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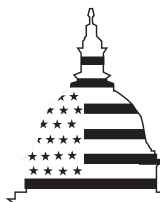
Report to Congressional Committees

November 2005

MEDICARE

Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries' Needs



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GAO-06-59

Highlights of GAO-06-59, a report to congressional committees

November 2005

MEDICARE

Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries' Needs

Why GAO Did This Study

For years, Congress has wrestled with rising Medicare costs and improper payments for outpatient therapy services—physical therapy, occupational therapy, and speech-language pathology. In 1997 Congress established per-person spending limits, or "therapy caps," for nonhospital outpatient therapy but, responding to concerns that some beneficiaries need extensive services, has since placed temporary moratoriums on the caps. The current moratorium is set to expire at the end of 2005.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required GAO to report on whether available information justifies waiving the caps for particular conditions or diseases. As agreed with the committees of jurisdiction, GAO also assessed the status of the Department of Health and Human Services' (HHS) efforts to develop a needs-based payment policy and whether circumstances leading to the caps have changed.

What GAO Recommends

GAO suggests that Congress give HHS interim authority to allow, under certain conditions, payments exceeding the caps after the moratorium expires. GAO recommends that HHS expedite developing a means to assess beneficiaries' therapy needs, and HHS concurs. GAO also recommends that HHS improve its system for identifying improper therapy claims beyond initiatives already under way.

www.gao.gov/cgi-bin/getrpt?GAO-06-59.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119 or steinwalda@gao.gov.

What GAO Found

Data and research available are, for three reasons, insufficient to identify particular conditions or diseases to justify waiving Medicare's outpatient therapy caps. First, Medicare claims data—the most comprehensive data for beneficiaries whose payments would exceed the caps—often do not capture the clinical diagnosis for which therapy is received. Nor do they show particular conditions or diseases as more likely than others to be associated with payments exceeding the caps. Second, even for diagnoses clearly linked to a condition or disease, such as stroke, the length of treatment for patients with the same diagnosis varies widely. Third, because of the complexity of patient factors involved, most studies do not define the amount or mix of therapy services needed for Medicare beneficiaries with specific conditions or diseases. Provider groups remain concerned about adverse effects on beneficiaries needing extensive therapy if the caps are enforced. HHS does not, however, have the authority to provide exceptions to the therapy caps.

Despite several related statutory requirements, HHS has made little progress toward developing a payment system for outpatient therapy that considers individual beneficiaries' needs. In particular, HHS has not determined how to standardize and collect information on the health and functioning of patients receiving outpatient therapy services—a key part of developing a system based on individual needs for therapy.

The circumstances that led to the therapy caps remain a concern. Medicare payments for outpatient therapy are still rising significantly, and increases in improper payments for outpatient therapy continue. HHS could reduce improper payments and Medicare costs by improving its system of automated processes for rejecting claims likely to be improper.

Beneficiaries for Whom 2002 Medicare Payments for Outpatient Therapy Services Would Have Exceeded Therapy Caps, Had They Been in Place, and by How Much

Cap	Projected number of beneficiaries whose payments would have exceeded caps	Projected percentage of beneficiaries whose payments would have exceeded caps	Average amount above cap (dollars)	Estimated total above cap (millions of dollars)[a]
Occupational therapy	129,509	17.4	$1,237	$160.2
Physical therapy and speech-language pathology	508,686	14.5	$1,263	$642.4

Source: Daniel E. Ciolek and W. Hwang, *Final Project Report* (Baltimore, Md.: Computer Sciences Corporation/AdvanceMed, 2004).

Note: Because of a moratorium, therapy caps were not in effect in 2002; use of outpatient therapy services might have been different had the spending caps been in place. Because hospital outpatient departments are exempt from the caps, payments for services provided by hospital outpatient departments were excluded from this analysis.

[a]This study estimated that the totals above the caps represented 23.7 percent of all outpatient therapy expenditures for 2002.

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Abbreviations

BBA	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
MedPAC	Medicare Payment Advisory Commission
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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United States Government Accountability Office
Washington, DC 20548

November 10, 2005

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Medicare, the federal health program insuring more than 40 million beneficiaries aged 65 and older or disabled, covers three outpatient therapy services: physical therapy, occupational therapy, and speech-language pathology. Medicare covers these services only if they are needed to improve a patient's condition (for example, to aid stroke recovery or combat the effects of Parkinson's disease) and are reasonable in amount, frequency, and duration. In 2002, the most recent year for which complete data are available, an estimated 3.7 million, or about 9 percent, of Medicare beneficiaries received one or more of these types of outpatient therapy.[1]

[1]Unless otherwise specified, throughout this report the terms *outpatient therapy* and *outpatient therapy services* refer to all three therapy categories collectively: physical therapy, occupational therapy, and speech-language pathology.

For many years, Congress has wrestled with rising Medicare costs of providing outpatient therapy services.[2] From 1990 through 1996, spending on these services grew at nearly double the rate of Medicare spending overall. Some of the growth was attributed to financial incentives in Medicare payment methods, which encouraged use of services, and to the lack of program oversight to prevent inappropriate payments. For example, in 1995 we reported widespread examples of overcharging Medicare for therapy services delivered to nursing home residents, including markups resulting from providers' exploiting regulatory ambiguity and weaknesses in Medicare's payment rules.[3] In 1997, as a means to control the spending growth, Congress established new caps on the amount that Medicare would pay for outpatient therapy services for a beneficiary in any given year. These therapy caps raised concern, however, that patients with extensive need for outpatient therapy services would be adversely affected—particularly patients who lacked access to hospital outpatient departments, which are exempt from the caps.[4] Since 1997, the caps were actually in effect only in 1999 and part of 2003; in other years, Congress placed temporary moratoriums on them. The current moratorium on the therapy caps is due to expire at the end of December 2005.[5]

As part of the 1997 legislation that established the therapy caps, Congress also required the Department of Health and Human Services (HHS) to report by 2001 on its recommendations for an alternative, "needs-based" payment system for outpatient therapy services. We have reported that, in contrast to less-targeted control over service use afforded by spending limits, such a payment system could help target payments to beneficiaries who genuinely require more services than could be paid for under the

[2]For example, since 1973 therapy provided by one type of outpatient therapy provider, independent physical therapists in private practice, has been subject to annual, per-beneficiary spending limits.

[3]GAO, *Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes*, GAO/HEHS-95-23 (Washington D.C.: Mar. 30, 1995). A list of related GAO products appears at the end of this report.

[4]Under the law, the caps on Medicare outpatient therapy payments do not apply to services provided by a hospital outpatient department. 42 U.S.C. § 1395l(g).

[5]The legislation provides for two caps per beneficiary: one for occupational therapy and one for physical therapy and speech-language pathology combined. The legislation set the caps at $1,500 each and provided that these limits be indexed by the Medicare Economic Index each year beginning in 2002. When last in place in 2003, the two caps were set at $1,590 each.

therapy caps.[6] A needs-based payment system could take into account the type and extent of therapy warranted by a beneficiary's health and functional status (that is, the person's ability to perform activities of daily living, such as bathing, dressing, eating, or moving from one location to another). In several laws enacted starting in 1997, Congress has directed HHS to take certain actions related to the development of such a system, including considering beneficiaries' functional status in the design of a new outpatient therapy policy and reporting on the development of standard instruments for assessing the health and functional status of patients receiving Medicare services, including outpatient therapy.[7] Within HHS, the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, has major responsibilities for this effort.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which put in place the most recent moratorium on therapy caps, directed us to report on the conditions or diseases that may justify waiving application of the caps.[8] To provide a greater range of information about these issues, as agreed with the committees of jurisdiction, we also examined HHS's efforts to date in developing a needs-based payment system. This report assesses (1) available information that could be used to justify waiving outpatient therapy caps for particular conditions or diseases, (2) the status of HHS's efforts to base Medicare payment policy on outpatient therapy on beneficiaries' needs, and (3) whether the circumstances initially leading to the caps have changed.

