2009 Medicaid Transformation Program Review
Outpatient Therapy Services

Description

Rehabilitative therapy services are optional Medicaid services which include physical therapy, occupational therapy, and speech and language therapy services. Rehabilitative therapy services are provided following an injury or illness to restore functional status. For example, rehabilitative therapy services may be provided following an illness in an attempt to restore strength and endurance. These services may also be provided after a traumatic injury such as a broken hip or a cerebrovascular accident (CVA). The objective in both examples would be to restore the individual to their pre-illness or pre-injury functional ability. In extreme cases the focus would be to assist the individual in performing basic activities of daily living (ADLs) such as feeding, dressing and bathing.

According to the Kansas Medicaid State Plan, outpatient physical, occupational, and speech/language therapy services must be rehabilitative and restorative in nature and provided following physical debilitation due to acute physical trauma or illness. Therapy services must be prescribed by a physician and are limited to six months per injury or illness for participants over the age of 20. This limitation does not apply to individuals from birth through age 20 or those individuals receiving therapy services through a Home and Community Based Service (HCBS) waiver, but a physician's order is still needed. Physical, occupational and speech/language therapy services are covered in accordance with 42 Code of Federal Regulation (CFR) 440.110. When a physician determines that rehabilitative therapy services are warranted due to illness or injury, an order or referral is written for a therapy evaluation. The patient is evaluated and a plan of care is developed to address the patient's physical debilitation needs. The plan of care developed by the therapists must include expected outcomes/goals and interventions necessary to restore physical function. The plan of care must also include frequency and duration of services provided.

If a change in the plan of care is warranted, the therapist must notify the physician and obtain an order for a change in the plan of care. Documentation in the medical record should provide evidence of both the need for care and assurance the patient is under the care of a physician. "The certification requirements" are met when the physician certifies the plan of care. If the signed order includes a plan of care, no further certification is required.

Providers of rehabilitative therapy services must be qualified to practice physical, occupational or speech/language therapy as approved by their licensure and area of discipline. The providers must enroll in Medicaid or be associated with an enrolled Medicaid provider for the provision of services to Medicaid eligible recipients.

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations,

disabilities or changes in physical function and health status. A qualified physical therapist (PT) is a person who is licensed as a PT by the Kansas Board of Healing Arts or has licensure or certification in the jurisdiction in which the service is provided. Physical therapy services may also be provided by a Physical Therapy Assistant (PTA), working under the supervision of a physical therapist. Currently physical therapists are the only rehabilitative therapists allowed to independently enroll as Medicaid providers and thus bill Medicaid for services provided.

Occupational therapy services are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status.

Occupational therapy is medically prescribed treatment aimed towards improving or restoring functions which have been impaired by illness or injury, or where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. A qualified occupational therapist (OT) is an individual who is licensed by the Kansas Board of Healing Arts or jurisdiction in which the service is provided. Occupational therapy services may also be provided by an Occupational Therapy Assistant (OTA), working under the supervision of an occupational therapist.

Speech-language pathology (SLP) services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. According to the Kansas Medicaid State Plan, speech therapy must be provided by a speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association. Kansas Medicaid does not reimburse for services rendered by speech therapy assistants.

In summary, "qualified professionals" means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform rehabilitative therapy services, and who also, may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide and may not supervise others.

Medicaid beneficiaries are allowed to receive rehabilitative therapy services from qualified professionals in a variety of settings. Outpatient rehabilitative therapy services may be provided in the home, school, clinics, outpatient hospitals, skilled nursing facilities, and physicians' office and in appropriate settings approved by the Traumatic Brain Injury (TBI) waiver program. Those individuals are eligible for six months of services under the state plan prior to accessing rehabilitative therapy services through the TBI waiver.

Table 1 – Medicaid Coverage of Rehabilitative and Habilitative Therapies

	Adults	**Children**
Rehabilitative	Coverage defined in state plan for outpatient rehabilitative therapy and limited to scope of practice for certain covered providers.	Coverage defined in state plan for outpatient rehabilitative therapy without limitations for participants from birth through age 20.
Habilitative	Not Covered	Required by the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) portion of state plan and approved for reimbursement for three school-based settings only. Rehabilitation providers not associated with an Early Childhood Intervention program (ECI), Local Education Agency (LEA) or Head Start are not allowed to bill Medicaid for habilitative services.

Kansas Medicaid utilizes Medicare criteria regarding service descriptions and provider qualifications for occupational, physical and speech/language therapy services as noted in Chapter 15 of the Medicare Benefit Policy Manual.

Medicare requires periodic review and re-assessment for continued need of therapy services, however this is not a requirement for Medicaid covered therapy services.

Medicare specifies that outpatient rehabilitative therapy services can only be furnished under a plan established by:

- A physician/non-physician practitioner - only a physician may establish a plan of care in a Comprehensive Outpatient Rehabilitation Facility (CORF);
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

Medicare Part B covers outpatient physical and occupational therapy services provided by a qualified therapist in private practice when the services are furnished in the therapist's office or the beneficiary's home. Speech/language therapy services are also covered by Medicare; as of July 1, 2009, speech providers may enroll as independent providers in private practice. Medicare utilizes a prospective payment system to reimburse providers for these services.

Medicare will only reimburse providers for services that are considered reasonable and necessary for the treatment of a beneficiary's illness or injury and are provided according to a plan of treatment approved by a physician. The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and

occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

Skilled services require the skills and knowledge of licensed or certified professionals or qualified providers. Services rendered by qualified professionals that could be provided by a family member or care giver are considered unskilled services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed. Services which do not meet the requirements for covered therapy services are not payable using codes and descriptions for therapy services.

Medicare does place limitations or caps on the amount of therapy services an individual may receive each year. Medicare has utilized therapy caps for the past few years in an attempt to control spending for therapy services. For physical therapy and speech/language pathology services combined, the limit on incurred expenses is $1840 for calendar year 2009. For occupational therapy services, the limit is $1840. If the needs of the beneficiary exceed the therapy caps, Medicare has made provisions for continuance of medically necessary care. Kansas Medicaid does not utilize monetary rehabilitative therapy caps or limit the number of visits a beneficiary may receive; instead, beneficiaries may receive services for up to six months per illness or injury.

Medicare has developed guidelines to contain therapy costs. For those services that are billed in 15 minute units, providers are instructed to use the following guidelines for billing when sessions are less than or exceed a 15 minute unit. This guideline is also helpful when services are provided by more than one discipline in a single therapy visit. As noted in the Medicare billing manual, providers should not bill for therapy services that were provided for less than eight minutes.

Additionally, Medicare has established a guide to facilitate accuracy of billing. This information assists providers in billing proper units for services rendered but also decreases the potential of Medicare payments in excess of the services rendered. This guide pertains to services that are reimbursed in 15 minute increments. For instance, if a beneficiary receives therapy services for 18 minutes, Medicare will reimburse only one unit of service. As noted in the guide below, it is not until the 23rd minute that Medicare will reimburse a provider for a second unit of service.

Table 2 – Medicare Billing Guide

Number of 15 minute Units	Number of Minutes
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

The largest expenditures for outpatient rehabilitative therapy services provided for Kansas Medicaid beneficiaries are paid to the following enrolled providers:

- Clinics
- Head Start
- Home Health Agencies
- Hospitals
- Independent Providers
- Local Education Agencies
- Physical Therapists
- Physicians
- Traumatic Brain Injury Waiver Providers

Outpatient rehabilitative therapy services are also provided by Critical Access Hospitals (CAH), Skilled Nursing Facilities (SNF), Comprehensive Outpatient Rehabilitation Facilities (CORF), Hospice and Rehabilitation Agencies or Outpatient Rehabilitation Facilities (ORF).

Rehabilitative therapy services in the home may be provided by a home health agency that employs therapists or contracts with therapists for the provision of the service. When therapy services are provided through the home health benefit, the service is billed as one unit equals one visit. Home health rehabilitative therapy services represent a fairly small portion of the total expenditures for outpatient rehabilitative therapy services. Rehabilitative therapy services may also be provided in the home by an independent therapy provider when the service is prescribed by a physician.

Rehabilitative therapy services are also provided in outpatient clinics. The services rendered include PT, OT, and Speech/language therapy. The physical therapist or other approved billing provider must bill for services rendered. Currently occupational therapists and speech/language pathologists are not allowed to enroll as independent Kansas Medicaid providers.

Outpatient rehabilitative therapy services are provided by hospitals and those services are rendered when the recipients has been discharged from the hospital or is not an inpatient. The recipient seeks therapy services as specified in the outpatient plan of care and services are

reimbursed fee-for-service. Outpatient rehabilitative therapy services are not reimbursed through Diagnostic Related Group (DRG) payments, which is the billing method used for inpatient hospital services.

Rehabilitative therapy services are also provided in nursing facilities. The nursing facilities may employ therapists or contract with therapists to provide rehabilitative therapy services to nursing home beneficiaries. The payment for rehabilitative therapy services rendered to a nursing home beneficiary is covered in the daily rate and is not billed separately for Medicaid beneficiaries. However, rehabilitative therapy services may also be provided in a nursing home setting for beneficiaries who are not residents of the nursing home.

Therapy services may be provided in the medical offices. Qualified professionals that may provide services in a physician's office include physical therapists, occupational therapists, speech/language pathologists, physicians, nurse practitioners, clinical nurse specialists, or physician assistants, who are licensed or certified by the state to perform therapy services, and who may also appropriately perform therapy services under Medicare policies. Generally therapy services provided in this setting are billed to Medicaid by the physician. Services may also be provided in the office of an enrolled physical therapy provider.

Habilitative therapy services are covered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services portion of the Medicaid state plan for participants from birth through age 20 and must be medically necessary. Habilititavie therapy services are only covered for recipients of EPSDT services. These therapy services are covered for any birth defect or developmental delay only when approved and provided by an Early Childhood Intervention (ECI), Head Start, or Local Education Agency (LEA) program. The purpose of habilitative therapy is to teach the recipient new functional skills and maintain maximum functioning. For example, children who sustain birth injuries or have cerebral palsy often require habilitative therapy services to develop basic motor skills. Habilitative therapy services provided in the school setting represents a significant portion of the total expenditure for all therapy services.

