,480	\$921	\$1,161	\$269	\$338	\$595	\$746	\$1,048	\$1,320
94th	\$969	\$1,222	\$755	\$952	\$104	\$133	\$404	\$506	\$867	\$1,093
93rd	\$798	\$1,008	\$617	\$781	\$0	\$0	\$249	\$312	\$715	\$903
92nd	\$658	\$831	\$497	\$629	\$0	\$0	\$132	\$165	\$586	\$742
91st	\$533	\$676	\$389	\$495	\$0	\$0	\$69	\$87	\$473	\$600
90th	\$424	\$539	\$288	\$370	\$0	\$0	\$0	\$0	\$370	\$471
89th	\$324	\$414	\$195	\$252	\$0	\$0	\$0	\$0	\$274	\$352
88th	\$232	\$300	\$115	\$150	\$0	\$0	\$0	\$0	\$186	\$241
87th	\$151	\$196	\$59	\$80	\$0	\$0	\$0	\$0	\$112	\$146
86th	\$92	\$120	\$0	\$0	\$0	\$0	\$0	\$0	\$60	\$83
85th	\$45	\$66	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
84th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
83rd	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
82nd	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
81st	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
80th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
75th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
50th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
25th	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

From the dollar percentile threshold levels listed on Table 47, the hospital exception works very well for those beneficiaries that have adequate access to hospital outpatient therapy services at anytime during the year. For example, only the top 3-4 percent of PT/SLP users and 2-3 percent of OT users that accessed outpatient hospitals for therapy services in CY 2008 also received services in excess of the respective PT/SLP or OT cap limits from other provider settings or professional offices, requiring the exceptions process. Very few beneficiaries that have adequate

access to outpatient hospital therapy services would be impacted by the elimination of the therapy cap exceptions process.

#### 4.7.2 Hospital not accessed

However, as Table 48 reveals, when beneficiaries were not able to obtain outpatient therapy services from outpatient hospitals at least some time during the year, they were much more likely than average to receive services that surpassed the cap limits, since all services furnished were counted against the cap limits. The dollars presented on this table reflect services that were furnished by any outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting. A significant percentage of beneficiaries that may have a justifiable need for outpatient therapy services beyond the cap limits may not be able to access outpatient hospital therapy services and would be negatively impacted by the elimination of the therapy cap exceptions process. As Table 48 indicates, 21 percent of PT/SLP users and between 25 and 26 percent of OT users that do not receive outpatient hospital therapy services, and could see benefit limitations despite having a need for therapy services if the exceptions process was eliminated.

**Table 48. Estimated cap paid percentile when hospital not accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$68,567	\$85,843	\$68,567	\$85,843	\$25,677	\$32,096	\$23,911	\$29,888	\$68,567	\$85,843
99th	\$8,780	\$10,986	\$5,733	\$7,188	\$6,398	\$8,003	\$5,053	\$6,316	\$6,213	\$7,787
98th	\$6,662	\$8,339	\$4,521	\$5,669	\$5,221	\$6,527	\$4,016	\$5,020	\$4,861	\$6,093
97th	\$5,568	\$6,972	\$3,872	\$4,858	\$4,566	\$5,708	\$3,442	\$4,302	\$4,148	\$5,202
96th	\$4,780	\$5,987	\$3,415	\$4,285	\$4,139	\$5,176	\$3,067	\$3,834	\$3,658	\$4,587
95th	\$4,210	\$5,275	\$3,090	\$3,879	\$3,766	\$4,709	\$2,781	\$3,476	\$3,289	\$4,125
94th	\$3,778	\$4,735	\$2,841	\$3,566	\$3,460	\$4,327	\$2,566	\$3,207	\$3,012	\$3,779
93rd	\$3,432	\$4,303	\$2,630	\$3,304	\$3,226	\$4,034	\$2,392	\$2,990	\$2,785	\$3,495
92nd	\$3,154	\$3,955	\$2,450	\$3,078	\$3,035	\$3,795	\$2,239	\$2,798	\$2,592	\$3,255
91st	\$2,935	\$3,676	\$2,294	\$2,883	\$2,872	\$3,592	\$2,102	\$2,628	\$2,424	\$3,044
90th	\$2,764	\$3,468	\$2,159	\$2,714	\$2,722	\$3,403	\$1,987	\$2,483	\$2,276	\$2,860
89th	\$2,591	\$3,251	\$2,040	\$2,566	\$2,578	\$3,224	\$1,886	\$2,357	\$2,147	\$2,698
88th	\$2,435	\$3,057	\$1,935	\$2,434	\$2,437	\$3,048	\$1,797	\$2,246	\$2,033	\$2,556
87th	\$2,295	\$2,883	\$1,842	\$2,317	\$2,312	\$2,891	\$1,710	\$2,138	\$1,931	\$2,428
86th	\$2,170	\$2,725	\$1,756	\$2,210	\$2,197	\$2,749	\$1,631	\$2,039	\$1,839	\$2,313
85th	\$2,057	\$2,584	\$1,680	\$2,115	\$2,097	\$2,623	\$1,563	\$1,954	\$1,754	\$2,207
84th	\$1,954	\$2,456	\$1,609	\$2,027	\$2,003	\$2,505	\$1,502	\$1,878	\$1,678	\$2,113
83rd	\$1,861	\$2,340	\$1,545	\$1,947	\$1,916	\$2,397	\$1,453	\$1,816	\$1,608	\$2,025
82nd	\$1,774	\$2,232	\$1,491	\$1,879	\$1,837	\$2,298	\$1,404	\$1,756	\$1,545	\$1,945
81st	\$1,696	\$2,134	\$1,452	\$1,825	\$1,764	\$2,207	\$1,360	\$1,700	\$1,491	\$1,878
80th	\$1,623	\$2,043	\$1,448	\$1,810	\$1,698	\$2,124	\$1,318	\$1,648	\$1,454	\$1,825
75th	\$1,401	\$1,771	\$1,270	\$1,602	\$1,461	\$1,827	\$1,126	\$1,408	\$1,306	\$1,646
50th	\$679	\$862	\$651	\$826	\$694	\$870	\$555	\$694	\$661	\$838
25th	\$282	\$366	\$283	\$367	\$256	\$323	\$208	\$261	\$284	\$368

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing only non-hospital settings/specialists

would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$3,879, OT only = \$4,709, SLP only = \$3,476, and PT/SLP combined = \$4,125. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who are not able to access outpatient hospital departments for outpatient therapy services when the caps apply without the exceptions process.

### 4.7.3 SNF accessed

As Table 49 reveals, those beneficiaries who received SNF outpatient therapy services at least once during the calendar year were much more likely than average to receive services that surpassed the cap limits. All SNF outpatient services furnished were counted against the cap limits. The dollars presented on this table reflect services that were furnished by SNF and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 49. Estimated cap paid percentile when SNF accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$56,949	\$71,186	\$33,289	\$41,611	\$25,677	\$32,096	\$23,911	\$29,888	\$33,289	\$41,611
99th	\$11,783	\$14,729	\$6,613	\$8,267	\$6,407	\$8,009	\$5,178	\$6,472	\$7,823	\$9,780
98th	\$9,416	\$11,770	\$5,384	\$6,731	\$5,201	\$6,501	\$4,109	\$5,136	\$6,312	\$7,892
97th	\$8,091	\$10,114	\$4,697	\$5,872	\$4,515	\$5,644	\$3,536	\$4,420	\$5,477	\$6,846
96th	\$7,199	\$8,998	\$4,228	\$5,286	\$4,057	\$5,072	\$3,159	\$3,949	\$4,904	\$6,130
95th	\$6,532	\$8,165	\$3,863	\$4,829	\$3,710	\$4,638	\$2,869	\$3,586	\$4,463	\$5,579
94th	\$5,999	\$7,499	\$3,574	\$4,468	\$3,432	\$4,290	\$2,647	\$3,309	\$4,113	\$5,142
93rd	\$5,562	\$6,953	\$3,340	\$4,176	\$3,204	\$4,006	\$2,468	\$3,085	\$3,834	\$4,793
92nd	\$5,188	\$6,485	\$3,144	\$3,931	\$3,012	\$3,764	\$2,312	\$2,891	\$3,588	\$4,486
91st	\$4,860	\$6,076	\$2,971	\$3,715	\$2,844	\$3,555	\$2,178	\$2,722	\$3,380	\$4,226
90th	\$4,579	\$5,724	\$2,820	\$3,526	\$2,697	\$3,371	\$2,058	\$2,572	\$3,199	\$3,999
89th	\$4,325	\$5,407	\$2,683	\$3,354	\$2,566	\$3,207	\$1,954	\$2,443	\$3,036	\$3,796
88th	\$4,102	\$5,128	\$2,560	\$3,200	\$2,439	\$3,049	\$1,863	\$2,329	\$2,890	\$3,613
87th	\$3,903	\$4,879	\$2,446	\$3,058	\$2,327	\$2,909	\$1,778	\$2,223	\$2,757	\$3,447
86th	\$3,718	\$4,648	\$2,339	\$2,925	\$2,225	\$2,782	\$1,699	\$2,124	\$2,636	\$3,295
85th	\$3,544	\$4,430	\$2,244	\$2,805	\$2,134	\$2,668	\$1,627	\$2,033	\$2,527	\$3,159
84th	\$3,388	\$4,236	\$2,153	\$2,692	\$2,049	\$2,561	\$1,561	\$1,952	\$2,420	\$3,025
83rd	\$3,245	\$4,056	\$2,070	\$2,588	\$1,970	\$2,463	\$1,503	\$1,878	\$2,323	\$2,904
82nd	\$3,113	\$3,891	\$1,995	\$2,494	\$1,896	\$2,370	\$1,456	\$1,820	\$2,232	\$2,790
81st	\$2,987	\$3,734	\$1,923	\$2,404	\$1,827	\$2,284	\$1,408	\$1,760	\$2,147	\$2,684
80th	\$2,886	\$3,608	\$1,858	\$2,323	\$1,764	\$2,205	\$1,370	\$1,712	\$2,067	\$2,585
75th	\$2,406	\$3,008	\$1,578	\$1,972	\$1,495	\$1,869	\$1,180	\$1,475	\$1,737	\$2,171
50th	\$1,092	\$1,365	\$833	\$1,042	\$767	\$959	\$597	\$747	\$884	\$1,105
25th	\$438	\$548	\$367	\$459	\$322	\$403	\$248	\$310	\$379	\$474

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing SNF (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$4,829, OT only

= \$4,638, SLP only = \$3,586, and PT/SLP combined = \$5,579. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access SNF for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.4 CORF accessed