To assess whether available information could be used to justify waiving outpatient therapy caps for particular conditions or diseases, we reviewed data and research including analyses of Medicare claims data by CMS contractors. We generally relied on the published results of CMS's

[6]GAO, *Medicare: Outpatient Rehabilitation Therapy Caps Are Important Controls but Should Be Adjusted for Patient Need*, GAO/HEHS-00-15R (Washington D.C.: Oct. 8, 1999).

[7]See, for example, the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4541, 111 Stat. 251, 454.

[8]Pub. L. No. 108-173, § 624, 117 Stat. 2066, 2317.

contracted analyses performed on Medicare 2002 claims data.[9,10] The claims data used by CMS contractors and other health care researchers are the most comprehensive data available for assessing Medicare outpatient therapy and the conditions and diseases of Medicare beneficiaries for whom payments would have exceeded the therapy caps had a moratorium on the caps not been in place. We also reviewed the literature on therapy treatment protocols and on the efficacy of outpatient therapy for Medicare beneficiaries with selected conditions and diseases, and we reviewed a related report by the Medicare Payment Advisory Commission (MedPAC), an independent group of health care experts that advises Congress on Medicare payment issues. To assess HHS's response to requirements for developing instruments to ensure that Medicare payments for outpatient therapy are targeted to beneficiaries' needs, we

[9]Studies based on 2002 claims data include Daniel E. Ciolek and Wenke Hwang, *Feasibility and Impact Analysis: Application of Various Outpatient Therapy Service Claim HCPCS Edits*, prepared for CMS (Baltimore, Md.: Computer Sciences Corporation/AdvanceMed, 2004); Daniel E. Ciolek and Wenke Hwang, *Development of a Model Episode-Based Payment System for Outpatient Therapy Services: Feasibility Analysis Using Existing CY 2002 Claims Data*, prepared for CMS (Baltimore, Md.: Computer Sciences Corporation/AdvanceMed, 2004); Daniel E. Ciolek and Wenke Hwang, *Utilization Analysis: Characteristics of High-Expenditure Users of Outpatient Therapy Services*, *CY 2002 Final Report*, prepared for CMS (Baltimore, Md.: Computer Sciences Corporation/AdvanceMed, 2004); and Daniel E. Ciolek and Wenke Hwang, *Final Project Report*, prepared for CMS (Baltimore, Md.: Computer Sciences Corporation/AdvanceMed, 2004). Studies based on other years and data include Judith M. Olshin et al., *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* (Columbia, Md.: DynCorp/AdvanceMed, 2002); Stephanie Maxwell and Cristina Baseggio, *Outpatient Therapy Services under Medicare: Background and Policy Issues*, prepared for CMS (Washington, D.C.: Urban Institute, 2000); and Stephanie Maxwell et al., *Part B Therapy Services under Medicare in 1998–2000: Impact of Extending Fee Schedule Payments and Coverage Limits*, prepared for CMS (Washington, D.C.: Urban Institute, 2001).

[10]To check the reliability of the information we used from CMS-contracted studies, we reviewed the analysis performed by the contractor; discussed the results with the CMS official overseeing the contract; obtained information about the methods and analysis from the contractor, specifically, from the principal investigator of the contracted study; and reviewed the contractor's summary of the study's scope and methods. We also discussed the methods and results of the analyses with provider groups and other researchers familiar with Medicare claims data, including representatives of the Medicare Payment Advisory Commission (MedPAC) and the Urban Institute. We determined that the data as published were generally reliable for our purposes. For one analysis—assessing variation in the length of treatment received by Medicare beneficiaries according to their diagnosis codes—we used the results from an unpublished analysis performed by CMS's contractor AdvanceMed. We verified the reliability of this analysis by obtaining information from the principal investigator about the reliability checks incorporated in that analysis and determined that the analysis was sufficiently reliable for our needs.

reviewed the legislative history of Medicare's outpatient therapy caps, related requirements for HHS, and studies by CMS contractors. We examined HHS's actions in response to the legislative requirements and studies' proposals and reviewed administrative options for ensuring that medically necessary therapy is available to beneficiaries over the short and long terms under Medicare's payment system. To determine whether the circumstances leading to therapy caps—specifically, significant growth in outpatient therapy payments and a high rate of improper payments—have changed, we reviewed preliminary CMS estimates of overall Medicare part B expenditures,[11] which include spending on outpatient therapy services, and CMS reports on improper payments for outpatient therapy services. Finally, we obtained the opinions of four national organizations representing the views of key providers of outpatient therapy services.[12] We conducted our work in accordance with generally accepted government auditing standards from January through October 2005.

Results in Brief

We found the data and research available to date insufficient for three reasons to identify particular conditions or diseases that would justify waiving Medicare's outpatient therapy caps:

- Medicare claims data are limited in the extent to which they identify the actual conditions or diseases for which beneficiaries receive therapy because the data often do not capture the clinical diagnosis for which therapy is received. Further, a CMS-contracted analysis of claims data for 2002 does not show any particular conditions or diseases as more likely than others to be associated with payments exceeding the therapy caps.
- Even for diagnoses that are clearly linked to a condition or disease, such as stroke, the CMS-contracted analysis of 2002 claims data shows that the length of treatment for patients with the same diagnosis varied widely.
- Because of the complexity of patient factors involved, most studies we reviewed do not define the amount or mix of therapy services needed for Medicare beneficiaries with specific conditions or diseases.

[11]Medicare part B includes coverage for physician services and payments to other licensed practitioners, clinical laboratory and diagnostic services, surgical supplies and durable medical equipment, and ambulance services. Medicare part A covers inpatient hospital and certain other services.

[12]We interviewed officials from the American Physical Therapy Association, the American Occupational Therapy Association, the American Speech-Language Hearing Association, and the National Association for the Support of Long-Term Care.

It is uncertain how many beneficiaries would be adversely affected because they have medical needs for therapy costing more than the caps and yet are unable to obtain needed care because they lack sufficient financial resources or access to a hospital outpatient therapy department. The CMS-contracted analysis of 2002 claims data shows that more than a half million Medicare beneficiaries in 2002 received therapy for which payments would have exceeded the caps had a moratorium not been in place. Provider groups also told us that a sizable number of beneficiaries would be adversely affected if the caps were enforced.

Although congressional mandates starting in 1997 have required HHS to take certain actions toward developing an outpatient therapy payment system that considers patients' individual needs for therapy, the department has made little progress toward such a system, except to contract for a series of studies of outpatient therapy use by Medicare beneficiaries. Two of these contracted studies have reported that functional assessments of patients—standard evaluations that would help determine a person's ability to perform the functions of daily life and specific needs for therapy—would be required to develop a needs-based payment system. CMS officials also said that developing a standard patient assessment instrument could take 3 years or longer. In response to a 2000 statutory requirement for HHS to report to Congress no later than January 1, 2005, on the development of standard patient assessment instruments for patients receiving a variety of services, including outpatient therapy, HHS and CMS have work in progress, but this work does not include outpatient therapy. Officials attribute this exclusion to the complexity of the project and to limited resources.

Circumstances that led to therapy caps do not appear to have changed since the caps were established. CMS assessments of Medicare claims data show that Medicare payments for outpatient therapy are still rising rapidly and that the rate of improper payments has increased substantially in recent years. Over a 4-year period from 1999 through 2002, for example, Medicare spending for outpatient therapy more than doubled, from an estimated $1.5 billion to $3.4 billion. CMS's assessment of the error rate for outpatient therapy claims found that improper payments—mainly due to insufficient documentation to support the services claimed—grew from about 11 percent in 1998 to more than 20 percent in 2000. CMS could reduce improper payments and the costs to Medicare by implementing the proposal in its contracted study of Medicare outpatient therapy claims to strengthen the agency's system for identifying and denying payment of improper outpatient therapy claims. Provider groups we spoke with agreed that such improvements in CMS's automated payment system

could help ensure that Medicare does not pay for unneeded services. Furthermore, an exception process based on a medical review could help determine the appropriateness of payment for therapy services. At present, however, HHS does not have the authority to implement such a process or to conduct a demonstration or pilot project to provide exceptions to the therapy caps.

