REPORT TO CONGRESS
MEDICARE FINANCIAL LIMITATIONS ON
OUTPATIENT REHABILITATION SERVICES

I. Reports

This report and the attached studies respond to the requirement in the Balanced Budget Act of 1997 (BBA) Sec 4541(d)(2) subsequently modified by Balanced Budget Refinement Act of 1999 (BBRA) Sec 221(c) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Sec 624(b) for recommendations on alternative approaches to the therapy caps and the requirement in BBRA Sec 221(d) as modified by MMA Sec 624(b), for a study of utilization patterns for therapy services from 1998 through 2000 with medical review of claims. CMS contracted with the Urban Institute[1] and AdvanceMed (DynCorp)[2] to support the preparation of the Reports to Congress. The reports are available on the CMS website **http://www.cms.hhs.gov/medlearn/therapy/** under "Research Tools for Specific Therapy Topics".

II. Medical Review of Claims

CMS performed medical review of a statistically significant number of claims (nearly 8,300 claims) randomly selected from the universe of outpatient therapy claims for 1998, 1999, and 2000. Utilizing techniques consistent with those used for the national Comprehensive Error Rate Testing (CERT) program, the study concluded that decreases in the utilization of therapy services in the capped year (1999) were not associated with elimination of Medicare payment for unnecessary or insufficiently documented services. The estimated national therapy paid claims error rate rose steadily from 10.9% in 1998 to 15.2% in 1999 and 20.4% in 2000. Similar types of errors were found in all three years, although there were differences in settings. Errors from private practices decreased while increases occurred primarily in claims from institutions paid by intermediaries, which were adjusting to a new billing system.

Most errors were due to insufficient documentation to support the services billed. The most prevalent type of error, representing 81-84% of all errors, was insufficient documentation. These are primarily related to absent records, and insufficient evidence of physician certification.

The qualifications of the persons rendering therapy services were an important influence on error rates. It was noted that some services billed as therapy services were performed by persons other than appropriately trained therapists, physicians and non-physician practitioners. Overall, the error rate was higher in claims submitted by physicians than by therapists.

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[1] Stephanie Maxwell, Cristina Baseggio, and Matthew Storeygard, Part B Therapy Services Under Medicare in 1998-2000: Impact of Extending Fee Schedule Payments and Coverage Limits (Washington, D.C.: The Urban Institute, September 2001).

[2] Judith M. Olshin, M.S., Daniel E. Ciolek, M.S. and Wenke Hwang, Ph.D., 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, Maryland: DynCorp/AdvanceMed, September 2002).

Future Planned Analysis

Since completion of the utilization study, CMS has contracted for a follow-up study, to further assess alternatives to current payment practices, including possibilities for a patient classification system that could be used as the basis for Medicare payment to a broad range of therapy providers.

We will continue to work on identifying patient characteristics and medical conditions that are related to higher utilization of therapy services. These may be useful in classification systems or models that make payments for broader units of services such as episodes.