As Table 50 reveals, those beneficiaries who received CORF outpatient therapy services at least once during the calendar year were much more likely than average to receive services that surpassed the cap limits. All CORF services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by CORF and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 50. Estimated cap paid percentile when CORF accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$41,150	\$51,438	\$33,289	\$41,611	\$20,876	\$26,095	\$10,572	\$13,215	\$33,289	\$41,611
99th	\$15,634	\$19,556	\$8,346	\$10,456	\$8,805	\$11,006	\$7,039	\$8,799	\$8,506	\$10,643
98th	\$13,011	\$16,267	\$6,951	\$8,698	\$7,696	\$9,620	\$5,218	\$6,523	\$7,094	\$8,879
97th	\$11,869	\$14,840	\$6,300	\$7,876	\$6,941	\$8,677	\$4,565	\$5,706	\$6,356	\$7,945
96th	\$10,779	\$13,481	\$5,805	\$7,259	\$6,487	\$8,108	\$4,329	\$5,411	\$5,871	\$7,339
95th	\$9,967	\$12,461	\$5,369	\$6,713	\$6,143	\$7,679	\$3,958	\$4,948	\$5,415	\$6,774
94th	\$9,413	\$11,766	\$4,999	\$6,251	\$5,923	\$7,404	\$3,732	\$4,665	\$5,049	\$6,313
93rd	\$9,007	\$11,266	\$4,772	\$5,967	\$5,670	\$7,087	\$3,386	\$4,232	\$4,795	\$5,995
92nd	\$8,635	\$10,794	\$4,581	\$5,727	\$5,417	\$6,772	\$3,150	\$3,937	\$4,606	\$5,760
91st	\$8,222	\$10,280	\$4,400	\$5,502	\$5,154	\$6,444	\$2,914	\$3,642	\$4,426	\$5,535
90th	\$7,730	\$9,666	\$4,236	\$5,296	\$4,979	\$6,223	\$2,698	\$3,373	\$4,257	\$5,322
89th	\$7,245	\$9,057	\$4,063	\$5,081	\$4,830	\$6,037	\$2,476	\$3,095	\$4,084	\$5,107
88th	\$6,837	\$8,557	\$3,861	\$4,833	\$4,706	\$5,883	\$2,408	\$3,010	\$3,893	\$4,869
87th	\$6,557	\$8,196	\$3,676	\$4,599	\$4,603	\$5,753	\$2,240	\$2,801	\$3,694	\$4,620
86th	\$6,331	\$7,916	\$3,498	\$4,375	\$4,516	\$5,647	\$2,088	\$2,610	\$3,515	\$4,397
85th	\$6,145	\$7,681	\$3,337	\$4,174	\$4,408	\$5,509	\$1,975	\$2,469	\$3,359	\$4,201
84th	\$5,956	\$7,447	\$3,221	\$4,028	\$4,326	\$5,408	\$1,853	\$2,316	\$3,241	\$4,053
83rd	\$5,753	\$7,195	\$3,171	\$3,965	\$4,235	\$5,294	\$1,735	\$2,168	\$3,183	\$3,979
82nd	\$5,528	\$6,914	\$3,088	\$3,864	\$4,143	\$5,179	\$1,668	\$2,085	\$3,101	\$3,880
81st	\$5,265	\$6,587	\$3,009	\$3,762	\$4,031	\$5,038	\$1,590	\$1,988	\$3,019	\$3,776
80th	\$4,922	\$6,154	\$2,926	\$3,662	\$3,898	\$4,873	\$1,502	\$1,878	\$2,937	\$3,673
75th	\$3,602	\$4,505	\$2,450	\$3,066	\$3,350	\$4,188	\$1,241	\$1,552	\$2,461	\$3,080
50th	\$1,542	\$1,930	\$1,367	\$1,710	\$1,641	\$2,052	\$487	\$608	\$1,368	\$1,712
25th	\$583	\$730	\$570	\$713	\$1,260	\$1,575	\$165	\$207	\$567	\$709

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing CORF (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$6,713, OT only = \$7,679, SLP only = \$4,948, and PT/SLP combined = \$6,774. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct

financial disadvantage for beneficiaries who access CORF for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.5 ORF accessed

As Table 51 reveals, those beneficiaries who received ORF outpatient therapy services at least once during the calendar year were much more likely than average to receive services that surpassed the cap limits since all ORF services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by ORF and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 51. Estimated cap paid percentile when ORF accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$41,150	\$51,438	\$32,302	\$40,377	\$20,876	\$26,095	\$15,054	\$18,818	\$32,302	\$40,377
99th	\$9,585	\$11,984	\$5,641	\$7,061	\$7,721	\$9,651	\$5,831	\$7,289	\$6,016	\$7,524
98th	\$7,449	\$9,311	\$4,487	\$5,611	\$6,404	\$8,011	\$4,617	\$5,771	\$4,701	\$5,879
97th	\$5,988	\$7,485	\$3,907	\$4,887	\$5,801	\$7,252	\$3,943	\$4,929	\$4,100	\$5,128
96th	\$5,153	\$6,443	\$3,445	\$4,308	\$5,192	\$6,490	\$3,519	\$4,399	\$3,609	\$4,514
95th	\$4,396	\$5,497	\$3,121	\$3,903	\$4,804	\$6,005	\$3,192	\$3,991	\$3,247	\$4,061
94th	\$3,839	\$4,801	\$2,896	\$3,622	\$4,551	\$5,689	\$2,948	\$3,685	\$2,990	\$3,740
93rd	\$3,445	\$4,308	\$2,710	\$3,389	\$4,346	\$5,433	\$2,736	\$3,420	\$2,795	\$3,496
92nd	\$3,148	\$3,938	\$2,528	\$3,162	\$4,166	\$5,209	\$2,557	\$3,197	\$2,610	\$3,264
91st	\$2,921	\$3,653	\$2,372	\$2,967	\$3,947	\$4,935	\$2,407	\$3,009	\$2,445	\$3,058
90th	\$2,751	\$3,441	\$2,236	\$2,798	\$3,716	\$4,645	\$2,272	\$2,840	\$2,298	\$2,874
89th	\$2,578	\$3,224	\$2,119	\$2,651	\$3,486	\$4,358	\$2,160	\$2,699	\$2,174	\$2,719
88th	\$2,422	\$3,031	\$2,017	\$2,523	\$3,315	\$4,145	\$2,045	\$2,556	\$2,066	\$2,583
87th	\$2,281	\$2,853	\$1,922	\$2,405	\$3,168	\$3,959	\$1,955	\$2,443	\$1,966	\$2,459
86th	\$2,158	\$2,699	\$1,837	\$2,298	\$3,049	\$3,811	\$1,872	\$2,340	\$1,878	\$2,349
85th	\$2,051	\$2,565	\$1,759	\$2,201	\$2,947	\$3,684	\$1,797	\$2,247	\$1,796	\$2,247
84th	\$1,951	\$2,441	\$1,690	\$2,115	\$2,861	\$3,577	\$1,712	\$2,140	\$1,723	\$2,155
83rd	\$1,861	\$2,328	\$1,622	\$2,030	\$2,767	\$3,459	\$1,636	\$2,046	\$1,654	\$2,069
82nd	\$1,778	\$2,225	\$1,563	\$1,955	\$2,674	\$3,342	\$1,573	\$1,966	\$1,589	\$1,989
81st	\$1,704	\$2,133	\$1,510	\$1,889	\$2,566	\$3,207	\$1,516	\$1,895	\$1,533	\$1,919
80th	\$1,634	\$2,045	\$1,470	\$1,839	\$2,452	\$3,065	\$1,465	\$1,831	\$1,487	\$1,861
75th	\$1,415	\$1,772	\$1,329	\$1,663	\$1,952	\$2,441	\$1,244	\$1,555	\$1,344	\$1,682
50th	\$754	\$943	\$735	\$919	\$928	\$1,160	\$577	\$722	\$738	\$924
25th	\$363	\$455	\$363	\$454	\$331	\$414	\$225	\$281	\$363	\$454

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing ORF (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$3,903, OT only = \$6,005, SLP only = \$3,991, and PT/SLP combined = \$4,061. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access ORF for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.6 HHA accessed

As Table 52 reveals, those beneficiaries who received outpatient therapy from HHA outpatient therapy services at least once during the calendar year were less likely than average to receive services that surpassed the cap limits. All HHA services furnished (excluding those furnished under Part A home health plans of care) were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by HHAs and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 52. Estimated cap paid percentile when HHA accessed** <sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$19,549	\$24,436	\$10,684	\$13,355	\$6,442	\$8,053	\$4,070	\$5,087	\$13,107	\$16,383
99th	\$6,895	\$8,619	\$4,836	\$6,045	\$3,884	\$4,855	\$3,223	\$4,029	\$5,389	\$6,736
98th	\$5,093	\$6,366	\$3,712	\$4,640	\$3,181	\$3,977	\$2,830	\$3,538	\$4,033	\$5,042
97th	\$4,243	\$5,304	\$3,020	\$3,803	\$2,920	\$3,650	\$2,587	\$3,234	\$3,236	\$4,045
96th	\$3,646	\$4,558	\$2,668	\$3,335	\$2,769	\$3,462	\$2,400	\$3,000	\$2,879	\$3,599
95th	\$3,150	\$3,938	\$2,349	\$2,945	\$2,268	\$2,835	\$2,133	\$2,667	\$2,512	\$3,140
94th	\$2,793	\$3,492	\$2,164	\$2,705	\$2,101	\$2,627	\$1,935	\$2,418	\$2,266	\$2,849
93rd	\$2,539	\$3,174	\$1,978	\$2,486	\$1,936	\$2,420	\$1,879	\$2,349	\$2,079	\$2,607
92nd	\$2,266	\$2,858	\$1,869	\$2,338	\$1,745	\$2,181	\$1,756	\$2,195	\$1,940	\$2,428
91st	\$2,100	\$2,625	\$1,741	\$2,177	\$1,625	\$2,031	\$1,500	\$1,875	\$1,823	\$2,279
90th	\$1,966	\$2,462	\$1,620	\$2,024	\$1,495	\$1,869	\$1,449	\$1,811	\$1,692	\$2,115
89th	\$1,874	\$2,346	\$1,518	\$1,902	\$1,464	\$1,830	\$1,370	\$1,713	\$1,573	\$1,968
88th	\$1,789	\$2,236	\$1,468	\$1,839	\$1,431	\$1,789	\$1,336	\$1,670	\$1,500	\$1,887
87th	\$1,644	\$2,054	\$1,451	\$1,816	\$1,383	\$1,729	\$1,274	\$1,593	\$1,465	\$1,832
86th	\$1,554	\$1,945	\$1,423	\$1,782	\$1,351	\$1,689	\$1,218	\$1,523	\$1,449	\$1,813
85th	\$1,486	\$1,863	\$1,365	\$1,708	\$1,295	\$1,619	\$1,140	\$1,425	\$1,407	\$1,768
84th	\$1,454	\$1,820	\$1,321	\$1,652	\$1,207	\$1,509	\$1,110	\$1,388	\$1,354	\$1,693
83rd	\$1,420	\$1,782	\$1,265	\$1,583	\$1,147	\$1,434	\$1,017	\$1,272	\$1,306	\$1,635
82nd	\$1,351	\$1,689	\$1,234	\$1,543	\$1,089	\$1,361	\$993	\$1,242	\$1,256	\$1,575
81st	\$1,308	\$1,636	\$1,191	\$1,489	\$1,040	\$1,299	\$977	\$1,222	\$1,229	\$1,537
80th	\$1,258	\$1,574	\$1,148	\$1,437	\$994	\$1,243	\$882	\$1,103	\$1,187	\$1,484
75th	\$1,058	\$1,324	\$970	\$1,213	\$801	\$1,001	\$786	\$983	\$999	\$1,250
50th	\$450	\$563	\$422	\$528	\$290	\$362	\$400	\$500	\$434	\$543
25th	\$109	\$136	\$99	\$124	\$119	\$148	\$149	\$187	\$105	\$132