To provide a means by which some Medicare beneficiaries could have access to appropriate outpatient therapy services and to obtain better data on the conditions and diseases of beneficiaries who have extensive outpatient therapy needs, we suggest that Congress consider giving HHS the authority to implement an interim process or demonstration project whereby individual beneficiaries could be granted an exception from the therapy caps under certain conditions determined by CMS. In addition, to expedite development of a patient assessment instrument for outpatient therapy services, we recommend that the Secretary of HHS include these services in the effort already under way to standardize the terminology for existing patient assessment instruments. To reduce payment for improper claims, we recommend that the Secretary of HHS implement improvements to CMS's system for identifying outpatient therapy claims that are likely to be improper.

In commenting on a draft of this report, HHS did not address our suggestion that Congress give the department interim authority to allow, under certain circumstances, payments exceeding the caps. HHS agreed with our recommendation to include outpatient therapy services in its effort under way to standardize the terminology for patient assessment. With regard to our recommendation to implement improvements to CMS's automated payment system, HHS referred to a current initiative to improve the coding on Medicare claims and noted that the department is exploring methods for improving the automated evaluation of claims. We believe, however, that HHS could improve the payment system beyond the initiative already under way.

Background

Outpatient therapy services—covered under part B of the Medicare program—comprise physical therapy, occupational therapy, and speech-language pathology to improve patients' mobility and functioning.[13] Medicare regulations and coverage rules require that beneficiaries be referred for outpatient therapy services by a physician or nonphysician practitioner and that a written plan of care be reviewed and certified by the providers at least once every 30 days. Beneficiaries receiving therapy are expected to improve significantly in a reasonable time and to need therapy for rehabilitation rather than maintenance.[14] Medicare-covered outpatient therapy services are provided in a variety of settings by institutional providers (such as hospital outpatient departments, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, outpatient rehabilitation facilities, and home health agencies) and by noninstitutional providers (such as physicians, nonphysician practitioners, and physical and occupational therapists in private practice).[15] Both institutional and noninstitutional providers—with the exception of hospital outpatient departments—are subject to the therapy caps.

For more than a decade, Medicare's costs for outpatient therapy services have been rising, and widespread examples of inappropriate billing practices, resulting from regulatory ambiguity and weaknesses in Medicare's payment rules, have been reported by us and others. In 1995 we reported, for example, that while state averages for physical, occupational, and speech therapists' salaries in hospitals and skilled nursing facilities ranged from about $12 to $25 per hour, Medicare had been charged

[13]Physical therapy services—such as whirlpool baths, ultrasound, and therapeutic exercises—are designed to improve mobility, strength, and physical functioning and to limit the extent of disability resulting from injury or disease. Speech-language pathology, included in the Medicare definition of outpatient physical therapy services, is the diagnosis and treatment of speech, language, and swallowing disorders. Occupational therapy services help patients learn the skills they need to perform daily tasks such as bathing and dressing and to function independently.

[14]Medicare does not cover maintenance therapy—that is, therapy services performed to maintain, rather than improve, a beneficiary's level of functioning. Maintenance therapy includes cases where a patient's restoration potential is insignificant relative to the therapy required to achieve such potential, where it has been determined that the treatment goals will not materialize, or where the therapy is considered a general exercise program. Medicare may, however, cover the development of a maintenance program established during the course of covered therapy.

[15]Unlike physical and occupational therapists, speech-language pathologists are not recognized as practitioners who can directly bill the Medicare program for outpatient therapy services.

$600 per hour or more.[16] HHS's Office of Inspector General reported in 1999 that Medicare reimbursed skilled nursing facilities almost $1 billion for physical and occupational therapy that was claimed improperly, because the therapy was not medically necessary or was provided by staff who did not have the appropriate skills for the patients' medical conditions.[17]

To control rising costs and improper payments, Congress established therapy caps for all nonhospital providers in the Balanced Budget Act of 1997.[18] The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 later imposed a moratorium on the caps for 2000 and 2001.[19] The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 then extended the moratorium through 2002.[20] Although no moratorium was in effect as of January 1, 2003, CMS delayed enforcing the therapy caps through August 31, 2003. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[21] placed the most recent moratorium on the caps, extending from December 8, 2003, through December 31, 2005.[22] The legislation establishing the caps provided for two caps per beneficiary: one for occupational therapy and one for physical therapy and speech-language pathology combined. The legislation set the caps at $1,500 each and provided that these limits be indexed by the Medicare Economic Index each year beginning in 2002. When last in place in 2003, the two caps were set at $1,590 each.

[16]See GAO/HEHS-95-23.

[17]The improper claims were filed under Medicare part A and part B. See Office of Inspector General, *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare*, OEI-09-97-00122 (Washington, D.C.: Department of Health and Human Services, August 1999).

[18]Pub. L. No. 105-33, § 4541, 111 Stat. 251, 454.

[19]Pub. L. No. 106-113, app. F, § 221, 113 Stat. 1501A-321, 1501A-351.

[20]Pub. L. No. 106-554, app. F, § 421, 114 Stat. 2763A-463, 2763A-516.

[21]Pub. L. No. 108-173, § 624(a), 117 Stat. 2066, 2317.

[22]Two bills were introduced in February 2005 to repeal the therapy caps: H.R. 916 and S. 438. As of October 2005, these bills had been referred to appropriate committees, and no further action had been taken. Another bill under consideration in the Senate as of October 31, 2005, would extend the moratorium on the therapy caps through 2006. See S. 1932, Deficit Reduction Omnibus Budget Reconciliation Act of 2005.

To process and pay claims and to monitor health care providers' compliance with Medicare program requirements, CMS relies on claims administration contractors, who use a variety of review mechanisms to ensure appropriate payments to providers. A system of automated checks (a process CMS terms "edits") flags potential billing errors and questionable claims. The automated system can, for example, identify procedures that are unlikely to be performed on the same patient on the same day or pairs of procedure codes that should not be billed together because one service inherently includes the other or the services are clinically incompatible.

In certain cases, automated checks performed by CMS claims administration contractors may lead to additional claim reviews or to educating providers about Medicare coverage or billing issues. The contractors' clinically trained personnel may perform a medical review, examining the claim along with the patient's medical record, submitted by the physician. Medical review is generally done before a claim is paid, although medical review may also be done after payment to determine if a claim was paid in error and funds may need to be returned to Medicare.

Insufficient Information Exists to Justify Waiving Therapy Caps for Particular Conditions or Diseases

The data and research available to date are insufficient to determine whether any particular conditions or diseases may justify a waiver of Medicare's outpatient therapy caps. Medicare claims data are limited in the extent to which they can be used to identify the actual conditions or diseases for which beneficiaries are receiving therapies because the claims often lack specific diagnostic information. In addition, analyses of the claims data show no particular conditions or diseases as more likely than others to be associated with payments exceeding the therapy caps. The data also show that treatment for a single condition or disease, such as stroke, may vary greatly from patient to patient. Finally, available research on the amount and mix of outpatient therapy for people aged 65 and older with specific conditions and diseases also appears insufficient to justify a waiver of the therapy caps for particular conditions or diseases. It is uncertain how many beneficiaries would have medical needs for therapy costing more than the caps and yet be unable to obtain the needed care because they have either insufficient financial resources or no access to a hospital outpatient therapy department.