Therapy services provided in association with school services include PT, OT and Speech-language therapy for children as a part of the Individualized Educational Plan (I.E.P). Medicaid reimburses local education agencies for all medically necessary services for children to receive a free and appropriate public education, as documented on the child's I.E.P. These services are generally habilitative, but Medicaid beneficiaries may also receive medically necessary rehabilitative therapy services in the school setting or by any qualified provider and without the place of service limitations which are imposed on habiltiatve services. Beneficiaries older than age 21 may receive rehabilitative services only.

Services provided by the LEA are not limited to the school setting and are allowed in other approved settings such as home and inpatient settings. Therapy services performed in the LEA setting may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness in accordance with the section 1905 (r) of the Social Security Act, which outlines EPSDT services. "EPSDT guidelines note that services must be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." This section notes that services must be provided in addition to other such necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses

and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Service Utilization and Expenditures

Kansas Medicaid does not limit the number of rehabilitative therapy visits a beneficiary may receive. The services are limited to post-trauma/illness only and the consumer must have the potential for rehabilitation to a previous level of functioning, or have the capability to regain a portion of functional ability lost due to illness or injury. During the six month time frame that therapy services are allowed per illness or injury, a consumer may be seen as many times as medically necessary. Once a consumer achieves their maximum functional ability a restorative plan of care or maintenance plan of care may be established by the therapist to assist the consumer in maintaining the gains made in therapy. The maintenance program does not require the skill of a qualified therapist and is most generally performed by the consumers or caregivers. Although there is not a limitation for outpatient rehabilitative therapy services, documentation must show evidence of medical necessity and the services must be rehabilitative in nature. The beneficiary must also show evidence for rehabilitation potential. In comparison to other states, Kansas is expansive in the coverage of rehabilitative therapy services. According to data on State Medicaid program characteristics collected by the Kaiser Family Foundation, physical therapy is a covered service in 34 states, while 17 states choose not to cover this optional service. Occupational therapy services are a covered benefit in 29 states, while 22 states do not cover this service. Speech services for hearing and language disorders are covered by 33 state Medicaid agencies, while this is not a benefit in 18 states. Reference to this information may be found by visiting the Kaiser Family Foundation website at
http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=3&cat=4&sv=29.

Currently the only limitation placed on rehabilitative therapy services for Kansas Medicaid beneficiaries is six months per illness/injury for beneficiaries age 21 and older. In contrast to other states, as referenced on the Kaiser Family Foundation website, most states which allow PT, OT, and speech/language services as a covered benefit limit the number of units or visits per year. Coverage of outpatient physical therapy and occupational therapy ranges from six hours per year (24 15-minute units) in the state of Colorado to 30 therapy sessions per month or a total of 360 visits per year in the state of Indiana.

Compared to Kansas, coverage of speech/language services is more stringent in 12 states in which they are covered. Idaho limits this service to one audiological testing and evaluation per year, and speech pathology is not covered. Colorado limits this benefit to diagnostic audiology procedures for specified conditions. Indiana limits coverage to one audiological testing and evaluation per three years and 30 therapy sessions per month in combination with other therapy providers if ordered by the physician prior to hospital discharge. Montana allows 70 speech pathology visits per year and 30 additional visits are possible with prior authorization.

In the state of Kansas, the largest population group utilizing PT, OT, and speech-language therapy services is the age group birth through age 20. Many of these services are provided in the school setting or in accordance with the IEP and consist primarily of habilitative services. This age group consumed 78% of therapy expenditures.

Table 3 provides a comparison of coverage of optional rehabilitative therapy services in Kansas with neighboring states; Nebraska, Iowa, Oklahoma, Colorado and Missouri. Currently, states are only mandated to cover therapy services when found medically necessary under EPSDT.

Table 3 – Coverage of Outpatient Rehabilitative Therapy in Neighboring States and in Medicare

State	Physical Therapy	Occupational Therapy	Speech/Language Therapy
Kansas	Yes – limited to post-trauma/illness only, rehabilitation potential required	Yes – limited to post-trauma/illness only, rehabilitation potential required	Yes – limited to speech pathology for post-trauma or illness only, physician order and rehabilitation potential required, specified limits regarding audiological testing and evaluation.
Nebraska	Yes –rehabilitation potential required	Yes – rehabilitation potential required	Yes – rehabilitation potential required
Iowa	Yes – limited to services meeting Medicare standards	No	Yes – limited to audiological assessment for hearing aid
Oklahoma	No	No	No
Colorado	Yes – Limited to 24 15-minute units per year	Yes – Limited to 24 15-minute units per year	Yes – Limited to 24 15-minute units per year
Missouri	No	No	No
Medicare	Medicare covered service with therapy caps – PT and speech combined limited to $1840 in calendar year 2009	Medicare covered service with therapy caps - the limit was $1840 in calendar year 2009	Medicare covered service with therapy caps - PT and speech combined limited to $1840 in calendar year 2009

In the state of Nebraska all three rehabilitative therapy services are covered Medicaid benefits, rehabilitation potential is required. The state of Iowa covers rehabilitative therapy services that meet Medicare guidelines. Rehabilitative therapy services are not a covered service by Oklahoma Medicaid. The state of Colorado limits outpatient rehabilitative therapy services to 24 15-minute units per year, which is a combined total of 18 hours per year of therapy services, six hours each for physical, occupational and speech/language therapy services. Outpatient rehabilitative therapy services are not a covered benefit by Missouri Medicaid.

Figure 1 – Expenditures for Outpatient Therapy Services FY 2005-2008

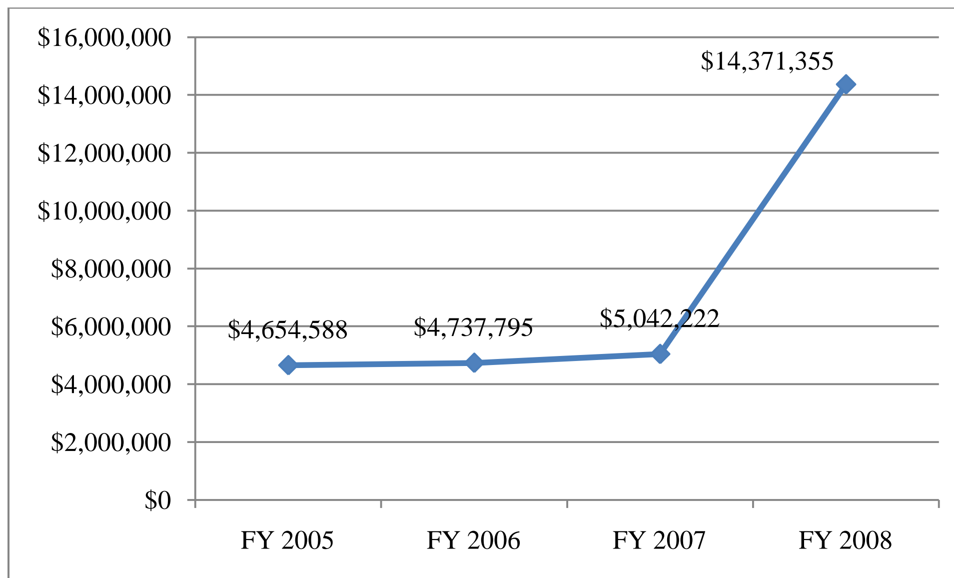


Figure 1 represents total expenditures for therapy services (habilitative and rehabilitative) for fiscal years 2005-2008. There was a significant increase in expenditures in 2008. The increase is a result of a change in the manner in which school based therapy services were reimbursed. Prior to 2007, Medicaid paid local education agencies a bundled rate for PT, OT and speech services provided in accordance with the individual educational plan. Under the bundled rate, schools were paid a set reimbursement each month for therapy services based upon the child's exceptionality, birth defect, or developmental delay. Due to the Center for Medicare and Medicaid Services (CMS) requirements, Kansas now reimburses LEA providers on a fee-for-service basis.

Table 4 - Total of Fee-for-Service Outpatient Therapy for SFY 2005-2008

SFY	No. of Paid Claims	No. of Unique Billing Providers	No. of Unique Consumers	Net Paid	Change from Previous Year	Net Paid per Consumer
2005	155,951	416	13,681	$4,654,588	N/A	$340
2006	157,773	436	13,389	$4,737,796	2%	$354
2007	159,787	428	12,756	$5,042,222	6%	$395
2008	373,228	428	20,074	$14,371,355	185%	$716

Table 4 provides a summary of expenditures for all therapy services provided over the last four fiscal years. Therapy services remained relatively stable for fiscal years 2005-2007, with only slight increases in the number of paid claims, billing providers, unduplicated consumer counts and average yearly expenditure per consumer. In fiscal year 2008, expenditures for therapy services increased by 185% due to the inclusion of services provided by the local education agencies. Excluding LEA services, outpatient therapy expenditures grew by just 2%, while

consumers decreased by 1,530, or 12%. The net paid per consumer was $456, this represents a 15% increase per consumer, which suggests that more intensive (i.e. more frequent) services were provided.