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing HHA (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$2,945, OT only = \$2,835, SLP only = \$2,667, and PT/SLP combined = \$3,140. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access HHA for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.7 PTPP accessed

As Table 53 reveals, those beneficiaries who received outpatient therapy services from an office based PTPP specialty at least once during the calendar year were more likely than average to receive services that surpassed the cap limits. All PTPP specialty services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by PTPP professional offices and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 53. Estimated cap paid percentile when PTPP specialty accessed <sup>71</sup>**

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$68,567	\$85,843	\$68,567	\$85,843	N/A	N/A	N/A	N/A	\$68,567	\$85,843
99th	\$5,830	\$7,330	\$5,316	\$6,690	N/A	N/A	N/A	N/A	\$5,342	\$6,718
98th	\$4,475	\$5,631	\$4,146	\$5,224	N/A	N/A	N/A	N/A	\$4,159	\$5,241
97th	\$3,776	\$4,753	\$3,539	\$4,458	N/A	N/A	N/A	N/A	\$3,549	\$4,471
96th	\$3,310	\$4,170	\$3,124	\$3,937	N/A	N/A	N/A	N/A	\$3,132	\$3,947
95th	\$2,972	\$3,747	\$2,826	\$3,563	N/A	N/A	N/A	N/A	\$2,833	\$3,572
94th	\$2,720	\$3,431	\$2,598	\$3,275	N/A	N/A	N/A	N/A	\$2,603	\$3,282
93rd	\$2,519	\$3,178	\$2,411	\$3,041	N/A	N/A	N/A	N/A	\$2,415	\$3,047
92nd	\$2,350	\$2,967	\$2,253	\$2,844	N/A	N/A	N/A	N/A	\$2,257	\$2,850
91st	\$2,204	\$2,784	\$2,116	\$2,673	N/A	N/A	N/A	N/A	\$2,120	\$2,679
90th	\$2,077	\$2,625	\$1,999	\$2,527	N/A	N/A	N/A	N/A	\$2,002	\$2,531
89th	\$1,966	\$2,486	\$1,895	\$2,397	N/A	N/A	N/A	N/A	\$1,898	\$2,401
88th	\$1,868	\$2,362	\$1,802	\$2,280	N/A	N/A	N/A	N/A	\$1,805	\$2,284
87th	\$1,779	\$2,250	\$1,718	\$2,175	N/A	N/A	N/A	N/A	\$1,721	\$2,178
86th	\$1,699	\$2,149	\$1,644	\$2,081	N/A	N/A	N/A	N/A	\$1,646	\$2,084
85th	\$1,626	\$2,060	\$1,576	\$1,996	N/A	N/A	N/A	N/A	\$1,578	\$1,999
84th	\$1,561	\$1,978	\$1,516	\$1,920	N/A	N/A	N/A	N/A	\$1,518	\$1,922
83rd	\$1,504	\$1,907	\$1,459	\$1,854	N/A	N/A	N/A	N/A	\$1,461	\$1,857
82nd	\$1,448	\$1,838	\$1,448	\$1,810	N/A	N/A	N/A	N/A	\$1,448	\$1,810
81st	\$1,448	\$1,810	\$1,437	\$1,810	N/A	N/A	N/A	N/A	\$1,438	\$1,810
80th	\$1,427	\$1,810	\$1,401	\$1,782	N/A	N/A	N/A	N/A	\$1,403	\$1,784
75th	\$1,255	\$1,592	\$1,231	\$1,561	N/A	N/A	N/A	N/A	\$1,232	\$1,563
50th	\$665	\$851	\$654	\$837	N/A	N/A	N/A	N/A	\$655	\$838
25th	\$312	\$411	\$306	\$403	N/A	N/A	N/A	N/A	\$307	\$403

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing PTPP specialty (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$3,563, OT only = N/A, SLP only = N/A, and PT/SLP combined = \$3,572. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access PTPP specialty offices for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.8 OTPP accessed

As Table 54 reveals, those beneficiaries who received outpatient therapy services from an office based OTPP specialty at least once during the calendar year were less likely than average to receive services that surpassed the cap limits even though OTPP specialty services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by OTPP professional offices and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 54. Estimated cap paid percentile when OTPP specialty accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$43,684	\$54,740	N/A	N/A	\$21,095	\$26,504	N/A	N/A	N/A	N/A
99th	\$9,647	\$12,082	N/A	N/A	\$5,066	\$6,358	N/A	N/A	N/A	N/A
98th	\$7,655	\$9,603	N/A	N/A	\$3,929	\$4,922	N/A	N/A	N/A	N/A
97th	\$6,580	\$8,261	N/A	N/A	\$3,290	\$4,126	N/A	N/A	N/A	N/A
96th	\$5,771	\$7,234	N/A	N/A	\$2,889	\$3,623	N/A	N/A	N/A	N/A
95th	\$5,163	\$6,486	N/A	N/A	\$2,632	\$3,305	N/A	N/A	N/A	N/A
94th	\$4,660	\$5,852	N/A	N/A	\$2,395	\$3,012	N/A	N/A	N/A	N/A
93rd	\$4,263	\$5,353	N/A	N/A	\$2,200	\$2,767	N/A	N/A	N/A	N/A
92nd	\$3,929	\$4,938	N/A	N/A	\$2,036	\$2,560	N/A	N/A	N/A	N/A
91st	\$3,631	\$4,566	N/A	N/A	\$1,892	\$2,382	N/A	N/A	N/A	N/A
90th	\$3,354	\$4,224	N/A	N/A	\$1,775	\$2,233	N/A	N/A	N/A	N/A
89th	\$3,122	\$3,937	N/A	N/A	\$1,667	\$2,098	N/A	N/A	N/A	N/A
88th	\$2,919	\$3,678	N/A	N/A	\$1,572	\$1,982	N/A	N/A	N/A	N/A
87th	\$2,765	\$3,486	N/A	N/A	\$1,494	\$1,884	N/A	N/A	N/A	N/A
86th	\$2,622	\$3,299	N/A	N/A	\$1,448	\$1,810	N/A	N/A	N/A	N/A
85th	\$2,479	\$3,129	N/A	N/A	\$1,415	\$1,791	N/A	N/A	N/A	N/A
84th	\$2,350	\$2,966	N/A	N/A	\$1,362	\$1,723	N/A	N/A	N/A	N/A
83rd	\$2,232	\$2,815	N/A	N/A	\$1,317	\$1,662	N/A	N/A	N/A	N/A
82nd	\$2,122	\$2,675	N/A	N/A	\$1,265	\$1,598	N/A	N/A	N/A	N/A
81st	\$2,021	\$2,553	N/A	N/A	\$1,217	\$1,537	N/A	N/A	N/A	N/A
80th	\$1,923	\$2,429	N/A	N/A	\$1,166	\$1,477	N/A	N/A	N/A	N/A
75th	\$1,536	\$1,944	N/A	N/A	\$960	\$1,217	N/A	N/A	N/A	N/A
50th	\$614	\$787	N/A	N/A	\$383	\$493	N/A	N/A	N/A	N/A
25th	\$198	\$261	N/A	N/A	\$130	\$173	N/A	N/A	N/A	N/A

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing OTPP specialty (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = N/A, OT only = \$3,305, SLP only = N/A, and PT/SLP combined = N/A. These limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access OTPP specialty offices for outpatient therapy services when the caps apply without the exceptions process.

#### 4.7.9 Physician accessed

As Table 55 reveals, those beneficiaries who received outpatient therapy services from an office based physician specialty at least once during the calendar year were more likely than average to receive services PT and PT/SLP services that surpassed the cap limits and less likely than average to receive OT services that surpassed the cap limits. The physician specialty services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by physician professional offices and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 55. Estimated cap paid percentile when physician specialty accessed<sup>71</sup>**