Medicare Claims Data Do Not Always Capture Clinical Diagnoses or Show Consistent Patterns That Would Justify Waiving Therapy Caps

Although Medicare claims data constitute the most comprehensive available information for Medicare beneficiaries who have received outpatient therapy, they do not always capture the clinical diagnosis for which beneficiaries receive therapy. As such, they are insufficient for identifying particular diseases and conditions that should be exempted from the caps. Patients' conditions or diseases are expressed in claims data through diagnosis codes, and the coding system allows providers to use nonspecific diagnosis codes that are unrelated to a specific clinical condition or disease.[23] A CMS-contracted analysis of 2002 Medicare outpatient therapy claims data,[24] for example, found generic codes, such as "other physical therapy," to be among the most often used diagnosis codes on claim forms (see table 1). Moreover, current Medicare guidelines for processing claims permit institutional providers, such as outpatient rehabilitation facilities and skilled nursing facilities, to submit services from all three therapy types on the same claim form, with one principal diagnosis for the claim; a claim seeking payment for occupational therapy and for speech-language pathology might therefore be filed under "other physical therapy."

[23]Diagnosis codes from the World Health Organization's ninth revision of its International Classification of Diseases (ICD-9 codes) are used on Medicare part B claim forms to identify a patient's diagnosis. In addition to clinically specific codes, such as osteoarthritis, the ICD-9 system also includes generic codes, such as "other physical therapy," "occupational therapy encounter," and "speech therapy."

[24]Ciolek and Hwang, *Final Project Report* (2004).

Table 1: The Five Most Reported Diagnosis Codes Related to Outpatient Therapy, Ranked by Frequency under Each Therapy Type, 2002

Physical therapy	Occupational therapy	Speech-language pathology[a]
Other physical therapy	Acute but ill-defined cerebrovascular disease	Dysphagia[b]
Lumbago[c]	Other physical therapy	Acute but ill-defined cerebrovascular disease
Abnormality of gait	Occupational therapy encounter	Speech therapy
Pain in joint, shoulder region	Abnormality of gait	Abnormality of gait
Cervicalgia[d]	Other general symptoms	Other physical therapy

Source: Ciolek and Hwang, *Final Project Report* (2004).

[a]The majority of outpatient speech-language pathology services are furnished by hospital and skilled nursing facility providers, and the claim forms do not contain fields for identification of a therapy-specific diagnosis. Often, if a beneficiary receives multiple therapies simultaneously, the physical therapy diagnosis is reported first on the claim, which may explain why the fifth-most frequent diagnosis code for speech-language pathology is “other physical therapy.”

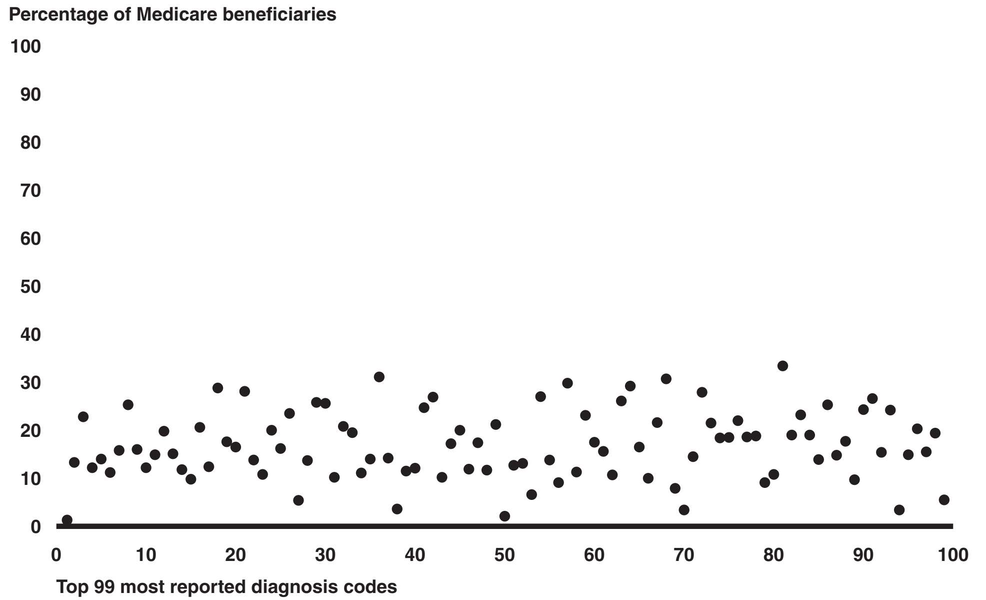
[b]Difficulty in swallowing.

[c]A painful condition of the lower back.

[d]A sharp pain or aching in the neck.

Analysis of 2002 claims data does not show any particular conditions or diseases that are more likely than others to be associated with payments exceeding the therapy caps for physical therapy and speech-language pathology combined or for occupational therapy. Among the top 99 most reported diagnoses for physical therapy and speech-language pathology, the analysis found no particular diagnoses associated with large numbers of beneficiaries for whom payments would have exceeded the combined physical therapy and speech-language pathology cap in 2002 had it been in effect (see fig. 1). A similar pattern existed for occupational therapy.

Figure 1: Top 99 Most Reported Diagnosis Codes and Associated Percentage of Medicare Beneficiaries for Whom Payments Would Have Exceeded the Combined Cap for Physical Therapy and Speech-Language Pathology, 2002



Source: GAO from Ciolek and Hwang, *Utilization Analysis* (2004).

Note: Each dot represents the percentage of Medicare beneficiaries, reported under each of the 99 most reported diagnosis codes (arrayed from 1 to 99 along the *x*-axis), for whom payments would have exceeded the combined cap for physical therapy and speech-language pathology had it been in effect in 2002.

Claims Data Do Not Provide Information about Patients' Therapy Needs

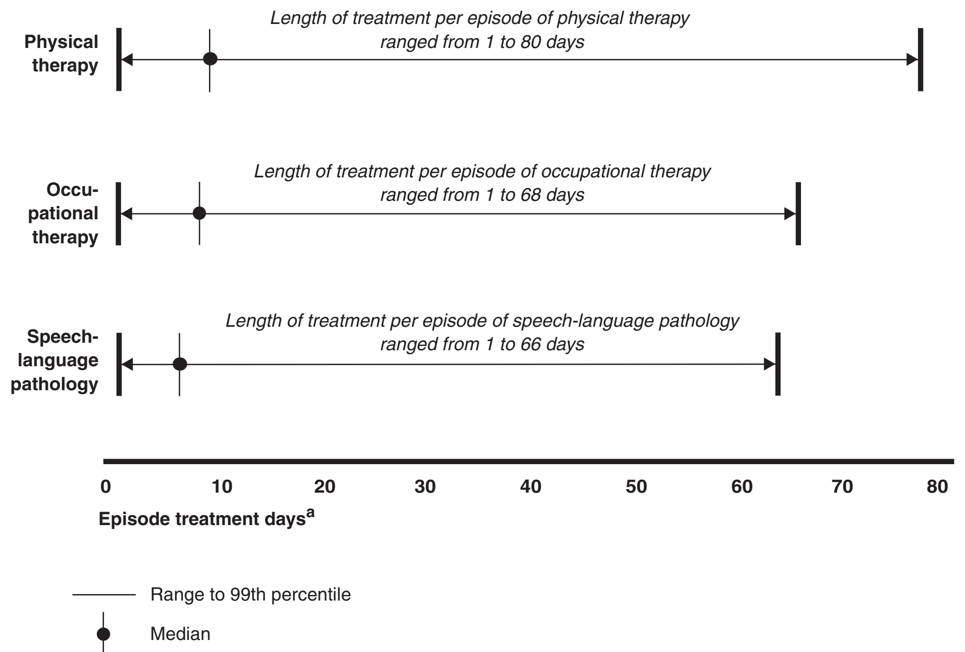
Medicare claims data do not provide information about patients' therapy needs that could be used to justify waiving the therapy caps. Even in those cases where particular conditions or diseases, such as stroke or Alzheimer's disease, are identified in the diagnosis codes, different individuals with the same diagnosis can need different intensities or types of therapy. For example, one patient with a stroke might be able to return home from the hospital a day or two after admission, while another may suffer a severe loss of functioning and require extensive therapy of more than one type. The CMS-contracted analysis of 2002 claims found wide variation in the number of treatment days required to conclude an episode

of care[25] for beneficiaries who had the same "diagnosis," such as stroke. For example, the analysis found that while the median number of days per episode of physical therapy for stroke patients was 10, episode length ranged from 1 to 80 days.[26] Similarly wide ranges in treatment length for stroke patients appeared for occupational therapy (1 to 68 days per episode, median 9) and speech-language pathology (1 to 66 days per episode, median 7). Figure 2 shows the range in length of treatment per episode for patients with a diagnosis of acute cerebrovascular disease (stroke) for the three types of therapy.