Figure 2 – Therapy Expenditures by Consumer Age Range FY 2008

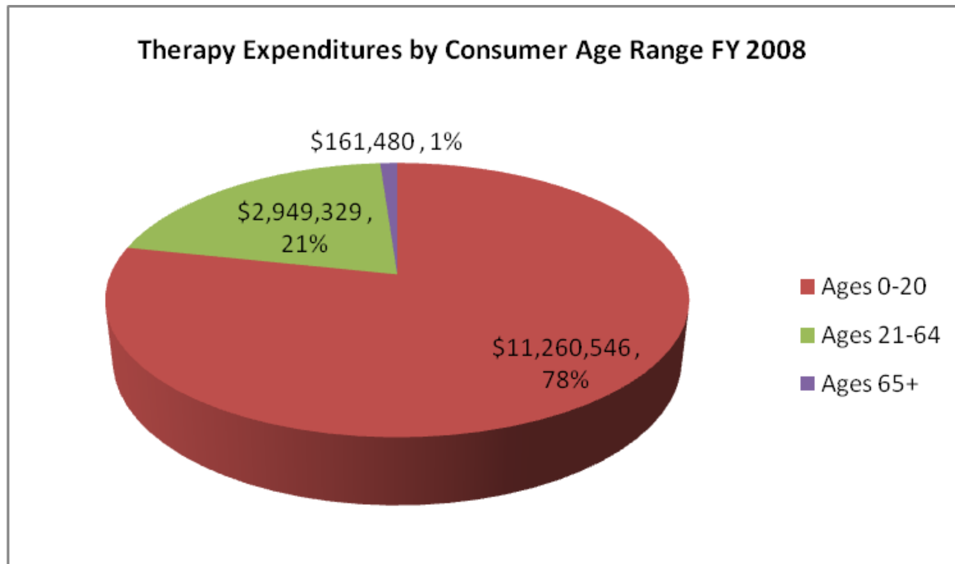


Figure 2 represents a breakout of outpatient therapy services by consumer age in 2008. As noted above, 78% of total expenditures, or more than $11.2 million dollars was spent on services for consumers from birth through age 20. The therapy services provided for children included both habilitative and rehabilitative. The next largest age group of consumers was for age 21 to 64 years of age. Twenty-one percent or $2.9 million dollars was expended for services for this age group. Lastly, expenditures for consumers age 65 and older was $161,000 or 1% of the total outpatient rehabilitative therapy expenditures.

Further analysis of utilization of expenditures by age revealed that Medicaid spent a significant amount on habilitative therapy services to address consumer needs related to birth defects and developmental delays. The middle age range captures individuals that required rehabilitative therapy services due to illness/injury or physical disabilities.

Less money was spent on the aged population for therapy services. This is likely due to Medicare coverage of services for this age group. The small percentage of total expenditures would represent Medicaid payment of Medicare “crossover claims” for Medicare beneficiaries that are also Medicaid eligible. Crossover claims are claims that are processed for Medicare beneficiaries, who meet the income requirement for Medicaid coverage. These claims are first processed by Medicare and are crossed over to Medicaid’s fiscal agent through Medicaid Management Information Systems (MMIS). If there is a remaining balance on the claim, Medicaid will make payment on the claim up to the allowed amount for reimbursement. Medicare payments to providers are usually more than Medicaid reimbursements and therefore if Medicare pays a claim the Medicaid payment is often zero dollars. Medicaid is a payer of last resort.

Figure 3 – Expenditures by Populations FY 2005-2008

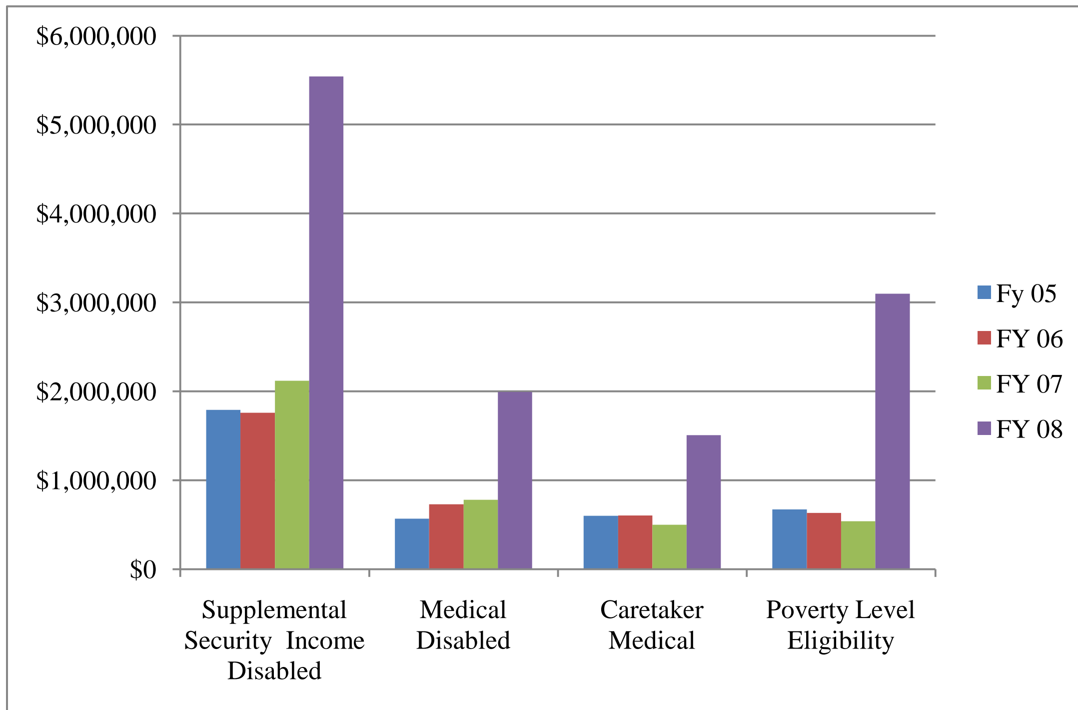
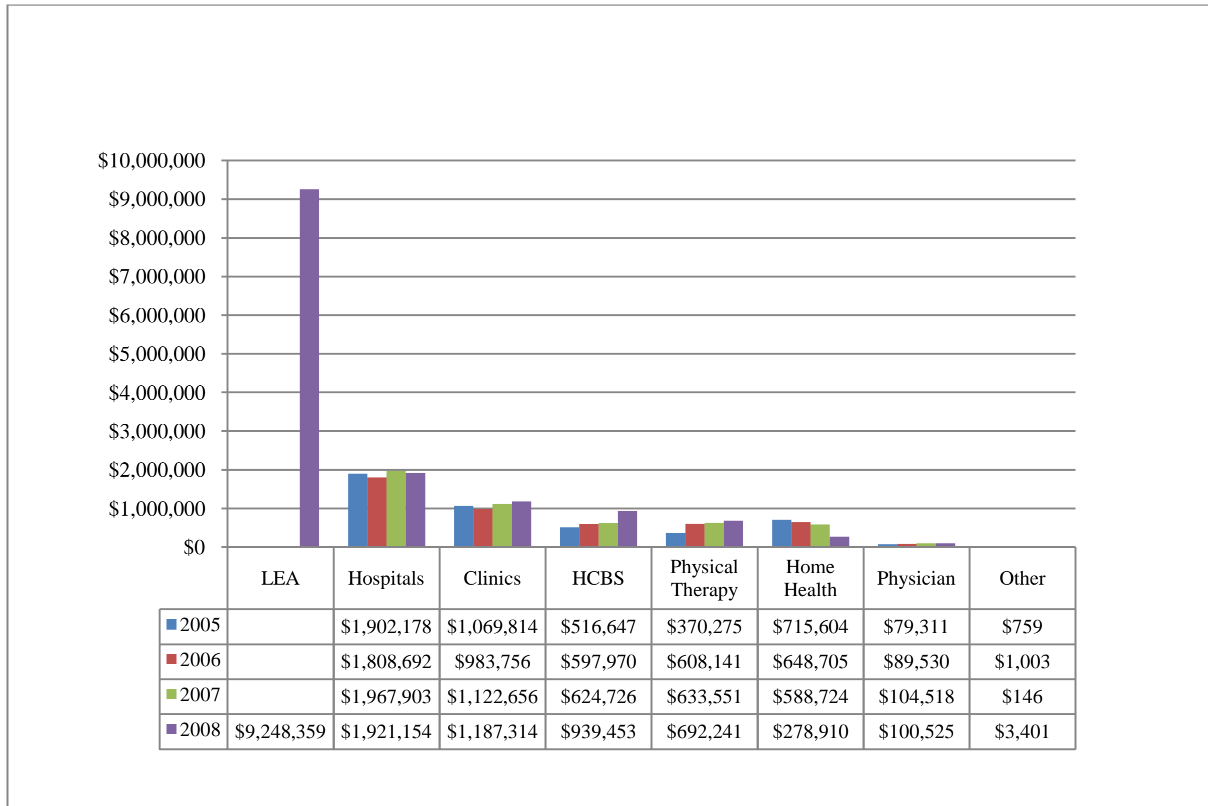


Figure 3 depicts expenditures paid for Medicaid beneficiaries grouped by the four most populous eligibility categories. The data revealed that there has been a steady increase in use by Supplemental Security Income Disabled individuals during the last four fiscal years, with the largest increase in fiscal year 2008. There have been steady increases in the expenditures for all of the population groups noted in Figure 3. Of the 14.3 million dollars spent for both habilitative and rehabilitative therapy services in fiscal year 2008, 12.1 million dollars, or 84% of the total amount paid was for population groups that include children. The large increases in therapy services in each population group, suggests the broad impact of the transition in funding for school-based services from a separately tracked bundled rate to the fee-for-service program.

Figure 4 - Expenditures by Provider Type FY 2005 – 2008



	LEA	Hospitals	Clinics	HCBS	Physical Therapy	Home Health	Physician	Other
2005		$1,902,178	$1,069,814	$516,647	$370,275	$715,604	$79,311	$759
2006		$1,808,692	$983,756	$597,970	$608,141	$648,705	$89,530	$1,003
2007		$1,967,903	$1,122,656	$624,726	$633,551	$588,724	$104,518	$146
2008	$9,248,359	$1,921,154	$1,187,314	$939,453	$692,241	$278,910	$100,525	$3,401

Figure 4 depicts expenditures paid by provider type during fiscal years 2005-2008. Outpatient hospitals averaged $1.9 million dollars per year. Expenditures paid to clinics were approximately one million dollars per year. Expenditures paid through HCBS waivers increased yearly from approximately $516,000 in fiscal year 2005, to more than $939,000 in fiscal year 2008. As previously noted, expenditures paid for school based therapy services were paid through the bundled rate prior to 2008 and are therefore not represented in expenditures for fiscal years 2005-2007. More detailed information on school based services and expenditures can be found in a separate program review. There were also fluctuations in expenditures for therapy services provided by home health agencies. Therapy expenditures for services provided by home health providers declined from approximately $715,000 in 2005 to about $278,000 in 2008. This reduction in home health expenditures for therapy services are attributed to more closely monitoring provider billing practices through Surveillance Utilization Reviews. Expenditures paid to physicians averaged less than $100,000 per year and has remained relatively stable. Expenditures paid to the category of “other” providers had a four year total of $5309.

