# Statement Of

# The National Athletic Trainers' Association (NATA)

# On

# Medicare Therapy Caps and Refined and Alternative Payment Methodologies

# Submitted by


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Chairman Stark

On behalf of the National Athletic Trainers' Association, I want to thank you for this opportunity to offer comments on Medicare's payment policy for outpatient therapy services.

As you may know, Athletic Trainers are highly skilled healthcare professionals who specialize in the prevention, evaluation, management and rehabilitation of injuries associated with physical activity. Athletic Trainers are legally authorized to practice in all 50 states and the District of Columbia. 46 states formally license or regulate Athletic Trainers and the remaining states authorize AT practice either through formal state statutes or under the delegatory authority of the physician.

Although historically linked to athletes at the high school, collegiate, and professional levels, Athletic Trainers have worked for the past 20 years in hospitals, rehabilitation facilities, and physicians' offices to provide rehabilitation services to a broad range of patients – including Medicare eligible individuals until 2005. As established physical medicine and rehabilitation services providers, the demand for their services continues to increase as the senior population maintains and improves its levels of physical activity.

Consequently payment policies for physical medicine and rehabilitation services and how they are paid to hospitals, clinics, and physicians affect thousands of Athletic Trainers and the patients they serve. Ironically, recent CMS policies regarding therapy services provided in physicians' offices, in conjunction with the enforcement of the "therapy cap", have served to decrease the availability of therapy services in many regions of the country. More importantly, these policies have increased patient costs and increased the likelihood that Medicare beneficiaries will have therapy expenses that exceed the cap.

Last year, the Medicare Payment Advisory Commission noted that the average per beneficiary cost of therapy services was dramatically less when provided in a physician's office rather than by a PT in private practice.***(1)*** The data analyzed by MedPAC was for years when Athletic Trainers were providing services to Medicare patients in physician's offices. When considering specific conditions, the cost differential was even more dramatic. According to MedPAC, the cost of treating patients with knee and lower leg musculoskeletal conditions differed significantly from setting to setting. For example, when patients with knee and lower leg conditions were treated by a PT in Private Practice, the average cost per beneficiary was $874.00. When those same conditions were treated by a physician in private practice, the average cost per beneficiary was $639.00. This was a savings of $235 per beneficiary to Medicare and the beneficiary combined.

For Medicare patients, this means that their out-of-pocket expenses are higher when they are treated by a PT in private practice AND, it means they are more likely to reach the cap when they are treated by a PT in private practice than if those same services were provided in the physician's office.

One of the obvious questions that must be asked is why this is happening? Is it due to inappropriate utilization? Overuse of services? Inappropriate personnel leading to increased visits?

Based upon a study of therapy services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs) by the General Accounting Office (GAO), we know that these differences "**cannot be explained by patient characteristics such as diagnosis, age, sex, disability and prior hospitalization."** ***(2)***

**Overuse of services?**

A recent study funded by the Agency for Healthcare Research and Quality (AHRQ) indicates that when PTs working with PT Assistants (PTA) provide services in private practice, patients incur far more visits than when similar patients are treated in other settings.***(3)*** Whether this is because PTs are attempting to increase visits in order to maximize payments is not clear. It does raise the question of why patients are able to be restored to full functionality with fewer visits when seen by a physician then when seen by a PT in private practice.

High PTA utilization was associated with more visits whereas other studies have shown that physician utilization of Athletic Trainers to provide rehabilitation services is associated with fewer patient visits. This could explain the MedPAC analysis demonstrating higher per patient costs for PTs in Private Practice relative to Medicare patients seen in physician's offices.

**Inappropriate Utilization?**

According to a 2002 Department of Health and Human Services Office of Inspector General (OIG) report reviewing Medicare claims for therapy services provided by PTs in private practice, 99% of claims reviewed by the OIG were inappropriate. Specifically, what the OIG found was that 2,709 of the 2,734 claims included in this study DID NOT meet one or more of Medicare's reimbursement requirements. ***(4)*** Although there were some claims for Occupational Therapy services included in the analysis, the vast majority of claims were for PT services.