[25]An "episode" was defined in the CMS-contracted study as extending from the date of a beneficiary's first therapy encounter until the last encounter for the same type of therapy. For example, if the first physical therapy encounter was on January 15 and the last was on January 22, the physical therapy "episode" extended from January 15 through January 22. If the same beneficiary began speech-language pathology services on January 20 and ended on January 28, the speech-language pathology episode lasted from January 20 through January 28. If a 60-day break intervened between therapy services of the same or a different type, the new round of therapy was considered a new episode.

[26]All analyses of ranges in treatment length reflect the ranges to the 99th percentile, to eliminate extreme outliers.

Figure 2: Variation in Length of Treatment per Episode among Medicare Beneficiaries Diagnosed with Stroke, 2002



Source: AdvanceMed.

Note: Illustrated ranges extend only to the 99th percentile to eliminate extreme outliers.

[a]An "episode" in this study was defined as the date of a beneficiary's first therapy encounter until the last encounter for the same type of therapy. If a 60-day break intervened between therapy services of the same or a different type, the new round of therapy was considered a new episode.

Available Research Does Not Define Amount or Mix of Outpatient Therapy Needed for Medicare Beneficiaries with Specific Diseases or Conditions

Available research on the efficacy of outpatient therapy for people aged 65 and older with specific conditions and diseases also appears insufficient to justify a waiver of particular conditions or diseases from the therapy caps. Although our literature review found several studies demonstrating the benefits of therapy for seniors and Medicare-eligible patients, this research generally did not define the amount or mix of therapy services needed for Medicare beneficiaries with specific conditions or diseases. One study, for example, examined the benefits of extensive therapy for stroke victims at skilled nursing facilities. The study concluded that high-intensity therapy may have little effect on beneficiaries' length of time spent in the facility when their short-term prognosis is good; beneficiaries with poorer prognoses, however, may benefit substantially from intensive therapy. Further, because of the complexity of patient factors involved, these

studies cannot be generalized to all patients with similar diseases or conditions. In addition, MedPAC, the commission that advises Congress on Medicare issues, suggests that research should be undertaken on when and how much physical therapy benefits older patients and that evidence gathered from this research would assist in developing guidelines to determine when therapy is needed.[27]

Payments for More Than a Half Million Beneficiaries Would Have Exceeded Therapy Caps in 2002, but Adverse Effect Is Unknown

Medicare claims data suggest that payments for more than a half million beneficiaries would have exceeded the caps had they been in place in 2002. It is uncertain, however, how many beneficiaries with payments exceeding the caps would be adversely affected because they have medical needs for care and no means to obtain it through hospital outpatient departments. According to the CMS-contracted analysis of 2002 claims data, Medicare paid an estimated $803 million in outpatient therapy benefits above what would have been permitted had the therapy caps been enforced that year. Payments for about 17 percent of occupational therapy users and 15 percent of physical therapy and speech-language pathology service users would have surpassed the caps in 2002; these beneficiaries numbered more than a half million (see table 2).

[27]This conclusion was part of a MedPAC letter to Congress on the advisability of allowing Medicare fee-for-service beneficiaries to have "direct access" to outpatient physical therapy services and comprehensive rehabilitation facility services. MedPAC concluded that the physician referral and review requirements are a necessary but not sufficient mechanism to help beneficiaries receive outpatient physical therapy services that are needed and appropriate for their clinical conditions. MedPAC also found that providers need to be made more aware of coverage rules for beneficiaries—for example, through increased educational initiatives by the professional associations, the claims contractors, and facilities in which physical therapists practice. Medicare Payment Advisory Commission, letter to Congress (Washington, D.C.: Dec. 30, 2004).

Table 2: Beneficiaries for Whom 2002 Medicare Payments for Outpatient Therapy Services Would Have Exceeded Therapy Caps and by How Much

Cap	Projected number of beneficiaries whose payments would have exceeded caps	Projected percentage of beneficiaries whose payments would have exceeded caps	Average amount above cap (dollars)	Estimated total above cap (millions of dollars)[a]
Occupational therapy	129,509	17.4	$1,237	$160.2
Physical therapy and speech-language pathology	508,686	14.5	$1,263	$642.4

Source: Ciolek and Hwang, *Final Project Report* (2004).

Note: Because of a moratorium, therapy caps were not in effect in 2002; use of outpatient therapy services might have been different had the spending caps been in place. Because hospital outpatient departments are exempt from the caps, payments for services provided by hospital outpatient departments were excluded from this analysis.

[a]This study estimated that the totals above the caps represented 23.7 percent of all outpatient therapy expenditures for 2002.

Although the claims data show that payments for more than a half million beneficiaries would have exceeded the caps in 2002, it is unknown whether beneficiaries would have been adversely affected had the caps been in place. The data do not show the extent to which these beneficiaries were receiving care consistent with Medicare requirements that therapy improve a beneficiary's condition and be reasonable in amount, frequency, and duration. Also, it is not clear to what extent hospital outpatient departments would serve as a "safety valve" for Medicare beneficiaries needing extensive therapy and unable to pay for it on their own. Past work by us and others has noted that the therapy caps were integral to the Balanced Budget Act's spending control strategy and were unlikely to affect the majority of Medicare's outpatient therapy users. We reported that the hospital outpatient department exemption from the cap was a mitigating factor in the mid-1990s, essentially removing the coverage limits for those users who had access to hospital outpatient departments.[28] CMS-contracted analyses of claims data for 2002, however, show that nearly all the Medicare beneficiaries whose payments would have exceeded the caps did not receive outpatient therapy in hospital

[28]GAO/HEHS-00-15R.

outpatient departments. Specifically, an estimated 92 percent (469,850 beneficiaries) of those whose payments would have exceeded the combined physical therapy and speech-language pathology cap—and 98 percent (126,488 beneficiaries) of those whose payments would have exceeded the occupational therapy cap—did not receive therapy services in a hospital outpatient department. These proportions, however, might have been different had the caps been in effect in 2002.

Provider groups we spoke with were concerned that a sizable number of beneficiaries with legitimate medical needs whose payments would exceed the caps could be harmed. One group told us that a cap on outpatient therapy services would severely limit the opportunity for patients with the greatest need to receive appropriate care, and another group said that therapy caps could hurt beneficiaries with chronic illnesses. According to a third group, payments can quickly exceed the caps for beneficiaries who suffer from serious conditions such as stroke and Parkinson's disease or who have multiple medical conditions.

HHS Has Made Little Progress toward a Payment System Based on Patients' Needs

Statutory mandates since 1997 have required HHS to take certain actions toward developing a payment system for outpatient therapy that considers patients' individual needs for care, but the agency has made little progress toward such a system. In particular, HHS has not determined how to standardize and collect information on the health and functioning of patients receiving outpatient therapy services—a key part of developing a system based on patients' actual needs for therapy.

To curb spending growth and ensure that outpatient therapy services are appropriately targeted to those beneficiaries who need them, Congress included provisions related to these services in several laws enacted starting in 1997 (see table 3). These provisions required HHS to report to Congress in 2001 on a revised coverage policy for outpatient therapy services that would consider patients' needs. The provisions also required HHS to report to Congress in 2005 on steps toward developing a standard instrument for assessing a patient's need for outpatient therapy services and on a mechanism for applying such an instrument to the payment process. As of October 2005, HHS had not reported its specific recommendations on revising the coverage policy based on patients' needs. HHS had, however, contracted with researchers to conduct several analyses of Medicare claims data as a means of responding to the mandates.