Table 5 - Expenditures by Providers and Place of Service SFY 2008

Place of Service:	School	Home	Acute/Rehab Hospital	Office	Hospital	Other Place of Service	Misc.	Total
Providers:								
LEA	$9,242,785	$5,575					$0	$9,248,359
Hospital			$1,921,154				$0	$1,921,154
Clinic	$107,288	$809,060		$13,102	$146,307	$111,431	$126	$1,187,314
HCBS		$909,373		$27,102	$-7,678	$10,522	$142	$939,453
Therapist	$24	$36,160		$655,542	$0	$-292	$807	$692,241
Home Health		$278,910					$0	$278,910
Physician		$0		$97,376	$2,796		$353	$100,525
Misc	$0	$47		$660	$0	$2,693	$0	$3,400
Total	$9,350,096	$2,038,125	$1,921,154	$793,782	$141,417	$124,353	$1,429	$14,371,355

Note: The negative numbers listed in Table 5 represent expenditures that were recouped.

Table 5 provides a summary of expenditures for rehabilitative therapy services by providers and place of service or settings. Although provider type and place of service are sometimes used interchangeably, the place of service distinction is most important in reference to place of service editing in MMIS for claims processing. Providers such as Head Start Programs, ECIs, and LEAs, most often do not have any place of service editing; therefore, those providers may render services in multiple settings. Providers such as home health agencies may only provide outpatient rehabilitative therapy services to beneficiaries in the home setting.

Table 6 - Total Fee-for-Service Outpatient Therapy for SFY 2005-2008
Provider 17- 170 (Therapist – Physical Therapist)

SFY	No. of Paid Claims	No. of Unique Billing Providers	No. of Unique Consumers	Net Paid	Change from Previous Year	Net Paid per Consumer
2005	13,491	81	880	$370,275	N/A	$421
2006	23,579	98	1203	$608,141	64%	$506
2007	24,818	98	1217	$633,551	4%	$521
2008	26,496	88	1227	$692,241	9%	$564

Table 6 summarized therapy services provided by physical therapists (provider type 17-170) for fiscal years 2005-2008. These expenditures are reflective of only a small portion of the total expenditures for outpatient rehabilitative therapy services and are reported on the Medical Assistance Report (MAR) for physical therapy services. These expenditures also include services provided by occupational and speech-language therapists who currently are not allowed to enroll and bill Medicaid for services. Kansas Medicaid recognizes physical therapists as both performing and billing providers. Therapy expenditures paid to physical therapists have increased significantly over the last four fiscal years. The sharpest increase of 64% occurred from fiscal year 2005 through 2006. In 2005, expenditures were $372,265, but increased to $610,028 in 2006. This increase was due to a physician rate increase which became effective on June 1, 2006. Through this policy, rates were increased on a select group of procedure codes paid to physicians. The CPT codes most often utilized to reimburse physical medicine or rehabilitative therapy services are physician codes and were therefore included in the physician rate increase. The codes that previously paid less than 83% of Medicare rates were increased to 83%. The adjustments in physician rates on the identified codes resulted in an increase for physical medicine codes which ranged from 12.6% to 139.2% to reach 83% of Medicare reimbursement for the procedure codes.

Expenditures paid to this provider type for therapy services continued to have modest (4-9%) increases in fiscal years 2007 and 2008. The increase in expenditures is due primarily to increased use of services, since the number of consumers was stable and rates were not changed. Table 5 depicts a 9% rise in per person spending between FY 2006-2008. Provider type 17-170 (Therapist – Physical Therapist) is allowed to be enrolled as a Medicaid billing provider. Occupational therapist and speech/language pathologist are not recognized as billing providers. Medicare now allows speech/language pathologists to independently enroll, effective July 1, 2009. Currently physical therapists are allowed to bill Kansas Medicaid for the range of approved physical medicine codes, which includes services performed by a speech/language pathologist and an occupational therapist. All rehabilitative therapists may only provide services within the scope of practice of their specified disciplines.

Figure 5 – Outpatient Expenditures by Place of Service 2008

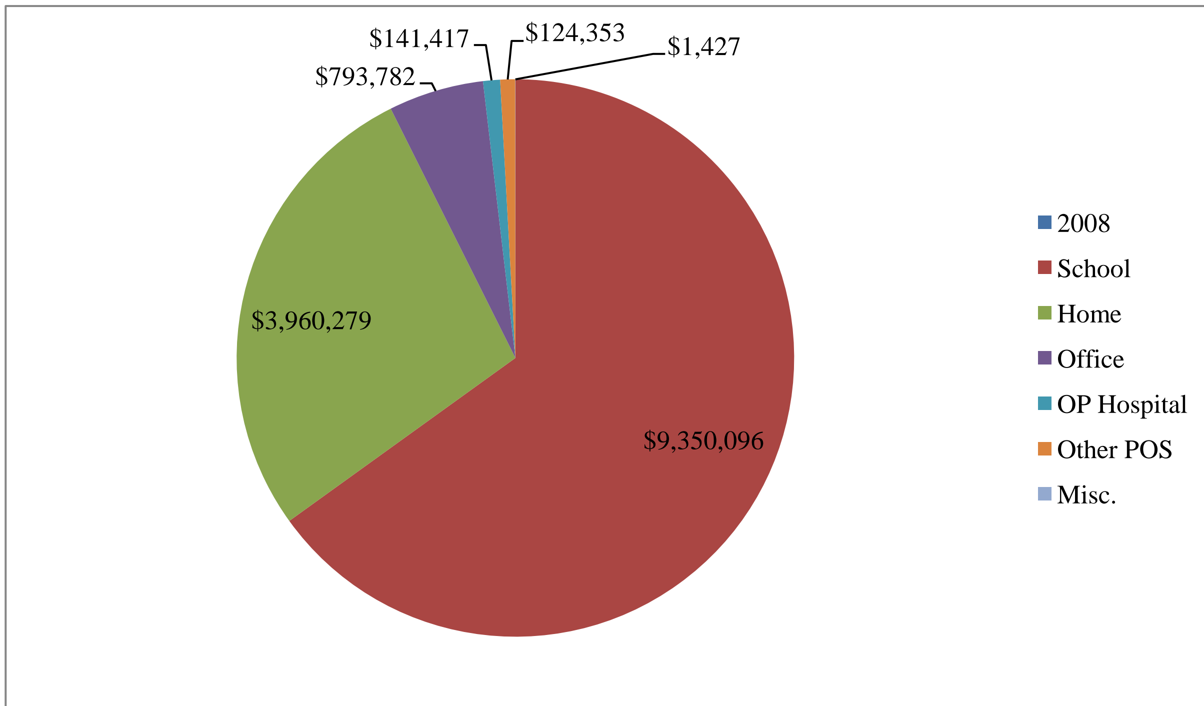


Figure 5 portrays the place of service for outpatient therapy services in 2008. In 2008, 75% of all services were provided in a school setting. More than one quarter of outpatient therapy services (28%) were provided in the home. Schools and independently enrolled providers are permitted to enter the consumers' homes to provide this service. Five percent of therapy services were provided in an office setting, while only one percent of services were provided in an outpatient hospital setting. The place of service other is less frequently used as Medicaid requires more specificity relating to place of service. Expenditures under miscellaneous place of service were minimal and totaled $1427 in fiscal year 2008.

Figure 6 – High Expenditure Outpatient Providers FY 2005-2008

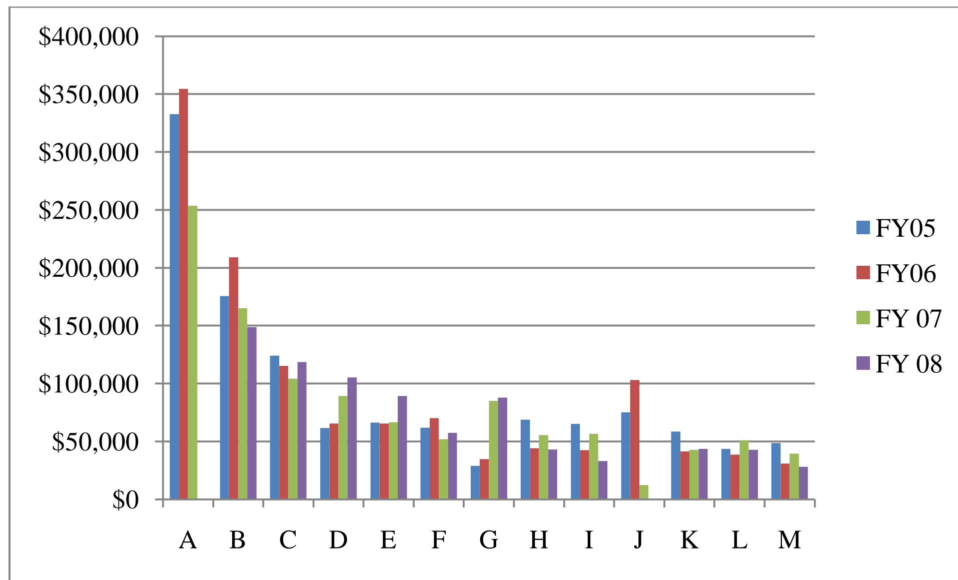
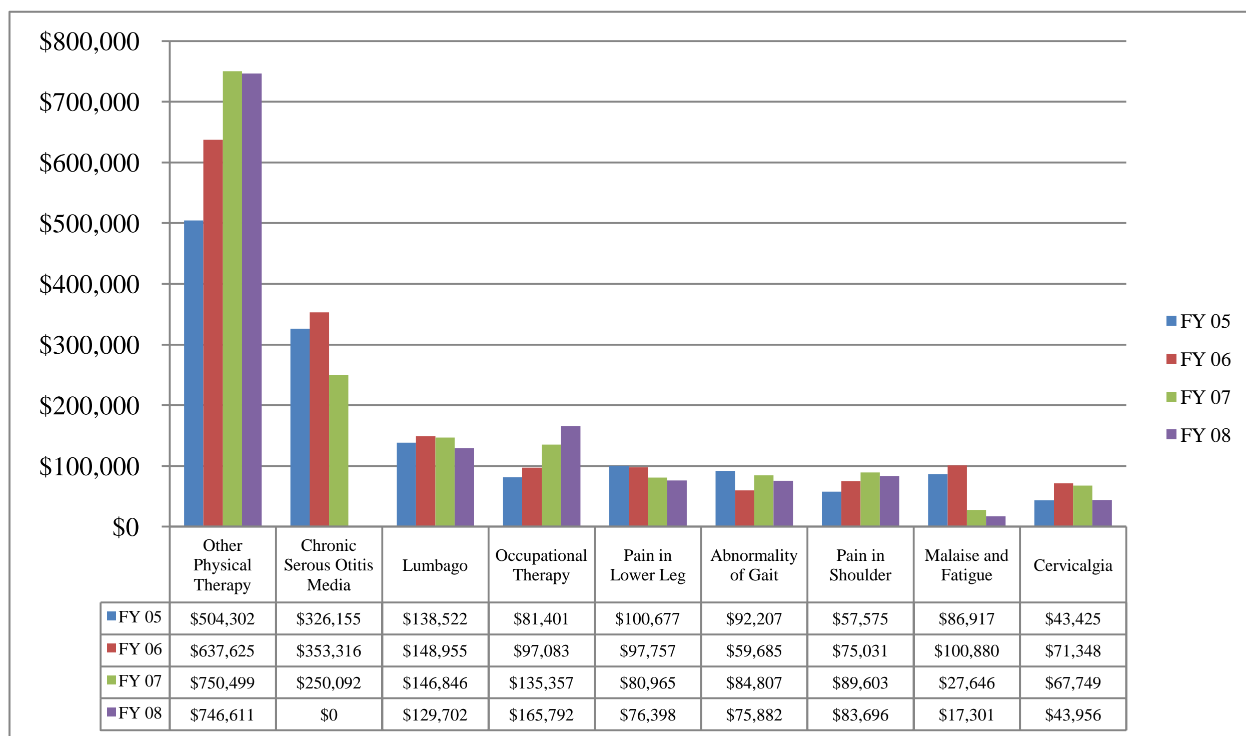