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$43,686	\$54,741	\$42,607	\$53,392	\$17,011	\$21,264	\$8,418	\$10,658	\$42,607	\$53,392
99th	\$7,131	\$8,955	\$6,051	\$7,611	\$4,887	\$6,109	\$1,448	\$1,836	\$6,010	\$7,558
98th	\$5,039	\$6,339	\$4,465	\$5,603	\$3,901	\$4,880	\$1,139	\$1,435	\$4,434	\$5,566
97th	\$3,956	\$4,980	\$3,637	\$4,575	\$3,060	\$3,836	\$898	\$1,139	\$3,602	\$4,531
96th	\$3,277	\$4,120	\$3,079	\$3,874	\$2,646	\$3,319	\$761	\$962	\$3,046	\$3,835
95th	\$2,854	\$3,593	\$2,718	\$3,420	\$2,198	\$2,762	\$653	\$834	\$2,687	\$3,385
94th	\$2,542	\$3,205	\$2,417	\$3,047	\$1,900	\$2,390	\$580	\$738	\$2,387	\$3,009
93rd	\$2,285	\$2,883	\$2,180	\$2,748	\$1,639	\$2,068	\$528	\$675	\$2,151	\$2,712
92nd	\$2,069	\$2,612	\$1,982	\$2,501	\$1,489	\$1,871	\$482	\$616	\$1,953	\$2,465
91st	\$1,895	\$2,392	\$1,823	\$2,306	\$1,448	\$1,810	\$440	\$565	\$1,797	\$2,272
90th	\$1,749	\$2,212	\$1,693	\$2,138	\$1,417	\$1,796	\$415	\$529	\$1,668	\$2,109
89th	\$1,629	\$2,060	\$1,580	\$1,999	\$1,352	\$1,710	\$393	\$497	\$1,556	\$1,972
88th	\$1,529	\$1,932	\$1,491	\$1,890	\$1,283	\$1,617	\$369	\$472	\$1,470	\$1,865
87th	\$1,448	\$1,832	\$1,448	\$1,810	\$1,208	\$1,527	\$350	\$450	\$1,448	\$1,810
86th	\$1,448	\$1,810	\$1,448	\$1,810	\$1,135	\$1,435	\$335	\$430	\$1,441	\$1,810
85th	\$1,416	\$1,807	\$1,407	\$1,794	\$1,070	\$1,353	\$322	\$412	\$1,393	\$1,774
84th	\$1,364	\$1,735	\$1,358	\$1,727	\$1,007	\$1,280	\$304	\$392	\$1,341	\$1,704
83rd	\$1,316	\$1,665	\$1,312	\$1,660	\$950	\$1,204	\$295	\$375	\$1,295	\$1,637
82nd	\$1,262	\$1,598	\$1,261	\$1,596	\$898	\$1,138	\$289	\$364	\$1,243	\$1,574
81st	\$1,212	\$1,535	\$1,212	\$1,535	\$852	\$1,080	\$276	\$361	\$1,194	\$1,512
80th	\$1,163	\$1,475	\$1,165	\$1,477	\$808	\$1,029	\$267	\$340	\$1,147	\$1,453
75th	\$955	\$1,214	\$962	\$1,222	\$637	\$811	\$221	\$287	\$945	\$1,200
50th	\$381	\$492	\$392	\$506	\$218	\$287	\$128	\$167	\$378	\$489
25th	\$107	\$142	\$105	\$142	\$69	\$95	\$99	\$131	\$106	\$140

If the cap policy were changed, for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing physician specialty (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be changed to the following allowed dollar thresholds; PT only = \$3,420 allowed, OT only = \$2,762, SLP only = \$834, and PT/SLP combined = \$3,385. With the exception of SLP, these limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access physician specialty offices for outpatient PT and OT services when the caps apply without the exceptions process.

#### 4.7.10 NPP accessed

As Table 56 reveals, those beneficiaries who received outpatient therapy services from an office based NPP specialty at least once during the calendar year were more likely than average to receive PT, OT, and PT/SLP services that surpassed the cap limits and less likely than average to receive SLP only services that surpassed the cap limits as the NPP specialty services furnished were counted against the cap limits. The dollars presented on this table reflect capped services that were furnished by NPP specialty and any other outpatient provider setting or professional office specialty during the same year other than the cap exempt hospital setting.

**Table 56. Estimated cap paid percentile when NPP specialty accessed**<sup>71</sup>

Percentile	All Paid	All Allowed	PT Paid	PT Allowed	OT Paid	OT Allowed	SLP Paid	SLP Allowed	PT/SLP Paid	PT/SLP Allowed
100th	\$41,150	\$51,438	\$20,274	\$25,343	\$20,876	\$26,095	\$1,448	\$1,987	\$20,274	\$25,343
99th	\$9,646	\$12,058	\$7,271	\$9,113	\$8,459	\$10,574	\$1,448	\$1,810	\$7,230	\$9,104
98th	\$7,402	\$9,294	\$5,339	\$6,704	\$7,452	\$9,315	\$1,387	\$1,810	\$5,297	\$6,637
97th	\$5,768	\$7,210	\$4,342	\$5,473	\$6,040	\$7,549	\$1,334	\$1,810	\$4,317	\$5,428
96th	\$4,620	\$5,839	\$3,905	\$4,932	\$5,033	\$6,373	\$1,314	\$1,668	\$3,883	\$4,873
95th	\$3,907	\$4,934	\$3,466	\$4,362	\$4,553	\$5,692	\$1,211	\$1,579	\$3,436	\$4,319
94th	\$3,469	\$4,362	\$3,155	\$3,966	\$4,334	\$5,417	\$1,205	\$1,553	\$3,125	\$3,943
93rd	\$3,139	\$3,955	\$2,942	\$3,714	\$4,177	\$5,221	\$1,141	\$1,503	\$2,932	\$3,681
92nd	\$2,912	\$3,668	\$2,808	\$3,544	\$3,845	\$4,806	\$1,135	\$1,434	\$2,782	\$3,517
91st	\$2,758	\$3,505	\$2,638	\$3,312	\$3,586	\$4,483	\$1,058	\$1,323	\$2,610	\$3,272
90th	\$2,598	\$3,255	\$2,484	\$3,127	\$3,192	\$3,990	\$1,038	\$1,298	\$2,462	\$3,090
89th	\$2,437	\$3,082	\$2,348	\$2,971	\$2,990	\$3,737	\$889	\$1,112	\$2,326	\$2,940
88th	\$2,287	\$2,917	\$2,208	\$2,787	\$2,784	\$3,480	\$544	\$680	\$2,174	\$2,747
87th	\$2,146	\$2,712	\$2,061	\$2,621	\$2,467	\$3,083	\$408	\$510	\$2,018	\$2,552
86th	\$2,004	\$2,521	\$1,923	\$2,436	\$2,020	\$2,525	\$387	\$484	\$1,878	\$2,383
85th	\$1,861	\$2,373	\$1,801	\$2,281	\$1,867	\$2,334	\$347	\$434	\$1,772	\$2,256
84th	\$1,756	\$2,227	\$1,717	\$2,156	\$1,802	\$2,252	\$333	\$417	\$1,680	\$2,130
83rd	\$1,666	\$2,106	\$1,624	\$2,040	\$1,485	\$1,857	\$325	\$406	\$1,600	\$2,015
82nd	\$1,587	\$2,010	\$1,542	\$1,944	\$1,388	\$1,772	\$307	\$384	\$1,518	\$1,912
81st	\$1,512	\$1,903	\$1,477	\$1,867	\$1,293	\$1,616	\$300	\$375	\$1,457	\$1,845
80th	\$1,451	\$1,833	\$1,448	\$1,810	\$1,168	\$1,506	\$265	\$332	\$1,448	\$1,810
75th	\$1,281	\$1,614	\$1,250	\$1,584	\$666	\$836	\$238	\$298	\$1,237	\$1,571
50th	\$408	\$522	\$415	\$527	\$81	\$104	\$98	\$123	\$403	\$518
25th	\$89	\$115	\$90	\$118	\$33	\$45	\$89	\$112	\$90	\$115

If the cap policy were changed for example, to set the cap limit at the 95<sup>th</sup> percentile by setting so that only about 5 percent of beneficiaries accessing NPP specialty (with or without services from other settings/specialties) would be impacted by the cap limits, the cap limits for such beneficiaries would need to be the following allowed dollar thresholds; PT only = \$4,362, OT only = \$5,692, SLP only = \$1,579, and PT/SLP combined = \$4,319. With the exception of SLP only, these limits are significantly higher than the cap limits of \$1,810 that applied in CY 2008 and reflect a distinct financial disadvantage for beneficiaries who access NPP specialty offices for outpatient PT and OT services when the caps apply without the exceptions process.

***Trend Spotlight – Change in the therapy caps per-beneficiary paid percentile thresholds by therapy type within each setting/specialty CY 2006–2008***

*Beneficiaries are more likely to benefit from the cap exceptions process in some provider settings/professional offices than others, regardless of therapy type. Since hospital outpatient therapy services are not counted against the therapy cap limits, beneficiaries who are able to access hospital settings are least likely to require the exceptions process to receive necessary outpatient therapy services. This pattern is consistent with prior years.*

## 5 – Implications

This report does not include analysis of the medical necessity of the services described and any differences in utilization patterns presented in the results do not, and should not, be used to imply that one therapy discipline, provider setting or professional specialty provides better outcomes or more cost effective care than another discipline, setting or specialty. High or low dollar amounts paid does not in any way reflect on the quality or efficiency of the services rendered. The outpatient therapy utilization patterns and year-to-year trends described in this report are limited to administrative claims data available from submitted claims including beneficiary demographics, diagnosis, and outpatient therapy procedures furnished.

Differences in outpatient therapy utilization patterns can be influenced by various factors not available on claims data such as; payment policy changes, regional HCPCS price variations, geographic availability of Part A and Part B providers and professionals, degree of impairments to a beneficiary's body structures and functions, degree of a beneficiary's problems in activities and participation, a beneficiary's environmental barriers or facilitators, and other beneficiary personal and social factors. There are no standardized outpatient therapy functional measures or outcomes measures submitted with Medicare outpatient therapy claims which could help better determine the medical necessity of the services furnished. CMS is currently investigating the development of such an instrument through the Developing Outpatient Therapy Payment Alternatives (DOTPA) project. In addition, it is impractical to perform medical review on over 20 million professional office, and nearly 8 million provider setting outpatient therapy claims to determine medical necessity.

Therefore, until additional clinically relevant information is available, the medical necessity of the services furnished in this utilization analysis is assumed by the fact that the billed services were submitted, and that services furnished beyond the cap limits were attested to as being medically necessary by use of the KX procedure code modifier by providers and professionals.

Despite these limitations, the results presented in this utilization report do provide clear indications of the impact of recent changes to outpatient therapy policies on the service delivery patterns furnished in outpatient therapy provider facilities and professional offices. These include:

- Outpatient therapy provider payment policy changes effective in 1999 that extended the MPFS from professional offices to institutional providers including hospital, SNF, CORF, ORF and HHA continues to result in a shift in enrollment and, to some extent payments, from these provider facility settings with higher operating costs, towards professional specialty offices that have lower operating costs.
- Outpatient therapy provider enrollment policy changes in 2003 that permitted therapist employees of physicians and NPPs to enroll as a PTPP, OTPP, (or SLPP effective in 2009) and assign Medicare payments to the employer physician or NPP continues to result in a shift in enrollment and utilization results from individual enrolled as physician and NPP professional office specialties towards the individual PTPP, OTPP, and SLPP professional office specialties. However, claims data can no longer differentiate whether a PTPP, OTPP, or SLPP service billed is generated by an independently practicing therapist, or a therapist who is employed by, or under contract to a physician or NPP.