Table 3: Legislation Affecting Medicare Spending on Outpatient Therapy Services, 1997–2003, and HHS Actions

Law	Key provisions	Response
Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4541, 111 Stat. 251, 454.	Required HHS to submit, no later than January 1, 2001, a report including specific recommendations on a revised coverage policy for outpatient therapy services under Medicare based on diagnostic category and prior use of services.	HHS did not submit a report to Congress by January 1, 2001. HHS, through CMS, contracted with the Urban Institute for a series of reports that were meant to help meet BBA's requirements.[a,b]
Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, app. F, § 221, 113 Stat. 1501A-321, 1501A-351.	Required HHS to compare and report on by June 30, 2001, the utilization patterns (nationwide and by region, setting, and diagnosis) of outpatient therapy services in 1998 and 1999 with those on or after January 1, 2000, including a review of a statistically significant number of claims for these services.	CMS contracted with the Urban Institute for a series of reports that were to meant help meet BBRA's requirements, including the requirement to study utilization of outpatient therapy services.[b] CMS contracted with AdvanceMed to meet BBRA's requirements for a study and report on utilization.[c] HHS did not submit a report to Congress by June 30, 2001, but AdvanceMed's report was completed in September 2002.
	As an amendment to the BBA reporting requirement, HHS was directed under BBRA to consider "functional status" and other criteria as the Secretary deemed appropriate in the design of a new outpatient therapy payment policy and to discuss methods to help ensure appropriate use of outpatient therapy.	No outpatient therapy payment policy designed, therefore, no response to "functional status" language.
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, app. F, § 545, 114 Stat. 2763A-463, 2763A-551.	Required HHS to report, no later than January 1, 2005, on the development of standard instruments for assessing the health and functional status of patients receiving any one of a variety of services, including speech-language pathology, physical therapy, occupational therapy, and both inpatient and outpatient settings; this report is to include a recommendation on the use of such "standard instruments" for payment purposes.	HHS did not submit a report to Congress by January 1, 2005. Officials told us in May 2005 that a report related to BIPA's requirement was in progress. An HHS official anticipated submitting this report to Congress by the end of 2005, but it will not include outpatient therapy.
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 624, 117 Stat. 2066, 2317.	Required HHS to submit, no later than March 31, 2004, overdue reports on payment for and utilization of outpatient therapy services.	In November 2004 HHS issued a report to Congress in response to the BBA, BBRA, and MMA requirements. This report included a review of medical claims and a discussion of a planned analysis of alternatives to current payment practices for outpatient therapy services. It did not specify a revised outpatient therapy payment policy.[d] HHS appended to this report seven reports by its contractors, the Urban Institute and AdvanceMed.[e]

Source: GAO.

[a]The HHS agency now known as CMS was called the Health Care Financing Administration (HCFA) before June 2001.

[b]Maxwell and Baseggio, *Outpatient Therapy Services* (2000), and Maxwell et al., *Part B Therapy Services* (2001).

[c]Olshin et al., S*tudy and Report* (2002).

[d]Centers for Medicare & Medicaid Services, Report to Congress, *Medicare Financial Limitations on Outpatient Rehabilitation Services* (Baltimore, Md.: November 2004).

[e]Maxwell and Baseggio, *Outpatient Therapy Services* (2000); Maxwell et al., *Part B Therapy Services* (2001); Olshin et al., *Study and Report* (2002); Ciolek and Hwang, *Feasibility and Impact Analysis* (2004); Ciolek and Hwang, *Development of a Model* (2004); Ciolek and Hwang, *Utilization Analysis* (2004); and Ciolek and Hwang, *Final Project Report* (2004).

HHS's response, implemented through CMS, to the principal legislative provisions addressing outpatient therapy services has been to contract for a series of studies, first by the Urban Institute and then by AdvanceMed (see table 4). In general, these studies have found that information available from Medicare claims data is insufficient to develop an alternative payment system based on patients' therapy needs, and a patient assessment instrument for outpatient therapy services that collected information on functional status and functional outcomes would be needed to develop such a system. They have also found that a needs-based payment system would be key to controlling costs while ensuring patient access to appropriate therapy.

Table 4: CMS-Contracted Studies of Outpatient Therapy Services, 2000–2004

Study	Key findings or conclusions	Selected recommendations
Urban Institute (2000)[a]	Insufficient research available on outpatient therapy practice patterns to design and implement a payment system based on diagnosis and prior use of services. Lack of functional status data on Medicare outpatient therapy patients impedes the development of such a system. Options were identified for managing outpatient therapy, including development of a database of functional status assessments made during beneficiaries' use of outpatient therapy services.	No recommendations.
Urban Institute (2001)[b]	Application of Medicare's physician fee schedule to skilled nursing facilities, rehabilitation agencies, and comprehensive outpatient rehabilitation facility outpatient therapy reduced spending on services in 1999 and 2000.	No recommendations.
AdvanceMed (2002)[c]	Application of Medicare's physician fee schedule to institutional outpatient therapy service providers reduced spending on these services before 2002. Diagnoses on claim forms do not accurately reflect the medical condition for which a patient received therapy and thus constrain CMS's ability to develop an alternative payment system based on patient condition.	No recommendations.
AdvanceMed (2004)[d]	Claims data show no pattern of diagnoses reflecting specific conditions that consistently result in payments for outpatient therapy services exceeding the spending limits. Claims data will not provide sufficient information to develop a needs-based payment system.	The final project report[d] discussed several options and recommended implementing a "global approach" comprising both short- and long-term strategies for managing outpatient therapy services, including developing a standardized outpatient therapy patient assessment instrument to collect clinical information needed to develop a classification scheme based on patient condition. The final project report proposed eliminating the therapy caps, because they may adversely affect some patients, and restraining outpatient therapy spending through improved program integrity and limited use through, for example: • targeted use limits or • improved administrative edits to better identify and deny payment of improper claims.

Source: GAO.

[a]Maxwell and Baseggio, O*utpatient Therapy Services* (2000).

[b]Maxwell et al., *Part B Therapy Services* (2001).

[c]Olshin et al., *Study and Report* (2002).

[d]Ciolek and Hwang, *Feasibility and Impact Analysis* (2004); Ciolek and Hwang, *Development of a Model* (2004); Ciolek and Hwang, *Utilization Analysis* (2004); and Ciolek and Hwang, *Final Project Report* (2004).

As of October 2005, HHS had taken few steps toward developing a patient assessment instrument for assessing beneficiaries' needs for outpatient therapy. Some health care settings, including inpatient rehabilitation facilities, home health agencies, and skilled nursing facilities, do have patient assessment instruments to collect functional status and other information on Medicare beneficiaries. Officials from HHS's Office of the Assistant Secretary for Planning and Evaluation and CMS told us they were collaborating to examine the consistency of definitions and terms used in these settings. They expected to report to Congress by the end of 2005 (in response to the requirement in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act) on this effort to standardize patient assessment terminology, although they have no plans to include outpatient therapy services in the effort. CMS officials and one of the provider groups we spoke with estimated that the development of a patient assessment instrument for outpatient therapy services would take at least 3 to 5 years. HHS officials said that the complexity of the task and resource constraints precluded them from including outpatient therapy services in their effort to standardize other patient assessment terminology. CMS has, however, funded a demonstration project with a private-sector firm that has developed a patient assessment instrument that collects functional status and functional outcomes for patients who receive outpatient therapy services, primarily physical therapy, in certain facilities.[29] A report from the firm to CMS is expected in summer 2006.

Circumstances That Led to Therapy Caps Remain

Recent assessments of Medicare claims data have shown that the circumstances that initially led to therapy caps—rising Medicare payments for outpatient therapy and a high rate of improper payments—remain. CMS, however, has not implemented its contracted researchers' proposal to strengthen its system of automated checks for denying payment of improper claims. Provider groups we spoke with agreed that Medicare was likely paying for some medically unnecessary therapy services and that improvements could be made to help strengthen the integrity of the payment system.