Figure 6 depicts the expenditures paid to the high expenditure providers for outpatient rehabilitative therapy services. During fiscal years 2005-2007, Provider A had expenditures in excess of $253,000 to $332,000. Close review of claims submitted by this provider revealed that speech therapy services were provided for consumers with middle ear infections. This provider modified their billing practices after a review by the Agency's Surveillance Utilization Review team. Provider A did not rank among the high expenditure providers in 2008.

The second highest expenditure group was Provider B, with expenditures ranging from $148,000 to $209,000. There was a peak in expenditures for this provider in 2006, with a decline in the past two fiscal years. The third highest expenditure provider had expenditures ranging from $104,000 to $124,000. The remaining top billing providers were paid less than $100,000 per year. This data excludes services billed by local education agencies, clinics and HCBS providers. Services provided in the local education setting will be addressed separately in a 2009 program review.

Figure 7 – Total Expenditures for Highest Volume Rehabilitative Therapy Diagnoses FY 2005-2008



	Other Physical Therapy	Chronic Serous Otitis Media	Lumbago	Occupational Therapy	Pain in Lower Leg	Abnormality of Gait	Pain in Shoulder	Malaise and Fatigue	Cervicalgia
FY 05	$504,302	$326,155	$138,522	$81,401	$100,677	$92,207	$57,575	$86,917	$43,425
FY 06	$637,625	$353,316	$148,955	$97,083	$97,757	$59,685	$75,031	$100,880	$71,348
FY 07	$750,499	$250,092	$146,846	$135,357	$80,965	$84,807	$89,603	$27,646	$67,749
FY 08	$746,611	$0	$129,702	$165,792	$76,398	$75,882	$83,696	$17,301	$43,956

The data shown in Figure 7 reflects the most frequently billed primary diagnosis codes in fiscal years 2005-2008. According to Medicaid policy, outpatient therapy procedures are considered rehabilitative when billed with a rehabilitative diagnosis. The range of habilitative diagnosis codes that are often used for children with birth defects and developmental delays were excluded from the analysis. Schools, clinics, and HCBS providers were also excluded as they most often provide habilitative services.

The most frequently billed primary diagnosis code for rehabilitative therapy was V57.1 (other physical therapy). This is an acceptable primary diagnosis as documented in Medicaid policy. However, providers are required to include a secondary diagnosis which could stand alone and is descriptive of the actual condition for which therapy services are rendered. The policy to include V57.1 as an acceptable primary diagnosis was implemented on December 1, 2006, resulting in an increase in claims containing this diagnosis. Since 2006, the expenditures for this diagnosis increased by more than $200,000 per year. Another contributing factor for the increase in expenditures was the adjustments to the physician fee schedule as previously noted in this report.

The second most frequently billed diagnosis was simple or unspecified chronic serous otitis media, or a middle ear infection. In most situations, therapy is not a recommended treatment for middle ear infections, but a total of 23,421 claims were paid with this primary diagnosis. Data in Figure 7, shows that otitis media did not rank in the category of most frequently billed diagnoses in 2008. As noted previously, the highest expenditure provider for rehabilitative therapy services was reviewed by Surveillance Utilization Review and a significant recoupment was identified.

The third most frequently billed primary diagnosis was lumbago or low back pain. Medicaid allows payment of this code as the primary diagnosis. More than $563,000 was reimbursed for this diagnosis code over the past four fiscal years. Additional monitoring of the code is necessary, as lumbago is often considered a chronic condition. Rehabilitative therapy services should be provided for acute physical trauma or illness only.

Diagnosis code V57.21 (encounter for occupational therapy) ranked fourth most frequently billed primary diagnoses. This code is in the range of the V codes, V57.0-V57.9 that were addressed in Medicaid policy. According to the Medicaid policy that was implemented on December 1, 2006, these codes should have a stand-alone secondary diagnosis for Medicaid reimbursement. As was noted with diagnosis code V57.1, this policy resulted in increased claims using this diagnoses code.

Pain in the joint, lower leg ranked fifth for primary diagnoses. There has been a steady decline in the number of claims containing this diagnosis and the expenditures paid to providers during the last four fiscal years.

Abnormality of gait was the sixth most frequently billed diagnosis. There have been fluctuations in expenditures for this code, but expenditures have ranged from $59,685 to $92,207 during fiscal years 2005-2008.

Pain in the joint, shoulder region ranked seventh for primary diagnoses. There was a steady increase in the number of claims containing this diagnosis during fiscal years 2005-2007, with a slight decline in expenditures paid to providers in 2008.

Other malaise and fatigue ranked eighth in the most frequently billed diagnosis. The expenditures for this code peaked in 2006, and the last two fiscal years have shown declines in reimbursements.

The ninth ranked diagnosis was cervicalgia, which is pain in the neck. Expenditures paid for the diagnosis cervicalgia during the past four fiscal years, averaged $56,619 per year.

Table 7 - ICD-9 Diagnosis Codes and Descriptions

V57.1	Other Physical Therapy
381.10	Simple or Unspecified Chronic Serous Otitis Media
724.2	Lumbago
V57.21	Encounter for Occupational Therapy
719.46	Pain in Joint, Lower Leg
781.2	Abnormality of Gait
719.41	Pain in Joint, Shoulder Region
780.79	Other Malaise and Fatigue
723.1	Cervicalgia

Table 7 represents the International Classification of Diseases, ninth edition (ICD-9) assignment and descriptions of the most frequently billed diagnosis codes for rehabilitative therapy services.

Table 8 - Medicare Coverage Requirements for Top Medicaid Diagnoses

ICD – Cluster	ICD-9(Cluster) Description	Physical Therapy	Occupational Therapy	Speech-Language Therapy
720.0-724.9	Dorsopathies	*	*	X
719.00-719.99	Other and unspecified disorders of joint	*	*	X
784.3-784.69	Aphasia, voice and other speech disturbance, other symbolic dysfunction	*	*	√
781.2	Abnormality of gait	√	√	X
780.71-780.79	Malaise and Fatigue	*	*	X
315.00-315.9	Specific delays in development	*	*	*
√	Automatic (only IDC-9 needed on claim)			
*	Complexity (requires another ICD-9 on claim)			
X	Does not serve as qualifying ICD-9 on claim			

Key:

√	Automatic (only IDC-9 needed on claim)
*	Complexity (requires another ICD-9 on claim)
X	Does not serve as qualifying ICD-9 on claim

Table 8 portrays Medicare Coverage Requirements regarding acceptable diagnosis codes for services that exceed therapy cap limitations. According to the Medicare Claims Processing Manual, many of the most frequently billed diagnoses for Medicaid would not be considered qualifying diagnoses on Medicare claims. Medicare requires specificity of diagnosis codes for therapy services that exceed established limitations. Table 8 is a comparison of the top billed diagnoses identified for rehabilitative therapy services and Medicare requirements for extended coverage. The majority of the diagnosis codes in Table 8 would not stand alone for Medicare extended coverage, as noted by the asterisk in the key to Table 8; another ICD-9 diagnosis would be required. The diagnosis codes in Table 7 are a compilation from the Medicare Claims Processing Manual and are used to compare the current Kansas Medicaid practice to Medicare practice.