- The outpatient therapy caps policy with exceptions as implemented from CY 2006 through the current date;
  - Does not appear to impact beneficiary initial access to outpatient therapy as evidenced by the continued increase in beneficiaries receiving outpatient therapy services after the caps with exceptions process was implemented.
  - Does not appear to impact the types of HCPCS procedures furnished by outpatient therapy providers and professionals as evidenced by relatively stable use of a small number of the available 76 outpatient therapy HCPCS codes.
  - Does not appear to impact the types of beneficiary principal claim diagnoses or derived CSC Classification Groups reported for outpatient therapy users.
  - Does not appear to impact the demographic distribution (age, gender, and state) of outpatient therapy users.
- 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 including; 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.
  - Older beneficiaries were more likely to surpass the cap limits and see service reductions,
  - Beneficiaries in states with traditionally higher per-user costs were more likely to surpass the cap limits and see service reductions,
  - Beneficiaries receiving OT services with traditionally higher per-user costs than PT/SLP services were more likely to surpass the cap limits and see service reductions,
  - Beneficiaries with principal claim diagnoses or derived CSC Classification Groups with traditionally higher per-user costs were more likely to surpass the cap limits and see service reductions, and
  - Beneficiaries receiving services from traditionally higher per-user cost providers (e.g. CORF, SNF) or professionals (e.g. PTPP) were more likely to surpass the cap limits and see service reductions,
- 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. Without additional clinical information, the medical necessity of the additional services furnished since CY 2006 cannot be determined.

These findings suggest that, until a long-term payment policy approach that can incorporate risk-adjusted clinical information related to beneficiary function and outcomes is implemented, short-term policy changes to enhance the required claims data may be necessary to provide CMS with better information related to beneficiary function and intervention complexity. Such changes would improve confidence that medically necessary services are indeed being furnished and that the recent utilization increases are not an indicator of inappropriate use of Medicare Part B Trust Fund resources. In a subsequent report under the STATS contract, we will be submitting

specific practical policy alternatives that are administratively feasible and that can be implemented in the short-term.

## Appendix A: Acronyms

ADL	Activities of Daily Living
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
FOTO	Focus on Therapeutic Outcomes, Inc.
GAO	U.S. Government Accountability Office
GN	Claim line HCPCS modifier representing a speech-language pathology POC
GO	Claim line HCPCS modifier representing an occupational therapy POC
GP	Claim line HCPCS modifier representing a physical therapy POC
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
IADL	Instrumental Activities of Daily Living
ICD-9	International Classification of Disease, 9 <sup>th</sup> Edition
ICF	International Classification of Function, Disability and Health
IDR	CMS Integrated Data Repository
LCD	Local Coverage Decision
MAC	Medicare Administrative Contractor
MedPAC	Medicare Payment Advisory Commission
MPFS	Medicare Physician Fee Schedule
NCH	National Claims History Database
NDB	CMS STARS National Database
NPI	National Provider Identifier
NPP	Non-physician Practitioner
OIG	Office of Inspector General
ORF	Outpatient Rehabilitation Facility
OT	Occupational Therapy
OTPP	Occupational Therapist in Private Practice
POC	Plan of Care
PT	Physical Therapy
PTPP	Physical Therapist in Private Practice
RTI	Research Triangle Institute
SD	Standard Deviation
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: STATS Therapy HCPCS Analysis Logic<sup>72</sup>

<p>If provider setting claim with Bill Type = 12X (hospital), 13X (hospital), 22X (SNF), 23X (SNF), 34X (HHA), 74X (ORF), or 75X (CORF) and Revenue Center – 042X (PT), 043X (OT), or 044X (SLP), or if professional office claim with Line Specialty Code = 65 (PTPP) or 67 (OTPP),</p>
<p>Then, all of the following 75 HCPCS are always outpatient therapy HCPCS: 64550, 90901, 92506, 92507, 92508, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 95831, 95832, 95833, 95834, 95851, 95852, 96105, 96110, 96111, 96125, 97001, 97002, 97003, 97004, 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97750, 97755, 97760, 97761, 97762, 97799, G0281, G0283, G0329, 0019T, 0029T.</p>
<p>Also, if professional office claim with Line Specialty Code = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 36, 37, 38, 39, 40, 41, 44, 46, 48, 66, 70, 72, 76, 77, 78, 79, 81, 82, 83, 84, 85, 86, 90, 91, 92, 93, 94, 98, 99, then physician specialty, or, if professional office claim with Line Specialty Code = 50, 89, or 97, then non-physician specialty,</p>
<p>Then, all of the following 51 HCPCS are always outpatient therapy HCPCS: 92506, 92507, 92508, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 96125, 97001, 97002, 97003, 97004, 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761, 97762, 97799, G0281, G0283, G0329.</p>
<p>Else, all of the following 24 HCPCS codes are only outpatient therapy services if the HCPCS code claim modifier GN (SLP POC), GO (OT POC), or GP (PT POC) is present: 64550, 90901, 92610, 92611, 92612, 92614, 92616, 95831, 95832, 95833, 95834, 95851, 95852, 96105, 96110, 96111, 97532, 97597, 97598, 97602, 97605, 97606, 0019T, 0029T.</p>
<p>For all provider setting outpatient therapy claim lines, the Revenue Center code 042X (PT), 043X (OT), or 044X (SLP) was used to identify therapy type to assure that all outpatient therapy claim lines were assigned to one of the three therapy types. For all professional office outpatient therapy claim lines, the HCPCS code claim modifiers GN (SLP POC), GO (OT POC), or GP (PT POC) were used to identify therapy type. A small number of professional office outpatient therapy claim lines containing ‘always therapy’ HCPCS did not have the required GN, GO, or GP therapy modifier appended, or had more than one outpatient therapy modifier. In such cases, we did not assign a therapy type to these claim lines but included the payments attributed to such lines to the overall outpatient therapy expenditure results.</p>

<sup>72</sup> See CMS Transmittal #1377, *2008 Annual Update to the Therapy Code List*, November 13, 2007 for details of ‘always therapy’ versus ‘sometimes therapy’ HCPCS applicable to CY 2008.

## Appendix C: Index of Attached EXCEL and Comma Separated Value (.csv) Files

### **EXCEL File Name: CY 2008\_Cap\_Demographics**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Cap by Therapy Type	Cap_Therapy Type	CY 2008_Cap_Therapy Type
2008 Outpatient Therapy Cap Analysis: Cap by Gender - PT Users	Cap_Gender_PT	CY 2008_Cap_Gender_PT
2008 Outpatient Therapy Cap Analysis: Cap by Gender - OT Users	Cap_Gender_OT	CY 2008_Cap_Gender_OT
2008 Outpatient Therapy Cap Analysis: Cap by Gender - SLP Users	Cap_Gender_SLP	CY 2008_Cap_Gender_SLP
2008 Outpatient Therapy Cap Analysis: Cap by Gender - PT/SLP Users	Cap_Gender_PT-SLP	CY 2008_Cap_Gender_PT-SLP
2008 Outpatient Therapy Cap Analysis: Cap by Age - PT Users	Cap_Age_PT	CY 2008_Cap_Age_PT
2008 Outpatient Therapy Cap Analysis: Cap by Age - OT Users	Cap_Age_OT	CY 2008_Cap_Age_OT
2008 Outpatient Therapy Cap Analysis: Cap by Age - SLP Users	Cap_Age_SLP	CY 2008_Cap_Age_SLP
2008 Outpatient Therapy Cap Analysis: Cap by Age - PT/SLP Users	Cap_Age_PT-SLP	CY 2008_Cap_Age_PT-SLP
2008 Outpatient Therapy Cap Analysis: Cap by State - PT Users	Cap_State_PT	CY 2008_Cap_State_PT
2008 Outpatient Therapy Cap Analysis: Cap by State - OT Users	Cap_State_OT	CY 2008_Cap_State_OT
2008 Outpatient Therapy Cap Analysis: Cap by State - SLP Users	Cap_State_SLP	CY 2008_Cap_State_SLP
2008 Outpatient Therapy Cap Analysis: Cap by State - PT/SLP Users	Cap_State_PT-SLP	CY 2008_Cap_State_PT-SLP

### **EXCEL File Name: CY 2008\_Cap\_ICD-9\_OT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: OT - In ICD-9 Order	Cap_ICD-9_OT_Rank_ICD-9 Order	CY 2008_Cap_ICD-9_OT_ICD-9 Order
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: OT - Rank by number of ICD-9 over Cap	Cap_ICD-9_OT_Rank_# Over Cap	CY 2008_Cap_ICD-9_OT_Number Over Cap
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: OT - Rank by percentage within ICD-9 over Cap	Cap_ICD-9_OT_Rank_% Over Cap	CY 2008_Cap_ICD-9_OT_Percent Over Cap

### **EXCEL File Name: CY 2008\_Cap\_ICD-9\_PT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT - In ICD-9 Order	Cap_ICD-9_PT_Rank_ICD-9 Order	CY 2008_Cap_ICD-9_PT_ICD-9 Order
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT - Rank by number of ICD-9 over Cap	Cap_ICD-9_PT_Rank_# Over Cap	CY 2008_Cap_ICD-9_PT_Number Over Cap
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT - Rank by percentage within ICD-9 over Cap	Cap_ICD-9_PT_Rank_% Over Cap	CY 2008_Cap_ICD-9_PT_Percent Over Cap

**EXCEL File Name: CY 2008\_Cap\_ICD-9\_PT-SLP**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT/SLP - In ICD-9 Order	Cap_ICD-9_PT-SLP_ICD-9 Order	CY 2008_Cap_ICD-9_PT-SLP_ICD-9 Order
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT/SLP - Rank by number of ICD-9 over Cap	Cap_ICD-9_PT-SLP_# Over Cap	CY 2008_Cap_ICD-9_PT-SLP_Number Over Cap
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: PT/SLP - Rank by percentage within ICD-9 over Cap	Cap_ICD-9_PT-SLP_% Over Cap	CY 2008_Cap_ICD-9_PT-SLP_Percent Over Cap

**EXCEL File Name: CY 2008\_Cap\_ICD-9\_SLP**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: SLP - In ICD-9 Order	Cap_ICD-9_SLP_Rank_ICD-9 Order	CY 2008_Cap_ICD-9_SLP_ICD-9 Order
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: SLP - Rank by number of ICD-9 over Cap	Cap_ICD-9_SLP_Rank_# Over Cap	CY 2008_Cap_ICD-9_SLP_Number Over Cap
2008 Outpatient Therapy Cap Analysis: Principal ICD-9: SLP - Rank by percentage within ICD-9 over Cap	Cap_ICD-9_SLP_Rank_% Over Cap	CY 2008_Cap_ICD-9_SLP_Percent Over Cap