[29]This demonstration project will analyze the feasibility of a pay-for-performance system in outpatient rehabilitation settings and also analyze the outcomes of therapy services for Medicare part B beneficiaries (who constitute about 15 percent of the 1.6 million patients in the firm's database) on the basis of their condition and functional status. The project expects to identify appropriate care for particular therapy-related diagnoses, although the data have limited applicability to the entire Medicare population.

According to recent CMS assessments of Medicare claims data, Medicare payments for outpatient therapy services continue to rise. Over the 4-year period from 1999 through 2002, Medicare spending for outpatient therapy more than doubled, from an estimated $1.5 billion to $3.4 billion, according to the CMS-contracted analysis of 2002 claims data released in 2004.[30] Although outpatient therapy spending for 2003 and 2004 has not been fully estimated, overall Medicare part B expenditures—which include spending on outpatient therapy services—showed rapid growth (15 percent) from 2003 to 2004, according to CMS estimates reported in 2005.[31] CMS attributed this growth to five factors, one of which was increased use of minor procedures such as therapy performed by physicians and physical therapists.[32] Payments for certain therapy services, for example, increased by 24 percent or more from 2003 to 2004. CMS officials told us that many valid reasons may exist for the significant growth in payments for outpatient therapy. For example, they said, some of the increase in therapy services could be due to the growth in recent years of elective services such as knee replacements.

CMS has also recently reported that improper payments made for outpatient therapy services have increased substantially in recent years. Specifically, in November 2004, CMS reported that the estimated error rate for claims rose steadily from 10.9 percent in 1998 to 20.4 percent in 2000.[33] CMS reported that most of the errors were due to insufficient documentation to support the services claimed, such as lack of evidence of physician review and certification of treatment plans. In January 2005, CMS reported error rates in a random sample of more than 160,000 fee-for-

[30]Ciolek and Hwang, *Final Project Report* (2004).

[31]Letter from the Director, Center for Medicare Management, Centers for Medicare & Medicaid Services, to the Chair, Medicare Payment Advisory Commission, March 31, 2005, and accompanying data.

[32]The five factors were increased spending for office visits (29 percent of overall growth), increased use of minor procedures including therapy (26 percent), more frequent and complex imaging services (18 percent), more laboratory and other tests (11 percent), and more use of prescription drugs in doctors' offices (11 percent). The greatest contributors to the increase in minor procedures were the administration of drugs and physical therapy, including procedures such as manual therapy and neuromuscular reeducation of movement. See Center for Medicare Management Director's letter (Mar. 31, 2005).

[33]Centers for Medicare & Medicaid Services, *Medicare Financial Limitations on Outpatient Rehabilitation Services* (Baltimore, Md.: November 2004).

service claims, which included therapy services, from 2003.[34] The agency found that claims submitted for therapy services were among those with the highest rates of payments made in error because of insufficient documentation or medically unnecessary services.[35] Such services included procedures frequently provided by therapists, such as therapeutic exercise,[36] therapeutic activities,[37] neuromuscular reeducation, electrical stimulation, manual therapy, and physical therapy evaluation. For example, 23.5 percent of claims for therapeutic activities lacked sufficient documentation, resulting in projected improper payments of more than $34 million.[38] Claims for therapeutic exercises had a "medically unnecessary" error rate of 3 percent, with projected improper payments of more than $18 million.

Our past work found that CMS needed to do more medical reviews of beneficiaries receiving outpatient therapy services. We reported in 2004, for example, that in Florida, comprehensive outpatient rehabilitation facilities were the most expensive class of providers of outpatient therapy services in the Medicare program in 2002.[39] Per-beneficiary payments for outpatient therapy services to providers in these facilities were two to three times higher than payments to therapy providers in other facilities. We recommended that CMS direct the Florida claims administration

[34]Centers for Medicare & Medicaid Services, *Improper Medicare Fee-for-Service Payments Report, Fiscal Year 2004* (Baltimore, Md.: January 2005).

[35]An "insufficient documentation" error means that the provider did not include pertinent patient facts (e.g., the patient's overall condition, diagnosis, or extent of services performed), or the physician's orders or documentation were incomplete. "Medically unnecessary" errors included situations where the claim reviewers identified enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary.

[36]Therapeutic exercises—such as treadmill use, stretching, and strengthening—develop strength, endurance, range of motion, or flexibility.

[37]Therapeutic activities—such as bending, lifting, and carrying—improve functional performance.

[38]CMS's estimate of improper payments was projected because the data collected had not been adjusted to exclude beneficiary co-payments, deductibles, or reductions to recover previous overpayments.

[39]GAO, *Comprehensive Outpatient Rehabilitation Facilities: High Medicare Payments in Florida Raise Program Integrity Concerns*, GAO-04-709 (Washington, D.C.: Aug. 12, 2004).

contractor to medically review more claims from comprehensive outpatient rehabilitation facilities.[40]

CMS's contracted researcher concluded that CMS could improve its claims system by identifying and implementing modifications to the agency's automated claims review system to better target payments to medically appropriate care.[41] In doing their analysis of the 2002 claims, they identified three types of specific edits that they found to be feasible and that would reject claims likely to be improper:

- Edits to control multiple billings of codes that are meant to be billed only once per patient per visit. The contracted researchers estimated that in 2002, the impact of this type of improper billing amounted to $36.7 million.
- Edits to control the amount of time that can be billed per patient per visit under a single code, since most conditions do not warrant treatment times exceeding 1 hour. The contracted researchers estimated that in 2002, the impact of this type of improper billing amounted to $24–$100 million, depending on the amount of time per visit billed under a given code.
- Edits of clinically illogical combinations of therapy procedure codes. In analyzing 2002 Medicare claims data, the contractor found limited system protections to prevent outpatient therapy providers from submitting claims for procedures that are illogical for a given diagnosis. One example, according to the contractor's report, was claiming for manual therapy submitted with a diagnosis of an eye infection. The estimated impact of improper billings based on illogical combinations of diagnosis and procedure codes in 2002 amounted to $16.7 million.

CMS officials agreed with the contracted researcher that such edits are worth considering, but the agency had not implemented them as of October 2005. A CMS official told us, however, that CMS is implementing the proposed edits to control multiple billings of codes meant to be billed only once per patient per visit; the agency expects these edits to be in place in early 2006. As of October 2005, CMS was still considering whether to implement the other two types of edits. In addition to the three types of edits identified by the contracted researcher, the researcher proposed routine data analysis of Medicare claims to identify other utilization limits

[40]According to a CMS official, this recommendation had not been implemented as of August 2005.

[41]Ciolek and Hwang, *Feasibility and Impact Analysis* (2004); Ciolek and Hwang, *Final Project Report* (2004).

that could be applied to better target Medicare payments. CMS is considering whether and how to implement this type of analysis.

Provider groups we spoke with agreed that Medicare was likely paying for some medically unnecessary therapy services and that improved payment edits could help ensure that Medicare did not pay for such services. Nevertheless, representatives from these groups stressed the importance of mechanisms that would allow Medicare to cover payments for beneficiaries who need extensive care. The representatives noted that an exception process, based on a medical review, could help determine the appropriateness of therapy services. Such an exception process could be invoked to review the medical records of beneficiaries whose providers seek permission for coverage of Medicare payments in excess of the caps. CMS officials agreed that an appeal process or waiver from the caps could be a short-term approach to focus resources on needy beneficiaries. They added that possible criteria for waiving the caps could include (1) having multiple conditions; (2) having certain conditions, levels of severity, or multiple conditions suggested by research as having greater need for treatment; (3) having needs for more than one type of service, such as occupational therapy and speech-language pathology; or (4) having prior use of services or multiple episodes in the same year. HHS does not, however, currently have the authority to implement a process, or to conduct a demonstration or pilot project, to provide exceptions to the therapy caps.