Table 9 - Expenditures for Hospitals

SFY	No. of Paid Claims	No. of Unique Billing Providers	No. of Unique Consumers	Net Paid	Change from Previous Year	Net Paid per Consumer
2005	92,628	158	8,867	$1,902,176	N/A	$215
2006	87,398	160	8,390	$1,808,692	-5%	$216
2007	90,310	160	7,820	$1,967,908	9%	$252
2008	85,919	162	7,138	$1,921,154	-2%	$269

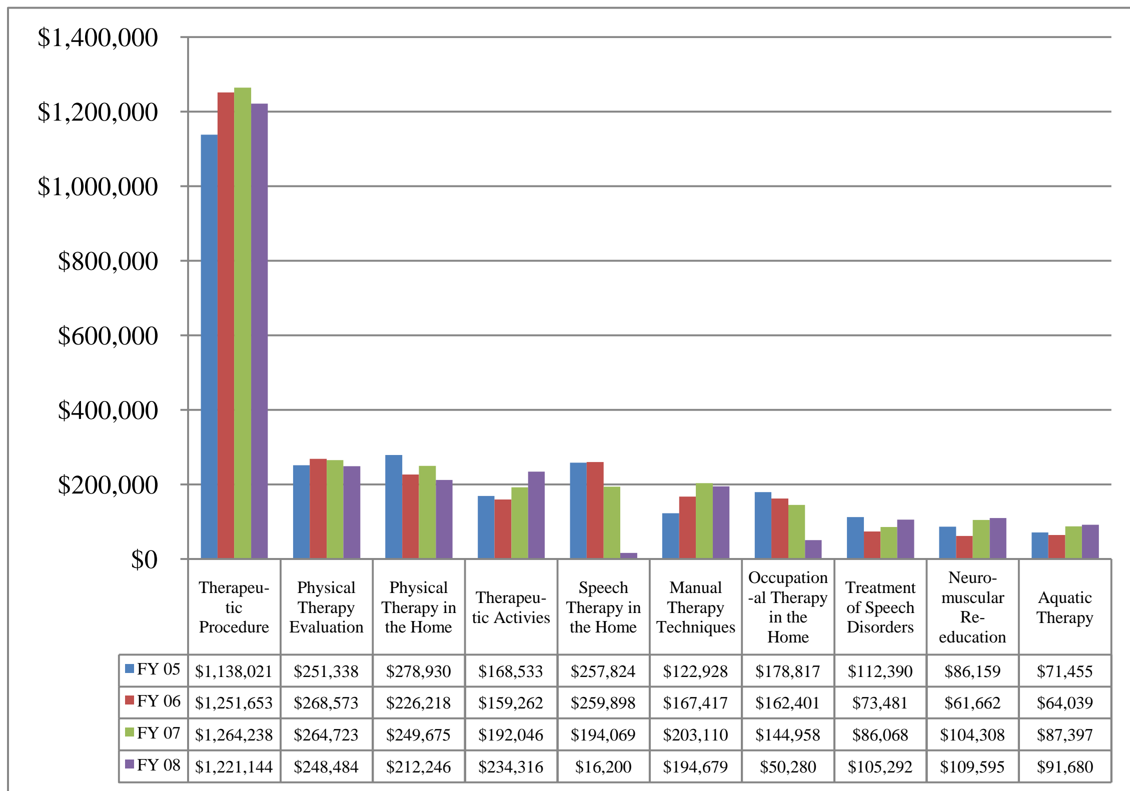
Table 9 summarizes expenditures paid to hospitals for outpatient rehabilitative therapy services. The data includes acute care hospitals and rehabilitation hospitals. A total of $7,599,927 was reimbursed to providers during fiscal years 2005-2008. Expenditures averaged approximately $1,700,000 per year for acute care hospitals. Only $680,418 was paid to rehabilitation hospitals during this time period or an average amount paid of $170,104 per year, less than 9% of the total expenditures paid to hospitals during this time period. Expenditures paid to hospitals for outpatient rehabilitative therapy services is a comparatively small amount of total expenditures paid for this service.

Table 10 - Expenditures for Clinics

SFY	No. of Paid Claims	No. of Unique Billing Providers	No. of Unique Consumers	Net Paid	Change from Previous Year	Net Paid per Consumer
2005	25,688	47	2,783	$1,069,814	N/A	$384
2006	22,926	34	2,583	$983,756	-8%	$381
2007	21,786	35	2,570	$1,122,656	14%	$437
2008	20,64047	30	2,345	$1,187,314	6%	$506

Table 10 summarizes all expenditures for therapy services paid to clinics during fiscal years 2005-2008. Although there are different clinic provider specialties, all of the expenditures paid to clinics during this time period, were paid to Early Childhood Intervention programs. ECI providers bill Medicaid for services provided to Medicaid eligible infants and toddlers, age birth through age three. This population most generally utilizes habilitative therapy services due to identified birth defects or developmental delays. This expenditure reflects services provided most often as a result of EPSDT screens, most of which are habilitative. Services are provided through the Infant and Toddler program until the child enters school, at which time services are provided through local education agencies. These beneficiaries are also eligible for rehabilitative therapy services. Medicaid has always reimbursed ECI providers fee-for-service, so the changes to reimbursement to LEAs had no impact on ECI providers. The expenditures and consumer counts have shown slight fluctuations over the last four fiscal years.

Figure 8 – Expenditures for Most Frequent Rehabilitation Services/Procedures FY2005-2008



	Therapeu-tic Procedure	Physical Therapy Evaluation	Physical Therapy in the Home	Therapeu-tic Activies	Speech Therapy in the Home	Manual Therapy Techniques	Occupation-al Therapy in the Home	Treatment of Speech Disorders	Neuro-muscular Re-education	Aquatic Therapy
FY 05	$1,138,021	$251,338	$278,930	$168,533	$257,824	$122,928	$178,817	$112,390	$86,159	$71,455
FY 06	$1,251,653	$268,573	$226,218	$159,262	$259,898	$167,417	$162,401	$73,481	$61,662	$64,039
FY 07	$1,264,238	$264,723	$249,675	$192,046	$194,069	$203,110	$144,958	$86,068	$104,308	$87,397
FY 08	$1,221,144	$248,484	$212,246	$234,316	$16,200	$194,679	$50,280	$105,292	$109,595	$91,680

Figure 8 summarizes expenditures paid for the most frequently billed rehabilitative therapy procedure codes during fiscal years 2005-2008. Therapeutic procedure (97110) was the most frequently billed procedure code. This code is used for the provision of physical, occupational, or speech-language therapy services, as there is not a discipline distinction. The expenditures for this procedure code averaged $1,218,764 per year. Physical therapy evaluation (97001) was the second most frequently billed procedure code, averaging $257,000 per year.

Expenditures for rehabilitative therapy services provided by a home health agency ranked third, fifth and seventh of the top ten most frequently billed procedure codes during fiscal years 2005-2008. Of these procedures, the greatest amount was paid for physical therapy service (S9131), averaging approximately $241,000 per year. Expenditures for speech therapy services (S9128) provided by home health agencies ranged from $257,854 in 2005 to $16,200 in 2008. This billing pattern is referenced in data related to top billing providers. Expenditures for occupational therapy (S9129) provided by home health agencies have also shown a pattern of decline each year, from $178,000 in 2005 to a little over $50,000 in 2008. The decline in expenditures for rehabilitative therapy services by home health agencies could be due to increased review of home health services. Another probable contributing factor is that home health agencies often have difficulty retaining therapists on staff or contracting with therapists for the provision of rehabilitative therapy services in the home. A third contributing factor to the decline in therapy expenditures paid to home health agencies is that beneficiaries are not required to be home bound and may leave the home to receive therapy services from providers in other settings.

Therapeutic activities (97530) were the fourth most frequently billed procedure code for rehabilitative therapy services. This code is also used by all three rehabilitative therapy disciplines. Expenditures ranged from approximately $159,000 in 2006 to over $234,000 in 2008. There has been a consistent increase in expenditures each fiscal year.

Manual therapy techniques (97140) ranked sixth in top 10 procedure codes. There has been an overall increase in expenditures for this procedure during fiscal years 2005, 2006 and 2007.There was a small decrease in expenditures in 2008 from $203,110 to $194,679.

The eighth most frequently billed procedure code was speech therapy (92507). There have been fluctuations during the last four fiscal years, ranging from approximately $73,000 to $110,000.

The ninth most frequently bill rehabilitative therapy code was neuromuscular re-education of movement, balance and coordination (97112). There have been small fluctuations in the expenditures for this service during the last two fiscal years.

The tenth most frequently bill procedure code for rehabilitative therapy services was aquatic therapy services (97113). There was a small decline in expenditures in 2007, but an increase during the last two fiscal years.

Commercial Health Insurance Rehabilitative Therapy Services

The Kansas Health Insurance Information System (KHIIS) was established under the authority of the Kansas Insurance Department. There are more than 20 insurance companies which presently submit data quarterly to the State for inclusion in the KHIIS database. This dataset does not include all of the commercial insurance providers in Kansas. It does not include data for Employee Retirement Income Security Act (ERISA) plans, companies with less than one percent premium volume, and self-insured plans. Currently the KHIIS data encompasses over 500,000 covered lives, but only data pertaining to outpatient rehabilitative therapy services has been extracted for this analysis. Review of the KHIIS data is helpful in comparing trends in the provision of services and expenditures by Medicaid and in the private sector.

Table 11 - KHIIS Expenditures for Rehabilitative Therapy for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	468,352	8,840	82,655	$18,332,828	N/A	$221
2006	494,593	8,569	81,127	$19,891,004	8.50%	$245
2007	496,334	7,853	79,629	$21,173,604	6.45%	$265
2008	508,609	6,693	77,780	$20,221,584	-4.50%	$259

Table 11 summarizes KHIIS claims data that covered the same set of physical medicine procedure codes used throughout the rehabilitative therapy report. A complete list of codes can be found in APPENDIX B. It is important to note that the unique claim count, the unique

consumer count, and the unique billing provider counts are not absolute. KHIIS data lack unique person identifiers so other methods for matching (i.e., membership ID, patient ID, patient DOB, patient gender, etc.) are used. Additionally, the insurance companies have in the past, changed some of these values with each quarterly data submission.