**EXCEL File Name: CY 2008\_Cap\_Percentile**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): Any Setting Accessed	Cap_All Settings	CY 2008_Cap_Percentile_All Settings
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): Hospital Accessed	Cap_Hospital_Accessed	CY 2008_Cap_Percentile_Hospital_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): Hospital Not Accessed	Cap_Hospital_Not Accessed	CY 2008_Cap_Percentile_Hospital_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): SNF Accessed	Cap_SNF_Accessed	CY 2008_Cap_Percentile_SNF Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): SNF Not Accessed	Cap_SNF_Not Accessed	CY 2008_Cap_Percentile_SNF_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): CORF Accessed	Cap_CORF_Accessed	CY 2008_Cap_Percentile_CORF_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): CORF Not Accessed	Cap_CORF_Not Accessed	CY 2008_Cap_Percentile_CORF_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): ORF Accessed	Cap_ORF_Accessed	CY 2008_Cap_Percentile_ORF Accessed

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): ORF Not Accessed	Cap_ORF_Not Accessed	CY 2008_Cap_Percentile_ORF_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): HHA Accessed	Cap_HHA_Accessed	CY 2008_Cap_Percentile_HHA_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): HHA Not Accessed	Cap_HHA_Not Accessed	CY 2008_Cap_Percentile_HHA_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): PTPP Accessed	Cap_PTPP_Accessed	CY 2008_Cap_Percentile_PTPP_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): PTPP Not Accessed	Cap_PTPP_Not Accessed	CY 2008_Cap_Percentile_PTPP_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): OTPP Accessed	Cap_OTPP_Accessed	CY 2008_Cap_Percentile_OTPP_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): OTPP Not Accessed	Cap_OTPP_Not Accessed	CY 2008_Cap_Percentile_OTPP_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): Physician Accessed	Cap_Physician_Accessed	CY 2008_Cap_Percentile_Physician_Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): Physician Not Accessed	Cap_ORF_Physician_Not Accessed	CY 2008_Cap_Percentile_Physician_Not Accessed
2008 Outpatient Therapy Cap Analysis: Percentiles: Simulated Analysis (Hospital Payments Excluded): NPP Accessed	Cap_NPP_Accessed	CY 2008_Cap_Percentile_NPP_Accessed
2008 Outpatient Therapy Utilization Percentiles: Simulated Cap Analysis (Hospital Payments Excluded): NPP Not Accessed	Cap_NPP_Not Accessed	CY 2008_Cap_Percentile_NPP_Not Accessed

**EXCEL File Name: CY 2008\_Demographics**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Utilization: Demographics by Therapy Type	Demographics_Therapy Type	CY 2008_Demographics_Therapy Type
2008 Outpatient Therapy Utilization: Demographics by Gender - All Therapies	Gender_All	CY 2008_Demographics_Gender_All
2008 Outpatient Therapy Utilization: Demographics by Gender - PT	Gender_PT	CY 2008_Demographics_Gender_PT
2008 Outpatient Therapy Utilization: Demographics by Gender - OT	Gender_OT	CY 2008_Demographics_Gender_OT
2008 Outpatient Therapy Utilization: Demographics by Gender - SLP	Gender_SLP	CY 2008_Demographics_Gender_SLP
2008 Outpatient Therapy Utilization: Demographics by Gender - PT/SLP	Gender_PT-SLP	CY 2008_Demographics_Gender_PT-SLP
2008 Outpatient Therapy Utilization: Demographics by Age - All Therapies	Age_All	CY 2008_Demographics_Age_All
2008 Outpatient Therapy Utilization: Demographics by Age - PT	Age_PT	CY 2008_Demographics_Age_PT
2008 Outpatient Therapy Utilization: Demographics by Age - OT	Age_OT	CY 2008_Demographics_Age_OT
2008 Outpatient Therapy Utilization: Demographics by Age - SLP	Age_SLP	CY 2008_Demographics_Age_SLP
2008 Outpatient Therapy Utilization: Demographics by Age - PT/SLP	Age_PT-SLP	CY 2008_Demographics_Age_PT-SLP
2008 Outpatient Therapy Utilization: Demographics by State - All Therapies	State_All	CY 2008_Demographics_State_All

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Utilization: Demographics by State - PT	State_PT	CY 2008_ Demographics_State_PT
2008 Outpatient Therapy Utilization: Demographics by State - OT	State_OT	CY 2008_ Demographics_State_OT
2008 Outpatient Therapy Utilization: Demographics by State - SLP	State_SLP	CY 2008_ Demographics_State_SLP
2008 Outpatient Therapy Utilization: Demographics by State - PT/SLP	State_PT-SLP	CY 2008_ Demographics_State_PT-SLP

**EXCEL File Name: CY 2008\_Episode\_CSC Classification**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: CSC Classification Groups: PT	CSC Classification_PT	CY 2008_Episode_CSC Classification_PT
2008 Outpatient Therapy Episode Analysis: CSC Classification Groups: OT	CSC Classification_OT	CY 2008_Episode_CSC Classification_OT
2008 Outpatient Therapy Episode Analysis: CSC Classification Groups: SLP	CSC Classification_SLP	CY 2008_Episode_CSC Classification_SLP

**EXCEL File Name: CY 2008\_Episode\_ICD-9\_OT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: OT - Rank by ICD-9 Episode Frequency	Episode_ICD-9_OT_Frequency	CY 2008_Episode_ICD-9_OT_Frequency
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: OT - Rank by Episode Days	Episode_ICD-9_OT_Days	CY 2008_Episode_ICD-9_OT_Days
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: OT - Rank by Episode Paid	Episode_ICD-9_OT_Paid	CY 2008_Episode_ICD-9_OT_Paid
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: OT - In ICD-9 Order	Episode_ICD-9_OT_ICD-9 Order	CY 2008_Episode_ICD-9_OT_ICD-9 Order

**EXCEL File Name: CY 2008\_Episode\_ICD-9\_PT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: PT - Rank by ICD-9 Episode Frequency	Episode_ICD-9_PT_Frequency	CY 2008_Episode_ICD-9_PT_Frequency
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: PT - Rank by Episode Days	Episode_ICD-9_PT_Days	CY 2008_Episode_ICD-9_PT_Days
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: PT - Rank by Episode Paid	Episode_ICD-9_PT_Paid	CY 2008_Episode_ICD-9_PT_Paid
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: PT - In ICD-9 Order	Episode_ICD-9_PT_ICD-9 Order	CY 2008_Episode_ICD-9_PT_ICD-9 Order

**EXCEL File Name: CY 2008\_Episode\_ICD-9\_SLP**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: SLP - Rank by ICD-9 Episode Frequency	Episode_ICD-9_SLP_Frequency	CY 2008_Episode_ICD-9_SLP_Frequency
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: SLP - Rank by Episode Days	Episode_ICD-9_SLP_Days	CY 2008_Episode_ICD-9_SLP_Days
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: SLP - Rank by Episode Paid	Episode_ICD-9_SLP_Paid	CY 2008_Episode_ICD-9_SLP_Paid
2008 Outpatient Therapy Episode Analysis: Principal ICD-9: SLP - In ICD-9 Order	Episode_ICD-9_SLP_ICD-9 Order	CY 2008_Episode_ICD-9_SLP_ICD-9 Order

**EXCEL File Name: CY 2008\_Episode\_Regression\_OT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: OT - Regression Model with Outliers - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_OT_1	CY 2008_Episode_Regression_OT_1
2008 Outpatient Therapy Episode Analysis: OT - Regression Model with One-Day Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_OT_2	CY 2008_Episode_Regression_OT_2
2008 Outpatient Therapy Episode Analysis: OT - Regression Model with Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_OT_3	CY 2008_Episode_Regression_OT_3
2008 Outpatient Therapy Episode Analysis: OT - Regression Model with One-Day and Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_OT_4	CY 2008_Episode_Regression_OT_4

**EXCEL File Name: CY 2008\_Episode\_Regression\_PT**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: PT - Regression Model with Outliers - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_PT_1	CY 2008_Episode_Regression_PT_1
2008 Outpatient Therapy Episode Analysis: PT - Regression Model with One-Day Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_PT_2	CY 2008_Episode_Regression_PT_2
2008 Outpatient Therapy Episode Analysis: PT - Regression Model with Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_PT_3	CY 2008_Episode_Regression_PT_3
2008 Outpatient Therapy Episode Analysis: PT - Regression Model with One-Day and Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_PT_4	CY 2008_Episode_Regression_PT_4

**EXCEL File Name: CY 2008\_Episode\_Regression\_SLP**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Episode Analysis: SLP - Regression Model with Outliers - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_SLP_1	CY 2008_Episode_Regression_SLP_1
2008 Outpatient Therapy Episode Analysis: SLP - Regression Model with One-Day Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_SLP_2	CY 2008_Episode_Regression_SLP_2
2008 Outpatient Therapy Episode Analysis: SLP - Regression Model with Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_SLP_3	CY 2008_Episode_Regression_SLP_3
2008 Outpatient Therapy Episode Analysis: SLP - Regression Model with One-Day and Right-Side Outliers Removed - Dependent Variable: Medicare Paid Amount (log transformed)	Regression_SLP_4	CY 2008_Episode_Regression_SLP_4

**EXCEL File Name: CY 2008\_HCPCS\_Professional**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Therapy HCPCS Utilization: Professional: All	Professional_All	CY 2008_HCPCS_Profesional_All
2008 Therapy HCPCS Utilization: Professional: PT	Professional_PT	CY 2008_HCPCS_Profesional_PT
2008 Therapy HCPCS Utilization: Professional: OT	Professional_OT	CY 2008_HCPCS_Profesional_OT
2008 Therapy HCPCS Utilization: Professional: SLP	Professional_SLP	CY 2008_HCPCS_Profesional_SLP
2008 Therapy HCPCS Utilization: Professional: >=2 Therapy Modifiers	Professional_>=2 Modifiers	CY 2008_HCPCS_Profesional_2 Modifiers
2008 Therapy HCPCS Utilization: Professional: No Therapy Modifiers	Professional_No Modifiers	CY 2008_HCPCS_Profesional_No Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – PTPP Provider Numbers	PTPP_All	CY 2008_HCPCS_Profesional_PTPP
2008 Therapy HCPCS Utilization: Professional: Setting – OTPP Provider Numbers	OTPP_All	CY 2008_HCPCS_Profesional_OTPP
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers	Physician_All	CY 2008_HCPCS_Profesional_Physician
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers	NPP_All	CY 2008_HCPCS_Profesional_NPP
2008 Therapy HCPCS Utilization: Professional: Setting – PTPP Provider Numbers – PT	PTPP_PT	CY 2008_HCPCS_Profesional_PTPP_PT
2008 Therapy HCPCS Utilization: Professional: Setting – PTPP Provider Numbers - >=2 Therapy Modifiers	PTPP_>=2 Modifiers	CY 2008_HCPCS_Profesional_PTPP_2 Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – PTPP Provider Numbers - No Therapy Modifiers	PTPP_No Modifiers	CY 2008_HCPCS_Profesional_PTPP_No Modifiers