Conclusions

Medicare payments for outpatient therapy continue to rise rapidly, and 20 percent or more of claims may be improper. To date, however, HHS has made little progress toward a payment system for outpatient therapy services that is based on patients' needs. Furthermore, while CMS is considering ways to reduce improper payments, it has not implemented the contractor's proposals for improving its claims-processing system.

HHS has been required for years to take steps toward developing a payment system based on beneficiaries' needs, which would require developing a process for collecting better assessment information. Studies contracted by CMS to respond to requirements under three laws suggest that the department would need to develop a standard patient assessment instrument to define a patient's diagnosis and functional status and thereby determine the patient's medical need for therapy. In response to a statutory requirement to report on the standardization of patient assessment instruments in a variety of settings, HHS and CMS have an effort under way to study and report to Congress on the development of

standard terminology that Medicare providers could use to assess patients' diagnosis and functional status. Although this provision requires that outpatient therapy services be included in this effort, HHS and CMS have not done so.

Concerns remain that when the current moratorium expires and the caps are reinstated, some beneficiaries who have medical needs for therapy beyond what can be paid for under the caps may not be able to obtain the care they need. Some beneficiaries may not be able to afford to pay for care or may not have access to hospital outpatient departments, which are not subject to the caps. In the absence of patient assessment information, therefore, an interim process, demonstration, or pilot project may be warranted to allow HHS to grant exceptions to the caps. For example, such a project could allow beneficiaries, under circumstances that CMS determines, an exception to the cap on the basis of medical review supported by documentation from providers regarding their patients' needs for extensive therapy. Such a project could also provide CMS with valuable information about the conditions, diseases, and functional status of beneficiaries who have extensive medical needs for therapy. The information gathered through the project could also facilitate development of a standardized patient assessment process or instrument. HHS, however, would need legislative authority to conduct such a project. Although exceptions could increase Medicare payments for outpatient therapy, exceptions could provide one avenue for Medicare coverage above the caps for some beneficiaries who need extensive therapy. Potentially, payment increases due to exceptions could be offset by implementation of the contractor-proposed improvements, such as edits.

Matter for Congressional Consideration

To provide a mechanism after the moratorium expires whereby certain Medicare beneficiaries could have access to appropriate outpatient therapy services and to obtain better data needed to improve the Medicare outpatient therapy payment policy, including data on the conditions and diseases of beneficiaries who have extensive outpatient therapy needs, Congress should consider giving HHS authority to implement an interim process or demonstration project whereby individual beneficiaries could be granted an exception from the therapy caps.

Recommendations for Executive Action

To expedite development of a process for assessing patients' needs for outpatient therapy services and to limit improper payments, we recommend that the Secretary of HHS take the following two actions:

- ensure that outpatient therapy services are added to the effort already under way to develop standard terminology for existing patient assessment instruments, with a goal of developing a means by which to collect such information for outpatient therapy, and
- implement improvements to CMS's automated system for identifying outpatient therapy claims that are likely to be improper.

Agency Comments

We provided a draft of this report to HHS for comment and received a written response from the department (reproduced in app. I). HHS did not comment on the matter for congressional consideration, in which we said that Congress should give HHS authority to implement an interim process or demonstration project whereby individual beneficiaries could be granted an exception from the therapy caps. HHS concurred with our recommendation that it ensure that outpatient therapy services are added to the effort already under way to develop standard terminology for existing patient assessment instruments. The department stated that it is preparing to contract for a 5-month study to develop a policy and payment guidance report as it explores the feasibility of developing a post–acute care patient assessment instrument.

In commenting on our recommendation to implement improvements to CMS's automated system for identifying outpatient therapy claims that are likely to be improper, HHS discussed a national edit system to promote correct coding methods and eliminate improper coding. This national edit system has been applied to some therapy-related claims starting in 1996, and HHS plans to apply it more broadly in 2006. While the national edit system is complementary to the edits proposed by CMS's contracted study, CMS can do more by also implementing improvements to its payment system as suggested by the study's specific findings. HHS also indicated that it was exploring other methods for automated evaluation of claims but commented that its claims-processing system cannot always identify an improper claim from the information that is available on claim forms. We agree that the current system cannot always identify an improper claim, given the lack of information on the claim forms about a patient's actual needs for therapy. It was this conclusion that led to our recommendation that HHS include outpatient therapy in its present efforts to improve the collection of patient assessment information. We believe that CMS can make improvements to its current automated system to

reduce improper claims, irrespective of its efforts to improve patient assessment information. As we noted in the draft report, CMS's contracted study found certain edits to be feasible using information already provided on claim forms, such as edits of clinically illogical combinations of therapy procedure codes.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7119 or at steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

A. Bruce Steinwald
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

OCT 20 2005

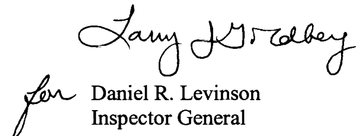
Mr. A. Bruce Steinwald
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Mr. Steinwald:

The Department appreciates the opportunity to comment on this draft report before its publication. Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO's) draft report entitled, "MEDICARE: Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries' Needs" (GAO-05-990). These comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,



for Daniel R. Levinson
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for U.S. Government Accountability Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

HHS COMMENTS ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED, "MEDICARE: LITTLE PROGRESS MADE IN TARGETING OUTPATIENT THERAPY PAYMENTS TO BENEFICIARIES' NEEDS" (GAO-05-990)

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the U.S. Government Accountability Office's (GAO) draft report.

GAO Recommendation #1:

Ensure that outpatient therapy services are added to the effort already under way to develop standard terminology for existing patient assessment instruments, with a goal of developing a means by which to collect such information for outpatient therapy.

HHS Comment:

HHS concurs with the recommendations to ensure that outpatient therapy services are added to the current effort to develop standard terminology for existing patient assessment instruments with a goal of developing a means of collecting outpatient therapy information. HHS is preparing to contract a 5-month study to develop a policy and payment guidance report as HHS explores the feasibility of developing a postacute care patient assessment instrument. The study will facilitate HHS's plan of a phased approach to the development of this instrument. The development approach would begin with a tool that can be used as part of the hospital discharge planning process to assess patients' status and ensure placement in the appropriate postacute care setting, with the eventual goal of enhancing the tool to assess and monitor patients' health and functional status across settings.

GAO Recommendation #2:

Implement improvements to CMS's automated system for identifying outpatient therapy claims that are likely to be improper.

HHS Comment:

This recommendation stems primarily from a study under contract with the Centers for Medicare & Medicaid Services (CMS) that identified improper payments for outpatient therapy based on claims analysis.

Medicare's National Correct Coding Initiative (NCCI) is an edit system that was developed to promote national correct coding methodologies and eliminate improper coding. These edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices.

The NCCI edits were initially applied to carrier claims from physicians and privately practicing physical therapists and occupational therapists in 1996. In 2000, the Outpatient Code Editor (OCE) version of the NCCI edits (including rehabilitative therapy services) was applied by fiscal intermediaries for services provided in an outpatient hospital setting. Beginning January 1, 2006, the OCE NCCI version will be applied to all claims from institutional therapy providers submitted to intermediaries, including skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies.

HHS is developing methods for automated evaluation of claims' technical compliance with national coverage and claims processing policies. Also, we are exploring limits to variables such as multiple units of service and/or visits, consistent with reasonable clinical guidelines. Ultimately, however, CMS's claims processing system cannot identify an improper claim unless the claim has information on it that permits it to be identified as improper. For example, Medicare currently validates the patient's needs only through medical review—a time intensive and expensive method of personal assessment by a reviewer. A current contract explores the potential of identifying variables that may be submitted with claim data and used to limit services consistent with beneficiaries' needs. The results of this study should be available for use in a demonstration in 2007.

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

A. Bruce Steinwald, (202) 512-7119 or steinwalda@gao.gov

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Related GAO Products

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