According to the OIG, the claims typically did not contain the data necessary to justify Medicare payment for services.

• The therapists did not maintain adequate documentation.
• The therapists did not meet the plan of care requirements.
• Someone other than the billing therapists performed the services.

The 99 percent error rate may indicate that the therapists did not have procedures in place to ensure that the billed services met Medicare requirements. If this study is typical of services being provided by PTs in private practice throughout the country, Medicare is spending dramatically more for PT services than is necessary.

This may also explain why CMS data shows that Medicare expenditures for services provided by PTs in Private Practice grew more than twice as fast (33%) from 2000-2004 than therapy services provided in most other settings, including physician's offices (14%). ***(5)***

These are shocking findings and suggest what many fear are serious problems involving therapy services being provided by PTs in Private Practice.

**Use of Inappropriate Personnel?**

The above referenced OIG report also found many PTs are using inappropriate personnel to provide services. While the OIG report did not provide specifics in this area, this finding is consistent with the analysis funded by AHRQ.

In the AHRQ study entitled, "State regulation and the delivery of physical therapy services" released earlier this year, the authors found that "Use of physical therapist assistants in place of physical therapists may result in lower quality of rehabilitation care." The study went on to note that the use of physical therapist assistants (PTAs) and therapy aides in place of licensed physical therapists (PTs) may reduce the efficiency and quality of care in outpatient rehabilitation. ***(3)***

Ironically, Physical Therapy Assistants (PTAs) are allowed to treat Medicare patients under the supervision of a PT. This authority has never been granted by Congress yet CMS permits this to occur. PTAs have 2 years of training receiving an Associates Degree upon completion of their 4 semester program.

Unlike a physician's office, where the use of Athletic Trainers appears to reduce the number of visits and improve quality, these researchers found that that use of PT Assistants or Aides, "were each independently associated with more visits per treatment episode and lower functional health upon discharge from treatment." One explanation for this finding could be that it is not uncommon for a single PT to simultaneously supervise 4 Physical Therapy Assistants and bill Medicare for the services provided by these PTAs as though the services were provided by the PT personally.

By contrast, CMS policy effectively prohibits physicians from utilizing Athletic Trainers, who are highly educated allied health care providers, from providing services to Medicare patients. Certified Athletic Trainers must have a minimum 4 year degree and pass a national certification exam administered by the athletic trainer Board of Certification in order to be credentialed as an AT (Athletic Trainer). 70% of ATs have a master's degree. They are also required to obtain continuing education units (CEUs) to maintain certification. ATs are licensed or otherwise regulated in 46 states and always work with physician supervision. ***(6)***

**What Does This Mean?**

Unfortunately, organizations that have a vested interest in restraining competition and preventing patients from obtaining services in the most cost-effective setting, have sought to convince Congress that providing therapy services in the physician's office is somehow either inappropriate or unethical. Nothing could be further from the truth.

Before Congress considers any legislation to either raise or waive the therapy cap or expand the authority of PTs to circumvent more cost effective treatment in the physician's office, it must get answers to the questions we raise above.

Medicare beneficiaries deserve to have health care provided by highly trained health care professionals. Athletic Trainers have comparable educational and credentialing standards that are well suited to the active senior, an increasingly common profile of Medicare beneficiaries. Educational and credentialing standards for different types of health professionals providing physical medicine and rehabilitation services should be consistent but do not have to be identical.

Identical standards serve only to establish—or in this case maintain—a monopoly for one group of providers. Similarly, identical standards and a homogeneous group of providers lessen the incentive for research and practice innovations in health care, whether clinical or business practice innovations. Standards should be consistent in order to ensure that providers who deliver these services have attained the level of education and qualification necessary to provide them safely and effectively.

Medicare does not restrict the delivery of medical services to physicians but rather covers these services if provided by physician assistants, nurse practitioners or nurse anesthetists. Similarly a wide variety of imaging professionals – radiologic technologists, mammographers, sonographers, radiographers, CT Technologists, etc. – deliver the vast majority of imaging services under the supervision of a physician. Why would you want to limit the delivery of physical medicine and rehabilitation services to one type of allied health professional when states have determined that others are equally qualified even though they may have a different credential after their name?

