Executive Summary

Supervision of Physical Therapist Assistants:

Analysis of State Regulations

Medicare conditions of coverage regulations require that physical therapists (PTs) in private practice maintain a "personal" level of supervision of physical therapist assistants (PTAs), when PTAs furnish therapy services to Medicare beneficiaries. As current regulations explain, a "personal" level requires the supervising PT to be "in the room" when PTAs furnish services. This report is intended to provide information and analyses to the Centers for Medicare and Medicaid Services (CMS) as it reviews its policies on PTA supervision.

Physical therapists provide evaluative and rehabilitative services to patients with physical impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes. PTs assess joint motion, muscle strength and endurance, heart and lung function, and performance of activities required in daily living, among other responsibilities. Common treatment interventions include therapeutic exercise (such as strengthening and mobility exercises), customization and training in the use of prosthetic devices and equipment, wound management, cardiovascular endurance training, and training in activities of daily living.

PTAs are skilled health care providers who work under the direction and supervision of PTs. Frequently, PTAs implement designated therapies in patient treatment plans formulated by PTs. For example, PTAs often train patients in exercises outlined by PTs, provide basic wound care, engage in data collection activities, and report to PTs on patient performance and responses. PTAs are not trained nor permitted to perform patient evaluations or design treatment plans.

Our analyses of 1999 national workforce estimates indicate a total of roughly 105,000 to 108,000 PTs and 28,000 to 36,000 PTAs in the US, resulting in rates of 39 to 40 PTs per 100,000 population and 12 to 13 PTAs per 100,000 population. Our trend analyses suggest that the PT rate and PTA rate increased an average of 5.1% and 4.2% per year, respectively, since 1980.

PT and PTA educational and professional differences

PT and PTA education programs

While both PT and PTA education programs prepare graduates to provide basic

physical therapy services, such as range of motion exercises, PT education programs train students in more complex therapy interventions and in physical therapy activities that are more analytic and evaluative in nature. These activities include patient screening, evaluation, diagnosis for physical therapy, prognosis, and care plan design. Recognizing these distinctions, the Commission on Accreditation in Physical Therapy Education (CAPTE), in conjunction with the American Physical Therapy Association (APTA), established academic requirements and guidelines that correlate to PT and PTA technical skill expectations.

As of 2002, a master's degree in physical therapy (MPT) is the entry-level education requirement for new PTs. An MPT generally consists of four semesters of classroom instruction and four to six months of clinical experience. A recent APTA survey of all accredited education programs indicates that on average, MPT programs' didactic component totals 1,642 clock hours of instruction. Clinical field placements are 1,136 hours long, on average (or 32.5 weeks, assuming 35-hour weeks).

PTA programs must offer curriculum designs that can be completed in five or fewer semesters of full-time enrollment. Program requirements consist of three didactic components (general education, applied physical therapy sciences, and technical skills) plus clinical field experience. As with its MPT program criteria, CAPTE requires that PTA students be exposed to patient care and teaching, as well as have opportunities to observe and participate in other aspects of field work, such as quality assurance activities. The APTA survey of accredited programs indicates that on average, PTA programs' didactic components total about 831 clock hours of instruction. Clinical field placements are about 667 hours long, on average (or 19 weeks, assuming 35-hour weeks).

Professional distinctions

Graduating from an accredited education program and passing a national exam are minimum requirements for state licensure, which is required of PTs in all states and of PTAs in most states. States that require licensure renewal often include periodic completion of continuing education credits. Unlike states that regulate PTAs, states with no PTA licensure-related process do not have administrative mechanisms for censuring PTAs or revoking their ability to work as PTAs. Relatedly, these states also do not have processes in place to tally any work-place violations of PTAs nor track cross-state movement of violators.

In our discussions with stakeholders, APTA representatives and those from the Federation of State Boards of Physical Therapy (FSBPT) noted that from both the educational and regulatory perspectives, PTAs do not have an independent, unique body of knowledge; their knowledge base exists within the PT knowledge base. Relatedly, PTAs do not have a "scope of practice"— a term strictly reserved for PTs in model definitions and the model state practice act for physical therapy. These representatives

further emphasized that, regardless of state and federal regulations, PTs are professionally and legally responsible for all care rendered under their license, including all services furnished by PTAs under their direction and supervision. FSBPT representatives added that PTs' legal risk regarding care furnished under their direction and supervision is greater in states that do not regulate PTAs.