Despite some of the limitations of the KHIIS data described above, comparisons between it and the MMIS data is still of value. For example, similarities in the data obtained through MMIS and the data from KHIIS include gradual increases in the number of claims submitted each fiscal year. There are also similar fluctuations in the number of providers billing for rehabilitative therapy services. The most significant finding when comparing Medicaid coverage of rehabilitative therapy services to those of private insurers, is that Medicaid expenditures per beneficiary are significantly more than the private sector. In fiscal year 2007, Medicaid paid $395 per consumer compared to $265 paid per consumer by private insurance providers. During fiscal year 2008, Medicaid experienced a 185% increase in expenditures for therapy services due to the inclusion of habilitative therapy services. The average yearly expenditure per consumer increased to $716. Medicaid's increase in expenditures is related to unbundling reimbursement for school-based services. The services are now reimbursed fee-for-service. KHIIS data revealed a 4.5% decrease in expenditures by other insurers in fiscal year 2008. As previously mentioned, two insurance carriers had incomplete data submission for 2008 and there is no way to determine how much of the decrease (part or all of the decrease) is attributable to the missing data.

Table 12 - KHIIS Rehabilitative Therapy Expenditures for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	430,623	7,987	72,863	$15,142,713	N/A	$207
2006	463,149	4,691	72,927	$16,870,687	11.41%	$231
2007	471,560	7,113	73,544	$18,546,017	9.93%	$252
2008	496,922	6,240	74,571	$18,529,361	-0.09%	$248

Note: Number of Paid Claims, Number of Billing Providers, and Number of Unique Consumers may be duplicated in the POS tables as a claim may have more than one place of service in the detail line data which is the source of the place of service.

Table 12 summarized KHIIS expenditures paid for services provided in the office setting. Claims data compiled through KHIIS indicate that the majority of rehabilitative therapy services are provided in offices. This is not true for Kansas Medicaid, with 5% of covered services provided in the office setting, and 65% of total expenditures were paid for services provided in the school setting during fiscal year 2008.

Table 13 - KHIIS Rehabilitative Therapy Office Based Outpatient Expenditures for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	25,578	874	8,042	$2,155,446	N/A	268
2006	21,684	797	6,946	$2,309,474	7.15%	332
2007	15,992	766	8,392	$1,877,445	-18.71%	348
2008	6,267	316	3,009	$1,409,567	-24.92%	468

Table 13 summarizes KHIIS expenditure data for services provided by outpatient hospitals. Although there has been a decline in the number of unique consumers and providers identified, there has been a steady increase in the amount paid per consumer in the outpatient hospital setting in the private sector. In fiscal year 2008, 6.97% of expenditures for outpatient rehabilitative therapy services paid by private insurers were for services provided in an outpatient hospital setting. Expenditures for services provided for Medicaid consumers in the outpatient hospital setting represented 1% of the total amount paid for outpatient rehabilitative therapy services in fiscal year 2008.

Table 14 - KHIIS Rehabilitative Therapy Home Setting Expenditures for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	1,828	152	504	$312,229	N/A	$542
2006	2,114	208	502	$264,769	-15.20%	$444
2007	2,914	234	664	$340,210	28.49%	$439
2008	1,742	211	456	$226,534	-33.41%	$292

Table 14 summarizes KHIIS expenditures for outpatient rehabilitative therapy services provided in the home setting. Expenditures paid by insurers in the private sector average of $285,935 per year, representing less than 1.5% of total therapy expenditures. In fiscal year 2008, 28% of Medicaid covered outpatient rehabilitative therapy services were provided in the home setting, totaling more than 3.9 million dollars.

Table 15 - KHIIS Rehabilitative Therapy Comprehensive Outpatient Rehabilitation Facility Expenditures for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	421	47	126	$140,665	N/A	$1,116
2006	680	66	204	$92,558	-33.97%	$455
2007	176	17	45	$36,685	-60.50%	$815
2008	14	2	3	$3,504	-90.45%	$1,168

Table 15 summarizes KHIIS expenditures for service provided in a Comprehensive Outpatient Rehabilitation Facility. During the past four fiscal years there has been an overall decline in the number of claims submitted and expenditures paid for such services by private insurers. Services in this setting were paid for only three consumers in fiscal year 2008. The number of Medicaid consumers that receive services in Comprehensive Outpatient Rehabilitation Facilities is comparatively small as well.

Table 16 - KHIIS Rehabilitative Therapy in Other Settings Expenditures for SFY 2005-2008

SFY	No. of Unique Claims Identified	No. of Unique Billing Providers Identified	No of Unique Consumers Identified	Net Paid Amount	Change from Previous Year	Net Paid Per Consumer
2005	10,991	1,051	3,527	$620,579	N/A	$175
2006	7,227	850	2,074	$394,862	-36.37%	$190
2007	5,973	767	2,002	$421,309	6.7%	$210
2008	4,323	544	1,189	$145,879	-65.37%	$122

Table 16 summarizes KHIIS expenditures for outpatient rehabilitative therapy services provided in all other settings. There has been a significant decrease over time in the number of claims, number of consumers served and the net paid amount. Review of Medicaid claims data revealed that less than 1% of services were rendered under other place of service, totaling $1,427. More than 99% of outpatient rehabilitative therapy services were provided in a school, home, office, or outpatient hospital setting.

A comparison of most frequently billed diagnosis codes for which rehabilitative therapy services was provided by private insurance revealed similarities to Medicaid in fiscal year 2008. Review of the top 10 diagnosis codes revealed four matching diagnosis codes. The majority of the diagnosis codes were in the ICD-9 range of 710-739, diseases of the musculoskeletal system and connective tissue. The most frequently billed diagnosis code extracted from the KHIIS database was lumbago or low back pain. Lumbago was the third most frequently billed diagnosis code for Kansas Medicaid. Other physical therapy was the most frequently billed Medicaid diagnosis code. This code did not appear in the top 10 KHIIS diagnosis codes. Cervicalgia or neck pain ranked second for KHIIS and number nine for Medicaid. Other matching diagnoses in the top 10 most frequently billed diagnosis codes included pain in the joint, lower leg region, and pain in the joint, shoulder region. An across the board comparison cannot be made between Medicaid coverage of rehabilitative therapy and coverage by other insurers. However, there is a similarity in the trends regarding provider counts, claim counts, consumer counts, and the expenditures paid per consumer. Review of diagnoses also revealed similarities. It appears that Medicaid coverage of outpatient therapy services is more generous than coverage in the private sector.

Program Evaluation

KHPA has taken questions from stakeholders regarding limitations on coverage of outpatient therapy services, which specifies places of service and providers that are allowed to bill Medicaid for habilitative therapy services. These questions have arisen in particular with respect to school based services. Currently, the local education agencies must provide services in accordance with the Individuals with Disabilities Education Act (IDEA), which entitles children with disabilities to a free, appropriate public education in conformity with an individualized education plan. Therapy services for children age birth through age 20 are most often provided in the ECI and school setting. Medicaid has reimbursed the school system for the provision of medically necessary habilitative therapy services provided to Medicaid eligible consumers. However, according to the formal description of coverage in the State plan approved by CMS,

Kansas Medicaid will only reimburse habilitative therapy services provided by ECI, LEA, and Head Start providers. Other providers have sought to provide habilitative therapy services for Medicaid beneficiaries. There have been inquiries from parents expressing concern about the level of services provided in the school setting, especially for children with a diagnosis of an Autism Spectrum Disorder (ASD). Current methods of treatment for ASD include, but are not limited to, intensive individual supports, which includes extensive services to develop expressive verbal language, receptive language, and nonverbal communication skills. Many families and providers alike have inquired about the provision of this service outside of the school setting.

In recent months, providers that are not in an ECI, LEA, or Head Start network have submitted claims for services rendered to children that are habilitative in nature due to a prior diagnosis of a birth defect or developmental delay. The providers have billed the services using diagnosis codes that are vaguely rehabilitative, such as lack of coordination or difficulty walking. Review of consumer records in a recent Surveillance Utilization Review (SURS) revealed that the services were habilitative and duplicative of the services mandated under IDEA in the public school setting. This presents a potential for duplication of services, as covered habilitative services must be a part of the educational plan and provided in an educational setting (ECI, LEA, or Head Start) and significant increase in costs. Medicaid could potentially reimburse multiple providers for therapy services for the same child in the absence of safeguards to monitor for medical necessity and functional improvement.

The TBI (Traumatic Brain Injury) Waiver is the only waiver in which PT, OT, and speech therapy services are content of the waiver for consumers ages 16 – 64 who have suffered a traumatic brain injury. The TBI waiver allows the provision of rehabilitative therapy services as content of the waiver for recipients when their Medicaid state plan services have been exhausted. A consumer who suffers a TBI would receive up to six months of therapy fee-for-service prior to accessing waiver therapy services. This raises concern, as there are no edits or audits in place to limit fee-for-service therapy to only six months for a consumer on the TBI waiver. Review of the data for rehabilitative therapy services revealed that $939,453 was spent for TBI rehabilitative therapy services in 2008. Research is needed to determine the amount of fee-for-service expenditures that have been paid for TBI waiver recipients past the six month state plan limitation prior to accessing these services through the TBI waiver plan of care. There is not a process in place to ensure the transition of services from fee-for-service to the TBI waiver plan of care. Any therapy provided beyond six months is to be provided through the TBI waiver, which is designed to be cost–neutral and is included in the long-term provision of services approved by CMS.

According to the Medicaid state plan, the limitation for optional rehabilitative therapy services is six months per illness or injury for beneficiaries over age 21. There are no edits in place to prevent consumers from receiving services in excess of six months. It is conceivable that a beneficiary could need therapy services due to acute pain and exacerbation of symptoms related to a chronic condition. Medicare uses therapy caps as noted previously in this report. Medicare also has established specific guidelines related to ICD-9 diagnoses should a Medicare beneficiary's condition warrant services beyond the yearly monetary therapy cap. Claims data from the Medicaid payment system revealed a significant number of consumers that received services in excess of the six month limitation and that providers have changed the diagnosis for which services are rendered to continue services beyond the limitation. At this time, the only way to identify providers with this unacceptable billing practice is through post pay review. Additional research is needed to determine whether a monetary limitation or a time limitation should be considered to avoid payment for services in which documentation of continued medical necessity is not provided and thereby avoid these costs pre-pay.