The issue of appropriately educated alternate providers, such as Athletic Trainers, is important to ensure an adequate supply of providers. There has been a steady decline in the number of physical therapy graduates as a result of the professional association's efforts to promote a clinical doctorate degree. Although no state and most employers do not require a clinical doctorate, all PT schools by 2009 will only offer a clinical doctorate program. This additional education requirement has only served to limit the number of graduates and increase the amount of debt carried by graduates. In fact, PT salaries increased almost 24% from 1999-2004. ***(7)*** The result is an increased demand for the only Medicare-approved rehab provider who has a high level of debt and need for improved compensation.

By restricting whom physicians can employ to provide these valuable services, you will only increase the cost of physical medicine and rehabilitation services and further limit their availability.

And there are clearly shortages of physical therapists. Legislation has been passed by congress to relax immigration standards to permit more foreign trained physical therapists to come into the country and the professional organizations representing PTs are promoting legislation that would extend National Health Service Corps scholarship and loan programs to PTs willing to practice in underserved areas. ***(8)***

Therefore, we urge Congress to restore to physicians the authority to utilize state licensed or certified Athletic Trainers to provide services to Medicare patients under the physician's supervision. Rep. Ed Towns (D-NY) has introduced a bill (H.R. 1846) that would authorize Medicare coverage for Athletic Trainers working under the supervision of the physician. Payment would be for services currently covered by Medicare that fall within the state scope of practice for Athletic Trainers and payment would go to the ATs employer – a hospital, clinic or physician. This bill is not only cost-effective but clearly will decrease the number of patients who may exceed the cap.

H.R. 1846 accomplishes this objective by restoring the ability of highly qualified health care professionals who have treated Medicare patients in the past, to resume that service. Athletic Trainers have a close relationship with their supervising physicians which affords better communication between providers and which enhances the patients' healthcare and improves outcomes.

Consider, for example, that the typical Athletic Trainer working in a hospital, clinic or physician's office has a Master's degree whereas the typical PT Assistant working for a PT in private practice has an Associates degree. The MD/AT team brings a much higher level of education and training to the patient encounter than does the PT/PTA team.

According to the American Physical Therapy Association, the highest degree earned by 46% of PTs is a Master's degree and only 6% have a earned a PhD. The APTA also states that for 70% of PTAs, the highest degree obtained is an Associates Degree. ***(9)*** Again, as noted previously, over 70% of Athletic Trainers have earned at least a Master's Degree.

Consistency in policy would authorize an Athletic Trainer working with physician supervision to be recognized by Medicare given that Medicare recognizes a PT Assistant working under physical therapist supervision.

Certainly there are patients whose therapy needs exceed the scope and ability of the Athletic Trainer-Physician team. We are equally cognizant of the fact that the physical medicine and rehabilitation needs of some patients are such that the current cap is a barrier to getting the services these patients need. However, the waiver process appears to be working and patients who are truly in need of more or higher cost physical medicine and rehabilitation services are gaining access to that care.

But most patients do not require therapy at the level of intensity or volume of services that would result in their exceeding the annual cap. According to Medicare's own data, the most commonly performed therapy services are services perfectly suited for delivery by a certified athletic trainer.

**Percent of total payments by Setting for most frequently reported outpatient therapy codes – CY 2004** ***(10)***

| Code | Description of Code | PT in Private Practice | Physician |
|---|---|---|---|
| 97110 | Therapeutic procedure, one ore more areas, therapeutic exercise to develop strength and endurance and range of motion | 46.2 | 39.42 |
| 97140 | Manual Therapy – 15 minute session | 16.44 | 13.58 |
| 97530 | Therapeutic activities, direct (one on one) patient contact to improve dynamic | 8.65 | 8.03 |

| | | | |
|---|---|---|---|
| | activities to improve functional performance | | |
| 97112 | Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception | 6.33 | 6.25 |
| 97035 | Ultrasound application (each 15 minutes) | 3.30 | 5.79 |
| 97116 | Gait Training (including stair climbing). | 1.75 | .51 |
| 97124 | Massage, including effleurage, petrissage and/or compression, percussion | 1.11 | 7.18 |
| **Total** | | 84% | 81% |

However, because patients are being denied the ability to receive their services in a setting that MedPAC has demonstrated is lower in cost, many patients are unnecessarily pushing up against the cap.