Current issues in PT practice and education

An important current policy and regulatory issue to the field is the allowance of "direct access" to PTs, or access to PTs without prior physician referral. All but three states allow PTs direct access to perform patient screenings, evaluations, and consumer education activities. In addition to these activities, 35 states allow PTs to provide a range of specified therapy services without physician referral. In their direct access regulations, some states specify prohibited procedures and/or require a minimum level of work experience. Physician consultations sometimes are required if therapy services are furnished beyond a specified period, such as 30 days.

While nearly all states allow direct access to some level of physical therapy services, some health plans require physician referral as a condition of coverage. As a result, the referral process is still common in some health care markets in states that allow direct access. Further, Medicare coverage regulations do not allow reimbursement for PT services absent physician referral. The direct access issue is not directly related to supervision of PTAs. However, policymakers might argue that removing the physician referral from the physical therapy patient intake process would eliminate an important source of patient oversight.

During our discussions with stakeholders, several commented that a potential transition, in the long run, to a doctoral-level degree as the entry-level PT education requirement would assist with direct access efforts. Related in part to this, recent literature indicates that some have suggested that the entry-level PTA degree should be transitioned at some point to the baccalaureate level. Our review of this discussion in the literature does not indicate that PTA supervision requirements or issues have been mentioned. However it is likely that any future establishment of a baccalaureate PTA degree might usher new discussion regarding PTA supervision regulations.

PTA supervision regulations

Medicare regulations

Medicare regulations require "personal" (meaning in-room) supervision of PTAs furnishing services in private therapist practices. APTA requests that "direct" supervision (meaning on-premises) be required instead. Medicare requires "general" supervision (meaning periodic inspection and PT availability by telecommunication) of

PTAs furnishing services in skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities, certified rehabilitation agencies, and home health agencies. Direct supervision is required in physician practices.

Stakeholder discussions and impact on private practices

In our discussions with policymakers and stakeholders, some speculated that historically, facilities have been permitted a looser level of PTA supervision compared to private practices under Medicare regulations because of the presence of other clinical personnel in facilities. Some also speculated that the looser facility regulations are due in part to the oversight provided by the periodic state survey and certification process undergone by facilities. Some stakeholders also noted that the patient assessment instruments required relatively recently by Medicare in the SNF, inpatient rehabilitation, and home health settings yield patient and service information— and thus review and oversight opportunities— not available regarding therapy furnished in either private practices or other ambulatory settings.

The safeguards in place in the private practice setting, by contrast, have been the stricter supervision requirement and the dollar-based coverage limits (which, many say, historically have effectively limited the patient mix served by private practices). In our discussions with stakeholders, others countered that some facilities (particularly some certified rehabilitation agencies) also do not have "other clinical personnel" on site, and have a case-mix generally equivalent— and thus patient safeguard needs that are generally equivalent— to that of private practices.

Our conversations with stakeholders indicate that most are not in favor of a personal supervision requirement regarding PTAs— applied to private practices or any other setting— for several reasons. Some were against a personal supervision requirement in private practices because it is a stricter requirement than states' PTA supervision regulations and is not consistent with Medicare regulations on PTA supervision in other settings. Some suggested that regulations be applied consistently in particular to private practices and certified rehabilitation agencies, given the similarities of these settings and their case-mix relative to other settings. Many stated that supervision is not the key to ensuring patient safety. Some stated that a personal supervision requirement might slow access to therapy services in rural areas or in other localized areas with PT supply shortages. Another issue raised during our discussions is that the requirement creates tensions between cost-efficiency from the provider perspective and patient privacy needs.

Regarding physical therapy regulations overall, many commented that states' reevaluation requirements, periodic supervision visit requirements, and maximum PTA to PT ratios (as summarized below) affect a facility's or practices' utilization of PTAs more than the actual supervision level required by states. Non-regulatory factors affecting

PTA utilization were discussed as well, including the length of a patient's therapy episode, a provider's volume of therapy patients, and local PTA supply.