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Therapy HCPCS Utilization: Professional: Setting – OTTP Provider Numbers – OT	OTTP_OT	CY 2008_HCPCS_Profesional_OTTP_OT
2008 Therapy HCPCS Utilization: Professional: Setting – OTTP Provider Numbers - >=2 Therapy Modifiers	OTTP_>=2 Modifiers	CY 2008_HCPCS_Profesional_OTTP 2 Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – OTTP Provider Numbers - No Therapy Modifiers	OTTP_No Modifiers	CY 2008_HCPCS_Profesional_OTTP No Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers – PT	Physician_PT	CY 2008_HCPCS_Profesional_Physician_PT
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers – OT	Physician_OT	CY 2008_HCPCS_Profesional_Physician_OT
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers – SLP	Physician_SLP	CY 2008_HCPCS_Profesional_Physician_SLP
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers - >=2 Therapy Modifiers	Physician_>=2 Modifiers	CY 2008_HCPCS_Profesional_Physician_2 Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – Physician Provider Numbers - No Therapy Modifiers	Physician_No Modifiers	CY 2008_HCPCS_Profesional_Physician_No Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers – PT	NPP_PT	CY 2008_HCPCS_Profesional_NPP_PT
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers – OT	NPP_OT	CY 2008_HCPCS_Profesional_NPP_OT
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers – SLP	NPP_SLP	CY 2008_HCPCS_Profesional_NPP_SLP
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers - >=2 Therapy Modifiers	NPP_>=2 Modifiers	CY 2008_HCPCS_Profesional_NPP_2 Modifiers
2008 Therapy HCPCS Utilization: Professional: Setting – NPP Provider Numbers - No Therapy Modifiers	NPP_No Modifiers	CY 2008_HCPCS_Profesional_NPP_No Modifiers

**EXCEL File Name: CY 2008\_HCPCS\_Provider**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Therapy HCPCS Utilization: Provider: All	Provider_All	CY 2008_HCPCS_Provider_All
2008 Therapy HCPCS Utilization: Provider: PT	Provider_PT	CY 2008_HCPCS_Provider_PT
2008 Therapy HCPCS Utilization: Provider: OT	Provider_OT	CY 2008_HCPCS_Provider_OT
2008 Therapy HCPCS Utilization: Provider: SLP	Provider_SLP	CY 2008_HCPCS_Provider_SLP
2008 Therapy HCPCS Utilization: Provider Setting: Hospital	Hospital_All	CY 2008_HCPCS_Provider_Hospital
2008 Therapy HCPCS Utilization: Provider Setting: SNF	SNF_All	CY 2008_HCPCS_Provider_SNF
2008 Therapy HCPCS Utilization: Provider Setting: CORF	CORF_All	CY 2008_HCPCS_Provider_CORF

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Therapy HCPCS Utilization: Provider Setting: ORF	ORF_All	CY 2008_HCPCS_Provider_ORF
2008 Therapy HCPCS Utilization: Provider Setting: HHA	HHA_All	CY 2008_HCPCS_Provider_HHA
2008 Therapy HCPCS Utilization: Provider Setting: Hospital - PT	Hospital_PT	CY 2008_HCPCS_Provider_Hospital_PT
2008 Therapy HCPCS Utilization: Provider Setting: Hospital - OT	Hospital_OT	CY 2008_HCPCS_Provider_Hospital_OT
2008 Therapy HCPCS Utilization: Provider Setting: Hospital - SLP	Hospital_SLP	CY 2008_HCPCS_Provider_Hospital_SLP
2008 Therapy HCPCS Utilization: Provider Setting: SNF - PT	SNF_PT	CY 2008_HCPCS_Provider_SNF_PT
2008 Therapy HCPCS Utilization: Provider Setting: SNF - OT	SNF_OT	CY 2008_HCPCS_Provider_SNF_OT
2008 Therapy HCPCS Utilization: Provider Setting: SNF - SLP	SNF_SLP	CY 2008_HCPCS_Provider_SNF_SLP
2008 Therapy HCPCS Utilization: Provider Setting: CORF - PT	CORF_PT	CY 2008_HCPCS_Provider_CORF_PT
2008 Therapy HCPCS Utilization: Provider Setting: CORF - OT	CORF_OT	CY 2008_HCPCS_Provider_CORF_OT
2008 Therapy HCPCS Utilization: Provider Setting: CORF - SLP	CORF_SLP	CY 2008_HCPCS_Provider_CORF_SLP
2008 Therapy HCPCS Utilization: Provider Setting: ORF - PT	ORF_PT	CY 2008_HCPCS_Provider_ORF_PT
2008 Therapy HCPCS Utilization: Provider Setting: ORF - OT	ORF_OT	CY 2008_HCPCS_Provider_ORF_OT
2008 Therapy HCPCS Utilization: Provider Setting: ORF - SLP	ORF_SLP	CY 2008_HCPCS_Provider_ORF_SLP
2008 Therapy HCPCS Utilization: Provider Setting: HHA - PT	HHA_PT	CY 2008_HCPCS_Provider_HHA_PT
2008 Therapy HCPCS Utilization: Provider Setting: HHA - OT	HHA_OT	CY 2008_HCPCS_Provider_HHA_OT
2008 Therapy HCPCS Utilization: Provider Setting: HHA - SLP	HHA_SLP	CY 2008_HCPCS_Provider_HHA_SLP

**EXCEL File Name: CY 2008\_Percentile**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Outpatient Therapy Utilization: Percentiles: Therapy Type - All Settings	Therapy Type	CY 2008_Percentile_Therapy Setting
2008 Outpatient Therapy Utilization: Percentiles: Setting - All Therapy Types	Therapy Setting	CY 2008_Percentile_Therapy Type

**EXCEL File Name: CY 2008\_Utilization Summary**

Worksheet Title	Worksheet Tab Name	Corresponding .csv file name
2008 Therapy HCPCS Utilization: Summary by Therapy Type	Therapy Type	CY 2008_Utilization Summary_Therapy Type
2008 Therapy HCPCS Utilization: Summary by Therapy Setting	Therapy Setting	CY 2008_Utilization Summary_Therapy Setting
2008 Therapy HCPCS Utilization: Summary of Therapy Setting and Type	Therapy Setting and Type	CY 2008_Utilization Summary_Therapy Setting_Type
2008 Therapy HCPCS Utilization: Summary of Therapy Type and Setting	Therapy Type and Setting	CY 2008_Utilization Summary_Therapy Type_Setting

## Appendix D: Principal Claim ICD-9 Codes Included in CSC PT Classification Groups

Physical Therapy	
CSC Classification Group	Principal Claim ICD-9 Codes Included in Classification Group
(1) Amputation	If episode ICD-9 code starts with: 897.0 or 897.2, or If episode ICD-9 code is exactly: V49.75
(2) Ankle/Foot	If episode ICD-9 code starts with: 355.6, 727.1, 735.0, 735.4, 824.2, 824.4, 824.8, or 826.0, or If episode ICD-9 code is exactly: 715.17, 715.97, 718.47, 719.07, 719.47, 719.57, 726.70, 726.71, 726.72, 726.73, 726.79, 825.25, 845.00, 845.09, or 845.10
(3) Cardiac/Vascular/ Pulmonary	If episode ICD-9 code starts with: 486, 496, 401.9, 428.0, 443.9, 454.0, 492.8, or If episode ICD-9 code is exactly: 414.00, 414.01, 427.31, 491.21, or 518.81
(4) Cervical	If episode ICD-9 code starts with: 721.0, 721.1, 722.0, 722.4, 723.0, 723.1, 723.3, 723.4, 739.1, or 847.0, or If episode ICD-9 code is exactly: 722.71 or 722.91
(5) Cognitive/Mental	If episode ICD-9 code starts with: 311, 290.0, 294.8, 298.9, 331.0, or If episode ICD-9 code is exactly: 290.40, 294.10, or 294.11
(6) Edema	If episode ICD-9 code starts with: 457.0, 457.1, 782.0, or 782.3, or If episode ICD-9 code is exactly: 459.81
(7) Elbow/Forearm	If episode ICD-9 code is exactly: 719.43, 726.31, 726.32
(8) Hip/Pelvis/Thigh	If episode ICD-9 code starts with: 726.5, 808.2, 808.8, 820.8, 820.9, 843.8, or 843.9, or If episode ICD-9 code is exactly: 715.15, 715.35, 715.95, 716.95, 719.45, 719.55, 820.21, 821.00, 924.01, V43.64, or V54.13
(9) Incontinence	If episode ICD-9 code starts with: 625.6, or If episode ICD-9 code is exactly: 788.31 or 788.33
(10) Knee/Leg	If episode ICD-9 code starts with: 717.2, 717.3, 717.7, 717.9, 822.0, 836.0, 836.1, 836.2, 844.0, 844.1, 844.8, or 844.9, or If episode ICD-9 code is exactly: 715.16, 715.36, 715.96, 716.96, 718.46, 719.06, 719.26, 719.46, 719.56, 719.96, 726.60, 726.61, 726.64, 823.00, 823.80, 924.11, or V43.65
(11) Lumbar/Sacral/Thoracic	If episode ICD-9 code starts with: 720.2, 721.2, 721.3, 724.1, 724.2, 724.3, 724.4, 724.5, 724.6, 724.9, 739.3, 805.2, 805.4, 846.0, 846.9, 847.1, 847.2, or 847.9, or If episode ICD-9 code is exactly: 721.42, 722.10, 722.51, 722.52, 722.73, 722.83, 722.93, 724.02, 737.30, or 756.11
(12) Metabolic	If episode ICD-9 code starts with: 585 or 285.9, or If episode ICD-9 code is exactly: 250.00, 250.01, 250.60, 250.80)
(13) Mobility	If episode ICD-9 code starts with: 719.7, 781.0, 781.2, 781.3, or 799.3, or If episode ICD-9 code is exactly: 781.92
(14) Multiple Sites	If episode ICD-9 code starts with: 714.0, or If episode ICD-9 code is exactly: 715.00, 715.09, 715.89, 715.90, 715.98, 718.49, 719.49, 719.59, or 728.87
(15) Neurologic	If episode ICD-9 code starts with: 340, 436, 332.0, 343.9, 437.9, 438.0, or 438.9, or If episode ICD-9 code is exactly: 342.90, 434.91, 438.20, 438.21, 438.22, or 438.89