If you consider the MedPAC finding that the cost of treating knee and lower leg problems in the physician's office is 30% less expensive than when treated by a PT in private practice, you can see how Medicare saves money, the patient saves money and the patient gets a higher quality of care when patients are treated in the physician's office.

Physicians should be allowed to decide who can most appropriately deliver the services for their patients' conditions, whether that is a physical therapist in private practice or an athletic trainer employed by a physician, a hospital rehabilitation department, or some other appropriate location.

**Alternative payment methodologies – Prospective Payment**

As the Committee considers alternative payment methodologies, particularly some type of prospective payment system, it is absolutely imperative that staffing decisions relative to the delivery of care be put in the hands of the providers or facility. Just as hospitals have wide latitude in determining who can or should most appropriately provide a particular service (within state scope of practice laws) so too should others have the same latitude. Medicare gives PTs the authority to delegate the actual delivery of services to PTAs (who by state law can ONLY work for PTs) working under the PTs supervision. Congress should support the physician's ability to delegate the delivery of physical medicine and rehabilitation services to state licensed and/or certified individuals working under the physician's supervision.

When you move to a prospective payment methodology, the number of visits becomes irrelevant to the payer as the risk is shifted to the provider. The provider has every incentive to use the most qualified, cost-effective person to deliver the care for the pre-determined price. But if the providers hands are tied by Congress stipulating whom the physician can or cannot employ, you undermine the attractiveness of a prospective payment system. If Congress moved to the Prospective Payment System for therapy, then the only question remaining is whether the patient is getting medically necessary care at an appropriate level of quality.

If states have authorized Athletic Trainers to provide these services and the physician is providing appropriate supervision, then we believe beneficiaries can be confident they are receiving high quality of care and Medicare is getting appropriate value for the services.

On behalf of the National Athletic Trainers' Association and the more than 30,000 Athletic Trainers we represent, I want to thank you for this opportunity to present our views.

***(1)*** Medpac report on Outpatient Therapy Services
http://www.medpac.gov/publications/other_reports/Dec05_Medicare_Basics_OPT.pdf?CFID=2293069&CFTOKEN=48024906

www.medpac.gov/publications%5Ccongressional_reports%5CJun06DataBookSec12.pdf

***(2)*** IBID (page 7).

***(3)*** "State Regulation and the Delivery of Physical Therapy Services", Resnik, Linda; Feng, Zhanlian; Hart, Dennis L. Health Services Research, Volume 41, Number 4, August 2006 , pp. 1296-1316(21)Publisher: Blackwell Publishing.

***(4)*** "Results Of The Medical Reviews Performed On Selected Medicare Claims For Physical And Occupational Therapy Services Provided During Calendar Year 2002 In The State Of Texas http://www.oig.hhs.gov

***(5)*** Medicare Part B Physician/Supplier National Data – Calendar Year (2003, 2004, 2005) Expenditures and services by specialty
http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp#TopOfPage

***(6)*** National Athletic Trainers Association. http://www.nata.org/about_AT/whatisat.htm

***(7)*** American Physical Therapy Association press release, December 2005 "ALEXANDRIA, VA, December 1, 2005 — Physical therapists are experiencing virtually no unemployment and are reporting overall increased salaries".

***(8)*** American Physical Therapy Association.

***(9)*** American Physical Therapy Association
http://www.apta.org/AM/Template.cfm?Section=Physical_Therapy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=26306

***(10)*** "Outpatient Therapy Alternative Payment Study". Computer Sciences Corporation, Daniel Ciolek and Wenke Hwang. Prepared under contract for the Centers for Medicare and Medicaid Services (CMS), May, 2006.