In our discussions, those most familiar with private practices relayed that the operational reactions by private practices following the 1999 regulations regarding personal supervision have varied, based on three main factors: a practice's physical or structural layout, its Medicare patient volume, and its Medicare volume relative to its total patient volume. Commenters stated that private practices with relatively open physical designs are affected less than others. Private practices with Medicare patient loads that are small in number (in absolute and relative terms) also are affected less than others. However, they stated that private practices with large Medicare caseloads and with physical layouts that do not accommodate in-room or in-sight supervision typically have reacted by reducing their number of PTA employees. Participants added that some practices with very small Medicare caseloads might have stopped accepting Medicare patients, rather than alter their staff mix. Overall, most participants familiar with private practices either stated or implied that private practices do not use PTAs to treat Medicare patients as frequently as they would, absent the personal supervision requirement

State PTA supervision regulations

If states have more stringent PTA supervision regulations than Medicare, then providers must follow state regulations when furnishing services to Medicare beneficiaries. We collected and analyzed states' statutes and administrative code regarding the practice of physical therapy pertaining to PTA supervision. Below, we summarize the variety of PTA supervision requirements existing at the state level.

While we found that supervision requirements vary across states, terminology and definitions differ as well. For example, depending on the state, "direct" supervision can refer to requiring full-time on-site supervision, periodic on-site supervision, or only telecommunication supervision. Though terminology varies, our content analysis of the regulations indicates that essentially four levels of PTA supervision are used by states. We describe these levels as:

- full-time on-site (or on-premises) supervision;
- periodic in-room (or in-sight) supervision, with telecommunication supervision at other times;
- periodic on-site (or on-premises, but not necessarily in-room or in-sight) supervision, with telecommunication supervision at other times; and
- telecommunication supervision at all times.

Overall, eight jurisdictions (seven states and Washington, DC) or 16% of all states require full-time on-site supervision; another seven states stipulate periodic in-room supervision; 16 states (31%) require periodic on-site supervision; another 16 states permit

telecommunication supervision. Five states (10%) do not explain their supervision requirements as clearly as other states. After reviewing all states' codes, we infer that these five permit telecommunication supervision at all times. If the five are included in the telecommunication category, then 21 states (41%) use that level of supervision.

Accompanying the periodic in-room and periodic on-site levels of supervision used by some states, some further specify a minimum frequency of supervisory visits. Most states requiring periodic in-room supervision expressly stipulate a minimum schedule where the supervising PT personally inspects or views the PTA furnishing services. States indicating periodic on-site supervision do not indicate a personal inspection requirement of PTA services, but rather the immediate, on-site availability of a supervising PT at a minimum schedule. While the minimum required schedules vary, the most commonly required frequency for periodic supervision is every 4 to 6 patient treatment visits or 30 days. A few states that require only telecommunication supervision also specify a maximum radial distance or time period within which a PT must remain when supervising PTAs.

In addition to their supervision-level requirements, two-thirds of all states (33) have established a maximum number of PTAs that a PT can supervise at one time. Of the 33 states, 25 establish ratios strictly between PTAs and PTs; the remaining eight states include aides with PTAs in their ratios. On average, states' ratios are slightly higher when aides are included (2.75 PTAs and aides to 1 PT, compared to 2.52 PTAs to 1 PT). While the ratios in both groups of states range from 2:1 to 4:1, the most commonly used ratio among states with a strict PTA to PT limit is 2:1; the most frequently used ratio among states that include aides is 3:1.

Also across supervision levels, some states specify a minimum frequency of patient reevaluations to be performed by a PT. The minimum schedule varies, but the most common requirement calls for reevaluations every 30 days or every 10 to 20 visits (depending on the state). While the purposes of periodic supervisory visits and patient reevaluations are distinct, discussions with clinicians and state physical therapy board members indicate that in practice, the two activities often overlap.

PTA supervision requirements and payment/coverage policies

In requesting analyses regarding supervision of PTAs, policymakers also queried whether any relationships and implications exist between PTA supervision requirements and Medicare payment or coverage policies.

Medicare Part B therapy furnished by private therapist practices (as well as by physician practices) has been paid under the physician fee schedule since 1992. Through 1998, Part B therapy payments to facilities were based on their costs as submitted to Medicare. As of 1999, the 1997 Balanced Budget Act (BBA) required that facilities

furnishing Part B therapy be paid under the physician fee schedule as well. Facilities were paid on a cost-basis in 1998, with a 10% payment reduction for savings.