<b>Physical Therapy</b>	
<b>CSC Classification Group</b>	<b>Principal Claim ICD-9 Codes Included in Classification Group</b>
(16) Neuromusculoskeletal-Other	If episode ICD-9 code starts with: 351.0, 355.8, 355.9, 356.9, 357.2, 727.3, 728.2, 728.3, 728.9, 729.1, 729.2, 729.4, 729.5, 729.9, 739.6, or 966.4, or If episode ICD-9 code is exactly: 715.18, 716.90, 719.40, 719.48, 719.50, 719.58, 719.80, 726.90, 727.00, 727.09, 728.85, 728.89, 729.81, 729.89, 781.99, V54.81, or V54.89
(17) Shoulder/Upper Arm	If episode ICD-9 code starts with: 726.0, 726.2, 840.0, 840.4, 840.6, 840.8, or 840.9, or If episode ICD-9 code is exactly: 715.11, 715.31, 715.91, 716.91, 719.41, 719.42, 719.51, 726.10, 726.11, 726.12, 726.19, 727.61, 812.00, 812.01, 812.03, 812.09, 812.20, 812.21, 831.00, or V43.61
(18) Skin - Decubitus	If episode ICD-9 code starts with: 707.0
(19) Skin - Not Decubitus	If episode ICD-9 code starts with: 682.6, 891.0, or If episode ICD-9 code is exactly: 707.10, 707.14, or 707.15
(20) Spinal Cord	If episode ICD-9 code starts with: 344.1
(21) Spine	If episode ICD-9 code starts with: 722.2, 722.6, 724.8, or 738.4, or If episode ICD-9 code is exactly: 721.90, 724.00, 733.00, 733.13, or 756.12
(22) Swallowing	If episode ICD-9 code starts with: 787.2
(23) Wrist/Hand	If episode ICD-9 code starts with: 354.0, or 728.6, or If episode ICD-9 code is exactly: 715.14, 715.94, 718.44, 719.44, 719.54, 727.03, 727.04, 727.05, 813.41, 813.42, 814.00, or 842.00
(24) Other	If episode ICD-9 code starts with: 389, 174.9, 276.5, 435.9, 578.9, 599.0, 780.2, 780.4, 784.0, V53.7, V57.1, or V57.9, or If episode ICD-9 code is exactly: 335.20, 386.11, 386.12, 780.39, 780.79, 780.99, 786.50, 786.59, 788.30, V45.89, V57.21, V57.89, V72.83, or V72.84

## Appendix E: Principal Claim ICD-9 Codes Included in CSC OT Classification Groups

Occupational Therapy	
CSC Classification Group	Principal Claim ICD-9 Codes Included in Classification Group
(1) Amputation	If episode ICD-9 code starts with: 897.0, or 897.2
(2) Ankle/Foot	If episode ICD-9 code starts with: 824.8, or If episode ICD-9 code is exactly: 719.47, 728.71, or 845.00
(3) Cardiac/Vascular/Pulmonary	If episode ICD-9 code starts with: 486, 496, 401.9, 413.9, 414.9, 428.0, 429.2, 443.9, 453.8, 492.8, 507.0, or 560.9, or If episode ICD-9 code is exactly: 410.90, 414.00, 414.01, 427.31, 427.89, 459.81, 491.21, 518.81, 786.09, V12.59, or V45.89
(4) Cervical	If episode ICD-9 code starts with: 721.0, 723.0, 723.1, 723.3, 723.4, or 847.0
(5) Cognitive/Mental	If episode ICD-9 code starts with: 311, 319, 290.0, 294.8, 294.9, 296.7, 298.9, 310.9, or 331.0, or If episode ICD-9 code is exactly: 290.10, 290.20, 290.40, 294.10, 294.11, 295.30, 295.70, 295.90, or 784.60
(6) Edema	If episode ICD-9 code starts with: 457.0, 457.1, or 782.3
(7) Elbow/Forearm	If episode ICD-9 code is exactly: 715.13, 718.43, 719.43, 719.53, 726.31, 726.32, 812.40, 813.01, 813.05, 813.41, 813.42, 813.44, 813.81, V54.12, or 715.93
(8) Hip/Pelvis/Thigh	If episode ICD-9 code starts with: 726.5, 808.2, 808.8, 820.8, or 820.9, or If episode ICD-9 code is exactly: 715.15, 715.35, 715.95, 719.45, 820.00, 820.09, 820.21, 821.00, 924.01, V43.64, or V54.13
(9) Knee/Leg	If episode ICD-9 code starts with: 844.9, or If episode ICD-9 code is exactly: 715.16, 715.36, 715.96, 718.46, 719.46, 726.60, 726.64, 726.90, or V43.65
(10) Lumbar/Sacral/Thoracic	If episode ICD-9 code starts with: 721.3, 724.2, 724.3, 724.4, 724.5, 805.2, 805.4, 846.0, or 847.2, or If episode ICD-9 code is exactly: 722.10, 722.52, 724.00, 724.02, 721.90, 733.00, or 733.13
(11) Metabolic	If episode ICD-9 code starts with: 585, 586, 244.9, 276.1, 276.5, 285.9, 584.9, or 593.9, or If episode ICD-9 code is exactly: 250.00, 250.01, 250.02, or 250.60
(12) Mobility	If episode ICD-9 code starts with: 719.7, 781.0, 781.2, 781.3, 783.3, or 799.3, or If episode ICD-9 code is exactly: 781.92
(13) Multiple Sites	If episode ICD-9 code is exactly: 715.09, 715.89, 715.98, 716.90, 716.99, 718.49, 719.48, 719.49, or 719.59
(14) Neurologic	If episode ICD-9 code starts with: 431, 436, 332.0, 333.4, 343.2, 343.9, 344.1, 348.1, 432.1, 435.9, 437.9, 438.0, or 438.9, or If episode ICD-9 code is exactly: 342.12, 342.90, 342.91, 342.92, 348.30, 434.91, 438.11, 438.20, 438.21, 438.22, 438.82, 438.84, 438.89, 854.00, or 959.01
(15) Neuromusculoskeletal-Other	If episode ICD-9 code starts with: 138, 340, 354.0, 354.2, 354.3, 355.9, 356.9, 359.1, 714.0, 728.2, 728.3, 728.9, 729.1, 805.8, or 996.4, or If episode ICD-9 code is exactly: 335.20, 715.00, 715.90, 718.40, 719.40, 719.50, 719.80, 727.00, 727.09, 728.85, 728.87, 728.89, 729.81, 729.89, 781.99, V54.19, V54.81, V54.89, or V58.78

Occupational Therapy	
CSC Classification Group	CSC Classification Group
(16) Shoulder/Upper Arm	If episode ICD-9 code starts with: 726.0, 726.2, 739.7, 840.4, or 840.9, or If episode ICD-9 code is exactly: 715.11, 715.91, 716.91, 718.41, 718.42, 719.41, 719.42, 719.51, 726.10, 726.11, 726.12, 726.19, 727.61, 812.00, 812.01, 812.09, 812.20, 812.21, 831.00, or V54.11
(17) Skin-Decubitus	If episode ICD-9 code starts with: 707.0, 682.6, or 682.9
(18) Spinal Cord	If episode ICD-9 code is exactly: 344.00
(19) Swallowing	If episode ICD-9 code starts with: 787.2
(20) Vision	If episode ICD-9 code is exactly: 362.50, 362.51, 362.52, 368.41, 369.08, 369.14, 369.18, 369.22, 369.24, 369.25, or 369.13
(21) Wrist/Hand	If episode ICD-9 code starts with: 728.6, 736.1, 883.0, 883.2, 886.0, 959.4, or 959.5, or If episode ICD-9 code is exactly: 715.04, 715.14, 715.34, 715.94, 716.94, 718.44, 719.44, 719.54, 727.03, 727.04, 727.05, 727.63, 814.00, 814.01, 815.00, 816.00, 816.01, 842.00, or 842.10
(22) Other	If episode ICD-9 code starts with: 389, 310.1, 174.9, 578.9, 599.0, 729.5, 729.9, 780.2, 780.4, 782.0, 783.7, 784.3, 784.5, V53.7, V53.8, V57.1, V57.3, or V57.9, or If episode ICD-9 code is exactly: 780.93, 780.09, 780.39, 780.79, 780.99, 786.50, 786.59, V57.21, V57.89, V72.83, or V72.84

## Appendix F: Principal Claim ICD-9 Codes Included in CSC SLP Classification Groups

Speech-Language Pathology	
CSC Classification Group	CSC Classification Group
(1) Cognitive	If episode ICD-9 code starts with: 311, 319, 290.0, 294.8, 294.9, 298.9, 310.9, 331.0, or 438.0, or If episode ICD-9 code is exactly: 290.10, 290.20, 290.40, 294.10, or 294.11
(2) Communication	If episode ICD-9 code is exactly: 438.10, 438.11, 438.12, 784.60, or 784.69
(3) Hearing	If episode ICD-9 code starts with: 389.2, or If episode ICD-9 code is exactly: 389.10, 389.11, 389.18
(4) Neurologic	If episode ICD-9 code starts with: 340, 431, 436, 332.0, 333.4, 343.9, 432.1, 435.9, 437.9, or 438.9, or If episode ICD-9 code is exactly: 342.90, 434.91, 438.20, 438.21, 438.22, 438.89, or 854.00
(5) Speech	If episode ICD-9 code starts with: 784.5, or If episode ICD-9 code is exactly: 438.19, or 478.31
(6) Swallowing	If episode ICD-9 code starts with: 486, 507.0, 787.2, or V41.6, or If episode ICD-9 code is exactly: 438.82
(7) Voice	If episode ICD-9 code starts with: 478.5, or If episode ICD-9 code is exactly: 478.30, 784.40, 784.41, or 784.49
(8) Other	If episode ICD-9 code starts with: 496, 389, 585, V57.3, 781.2, V57.1, 719.7, 428.0, 784.3, 401.9, 799.3, 728.2, 599.0, 786.2, 820.8, 783.3, 728.9, 724.2, 781.3, 161.9, 578.9, 276.5, 780.2, 933.1, 784.9, 707.0, 285.9, 780.4, 244.9, 161.0, 443.9, 310.1, 729.9, 530.3, 682.6, or 783.7, or If episode ICD-9 code is exactly: V57.89, 250.00, 780.79, 728.87, 780.99, 781.92, 530.81, 715.90, 250.01, 427.31, 780.39, V57.21, 335.20, 414.00, 518.81, 733.00, 729.89, 718.44, 781.99, 381.81, 716.90, 715.09, 783.21, 820.21, V10.21, 386.11, or 718.49