Therapy furnished by private practice therapists has been subject to annual, per beneficiary coverage limits since 1974. The 1997 BBA required, effective 1999, the coverage limits to be extended to all Part B therapy providers except hospitals. The caps are not currently implemented; Congress placed a moratorium on them for 2000 through 2002. Several therapy organizations have requested that Congress extend the moratorium at least through 2003. In addition, a bill was proposed in spring 2001 that would simply eliminate the caps, rather than extend the moratorium. The bill's sponsors state that repealing the caps would cost about $500 million over five years, according to a PricewaterhouseCoopers cost estimate. Compared to Congressional cost estimates, the PricewaterhouseCoopers estimate is conservative. CBO estimated that the one-year cost of the moratorium during 2002 is $200 million.

Our prior research on Medicare Part B therapy expenditures shows that both aggregate and per patient spending fell substantially in 1999, due to the across-the-board implementation of the fee schedule as well as due to the coverage limits. Nominal aggregate expenditures declined from $2.2 billion in 1998 to $1.4 billion in 1999; per patient annual payments fell from $709 to $480. In 2000— the first year of the coverage limit moratorium— expenditures climbed back up to a level between 1998's and 1999's spending levels. Aggregate payments rose to about $2.0 billion; per patient spending rose to $642.

To the extent that Medicare PTA supervision requirements affect a provider's therapy staff mix and overall costs, supervision requirements would impact Medicare spending (and a dollar-based coverage policy) under a *cost-based* reimbursement policy. Under a *fee schedule* payment policy, PTA supervision requirements would impact Medicare expenditures and coverage limits if a provider's therapy staff mix affects the number of therapy services furnished per patient. We have not found prior research studies analyzing the effect of PTA utilization relative to PT utilization on the number of therapy services consumed. Anecdotally, some clinicians commented to us that they believed PTs often can obtain a given patient outcome earlier than PTAs because of PTs' additional analytic and evaluative training. Other commented that their experiences regarding this issue were too diverse to generalize.

The incentives of a fee schedule payment policy suggest that a supervision requirement, to the extent that it affects staff mix, clearly affect costs from the *provider* perspective. Under a cost-based reimbursement policy, a provider generally can pass along to a payer the higher costs associated on average with using both PTAs and in-room or in-sight supervising PTs to furnish all services, rather than PTAs to furnish most services. Similarly, the higher costs of employing only PTs to furnish all services, instead of using PTAs to furnish most services, could be recouped as well. Under a fee

schedule payment policy, however, providers have an incentive to utilize the lowest-cost staff that can furnish services.

The private practice participants in our stakeholder discussions commented that their use of PTAs remains somewhat cost-efficient, from their perspective, when treating Medicare patients in open or gym-like areas (where PTs can maintain in-room or in-sight supervision over multiple PTAs and patients). However, in circumstances where privacy needs dictate that Medicare patients receive services in individual rooms, participants stated that typically it is not cost-efficient from their perspective to use the combination of a PTA and an in-room supervising PT. It is more cost-efficient to rely solely on a PT to furnish these services. And if supervision regulations permitted, a provider's cost savings would be greatest when using PTAs to furnish these services.

The efficiency incentive of a fee schedule is compatible with the philosophy underlying the resource-based foundation of the Medicare physician fee schedule. The resource-based fee schedule originally was designed so as to pay for a service based on the work effort and practice expense necessary to perform the service, rather than on the type of provider furnishing the service. Under this principle, the current physician fee schedule rate for a given physical therapy service (such as, for example, range of motion exercises) would be appropriate— regardless of the type of staff used and supervision level— only if the therapy staff mix and supervision patterns in existence today were reflected in the original development of the work effort and practice expense components of the fee schedule rates for physical therapy services.

However, current staffing or supervision patterns may vary substantially from the patterns in place when the work effort and practice expense components of the fee schedule were developed. Specifically, if today's relatively expanded role of PT assistants in providing therapy services was not reflected in the original development of the work effort and practice expense components of therapy services, then the work effort components, for example, would be overvalued for a service when performed by a PT assistant. Similarly, the practice expense component may undervalue the supervision activities of a PT. In this case, reexaminations of such components would be warranted analytically.