This program review identified the following challenges and opportunities for potential savings or more efficient use of outpatient therapy services:

1. Provision of rehabilitative therapy services for children that also receive habilitative therapy services. Although these individuals are eligible for both rehabilitative and habilitative therapy services, providers are not permitted to provide habilitative services under the guise of rehabilitative services. During the past 12 to 18 months some rehabilitative therapy providers have inquired about becoming eligible to provide habilitative therapy services for children with birth defects and developmental delays. Services provided by these providers would have a potential to be duplicative of the habilitative therapy services provided in the schools, Head Start and the Early Childhood Intervention programs which are governed by IDEA Part B and Part C. The providers seeking Medicaid approval to deliver habilitative therapy services are not "bound by IDEA" as they are not ECI or LEA providers and do not receive funding from the State Department of Education for the provision of special education services. The IDEA mandates services in these settings, and the inclusion of the new providers presents the potential to duplicate services and impact continuity of care due to potential lack of coordination.

   Several providers began rendering habilitative services to children who also received school based services through an Individual Educational Plan (IEP). Upon review of claims data, it was determined that the providers submitted claims which contained a rehabilitative therapy procedure code and a vague diagnosis code which were only remotely rehabilitative in nature. The diagnoses used included difficulty walking, lack of coordination, muscle/ligament disorder, and aphasia. Although rehabilitative therapy services were billed, the services rendered were more habilitative in nature and related to the beneficiaries' birth defects and developmental delays. The service involved attempting to teach children new skills rather than restoration of function lost due to an injury or illness, which is the focus of rehabilitation. These services are addressed in the rehabilitative therapy option of the state plan, while habilitative therapy services are covered under EPSDT.

2. Service site and provider type limitations for habilitative therapy services. Medicaid reimburses habilitative therapy services for children with birth defects and developmental delays for services provided in specific settings by specified providers. These services are accessed at Local Education Agencies, Early Childhood Intervention and Head Start Programs. However, habilitative therapy services are not an optional service as states are required to provide services to children that meet reasonable standards of medical practice to address conditions identified through EPSDT.

   The autism waiver does not currently include the provision of services that are available to children under IDEA; therefore these children are receiving needed habilitative therapy services through the EPSDT portion of the state plan.

   Expanding habilitative therapy services to all qualified providers of outpatient rehabilitative therapy services could have a significant fiscal impact and would present difficulty in ensuring that services are reasonable, medically necessary and delivered in a manner that is efficient and cost effective. Within this context, KHPA has been

exploring options for expanding where habilitative therapy services can be accessed by the EPSDT population.

3. Provider billing practices for outpatient rehabilitative therapy services. Review of claims information and SURS reviews have shown that providers do not bill partial units of service, but have sought reimbursement for the next full unit of service, when the therapy session only extended one or two minutes into the next unit. Utilization of billing rules used by Medicare could potentially save Medicaid dollars, as it will allow providers to more accurately bill for services rendered, will not allow payment for therapy sessions that last less than eight minutes and will decrease the potential for over-payment of therapy services. The billing guidelines are noted under the Medicare coverage section of this report.

4. Provision of services past the six month limitation per injury or illness for rehabilitative therapy services. There are no edits in the system that would prevent payment of therapy services past the six month limitation. Review of claims data revealed that some providers have simply changed the diagnosis on the claims to allow continued payment of services past the six month limitation. Implementation of edits or limitations per beneficiary per year would prevent providers from rendering services in excess of the established limitations. This intervention could better ensure that services rendered are reasonable and necessary and decrease the potential of Medicaid paying for services that exceed the six month limitation without additional documentation to support medical necessity.

5. Provision of intensive therapy services without sufficient assessments to support the duration and frequency of visits. There is no documentation requirement for the continued need for therapy services after the six month limitation. Medicare requires providers to re-evaluate the consumers at frequent intervals to ensure that services are reasonable and necessary. Medicaid does not require such documentation from providers. Providers are not required to periodically submit documentation to indicate that a consumer has reached a plateau or has maximized the benefit of therapy. This is often true regarding habilitative therapy services, as PT, OT and speech language services are written into the IEP and are on-going. Once a beneficiary has maximized the benefit of therapy services, continued services are considered maintenance. Maintenance services would include range of motion and required function to complete activities of daily living tasks. Range of motion exercises provide movement to extremities and joints such as shoulders, knees, elbows to maintain function and avoid contractures and decreased mobility. If an individual is not able to perform activities of daily living, family or paid caregivers may assist with these tasks, as the skill of a qualified therapist is not needed for maintenance. Ensuring that Medicaid dollars are only spent on skilled services and that proper resources are utilized for maintenance or non-skilled services has a potential to result in a cost savings.

The following changes have been implemented recently for outpatient rehabilitative therapy services to improve efficiency of the provision of service, billing and management of therapy services:

1. On December 1, 2006 a consolidated Medicaid policy was implemented to clarify which diagnosis codes are truly habilitative and now includes only birth defects, developmental delays, and conditions most often identified through EPSDT screens. The previous groupings of habilitative diagnoses contained diagnoses such as adult failure to thrive and diagnoses related to nutrition and weight. The age of the beneficiary and diagnoses

for which therapy services are billed determines whether the services are habilitative or rehabilitative. When therapy services are provided due to a loss of function, it is considered rehabilitative. When services are provided to acquire new skills, these services are habilitative. The policy resulted in a consolidation of all therapy policies which encompassed current coverage of habilitative therapy services and noted those policies which had been superseded.

2. On December 1, 2006 a Medicaid policy was implemented to consolidate all policies that pertained to rehabilitative therapy services. This policy also provided documentation regarding provider use of diagnosis codes V57.0-V57.9. These codes are approved by Medicare as a primary diagnosis when used in conjunction with a secondary diagnosis that clearly specifies the affected body part and purpose of therapy. Several of these procedure codes were already approved for coverage in response to ad hoc provider inquiries, but the policy served as documentation. Subsequent review of rehabilitative therapy claims data revealed that not all providers are including a separate secondary diagnosis when these diagnosis codes are used as the primary diagnosis and there are no edits in the system to prevent using the V codes as independent diagnoses.

3. While researching habilitative and rehabilitative therapy policies and also as a result of provider inquiry, it was discovered that the National Correct Coding Initiative (NCCI) guidelines in the system had not been updated in the MMIS for nearly two years (October 2003 - May 2005). The NCCI edits were developed by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payments of Medicare Part B claims, which Medicaid utilizes to pay for low-income dual eligibles. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS annually updates the National Correct Coding Policy Manual for Medicare Services (Coding Policy Manual). CMS periodically issues tapes with NCCI edit updates. The importance to the NCCI editing to reimbursement of therapy services is that some combinations of codes cannot be billed on the same date of service, or the claim on one code is subsumed into another as content of service of a greater code. This billing issue was resolved by instructing providers to utilize a special code or modifier, for separate and distinct therapy services. For example if a child received both physical therapy and speech therapy on the same date of service, both therapists should be paid and attaching the modifier would allow payment for both therapies on the same date of service.

4. A Medicaid policy has been written that has an implementation date of October 1, 2009, which will allow occupational therapists to enroll as providers in private practice.

Recommendations

1. Implement therapy limitations for the units or duration of service that can be more easily monitored and enforced. The number of appropriate units will be established in collaboration with providers.

2. Send a billing reminder to providers regarding the need of a secondary diagnosis when certain procedure codes (V57.0-V57.9) are used as the primary diagnosis.

3. Implement Medicare's guidelines for billing units of therapy service. This will allow payment for actual units of therapy services provided.

4. Continue to closely monitor the billing practices of providers of rehabilitative therapy and monitor claims data for trends of interest. Such trends may include but are not limited to billing proper units, monitoring for accurate use of procedure codes and diagnosis codes, ensuring medical necessity and rehabilitation potential, and ensuring that services do not exceed the six month state plan limitation.

5. Conduct additional research on the provision of state plan rehabilitative therapy services for those individuals on the TBI waiver. These individuals are eligible for six months of services under the state plan and therapy services past the six month limitations are covered by the TBI waiver. Possible modifications to the Medicaid payment system may be necessary to include edits or date ranges per consumer for episodes of care to adhere to the six month provision of state plan services.

6. Update the rehabilitative provider manual to provide clarification on chronic conditions which may present with acute exacerbations of symptoms for which an episode of therapy services is warranted due to pain and a decline in function and mobility.

7. Support the efforts of autism stakeholders, including advocacy groups, providers, and insurance carriers, in a review of the costs and burden of autism that will provide information to make future state policy decisions.

APPENDIX A: DEFINITIONS

Acute – Having rapid onset, severe symptoms and a short course; not chronic. Rehabilitation services can only be provided following an acute physical trauma or injury.

Ameliorate - To make or become better; improve. Rehabilitation services can be provided to children up to age 21 to treat or improve physical or functional deficits due to acute physical trauma, injury, illness, birth defects or developmental delays.

Chronic – Designating a disease of showing little change or of slow progression and long continuance. Rehabilitation services are not appropriate for chronic conditions where there is little chance of improvement of the condition or functional capacity.

Dorsopathies - is a term used to describe various diseases of the back and or spine.

Episode of Outpatient Therapy – An outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that discipline in that setting. During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun.

EPSDT – Early and Periodic Screening, Diagnosis, and Treatment of Individuals under Age 21 who are eligible Medicaid recipients, to ascertain physical and mental defects, and provide treatment to correct or ameliorate defects and chronic conditions found (42 CFR 441.50). Habilitative therapy services are most often provided for conditions identified as a result of DPSDT screenings.

Exacerbation – Increase in the severity of any symptoms or disease. Rehabilitation services may be considered to treat acute pain and or a decline in function and mobility related to a chronic condition.

Habilitative Therapy – Services covered for birth defects/ developmental delays. This service is designed to help individuals acquire new functional abilities rather than restore function. Habilitative therapy often focuses on the development of cues and skills to meet consumer needs in the area of hygiene and activities of daily living.

Lumbago – A general nonspecific term for dull, aching pain in the lumbar region of the back. Rehabilitation services are not typically warranted for lumbago, as the condition is chronic and the potential for improvement in the condition is very low.

Outpatient hospital services – Preventative, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients, and furnished by or under the direction of a physician or dentist; and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting - 42 CFR 440.20 (a).

Range of Motion (ROM) – Services which provides repetitive movement in a joint such as shoulders, knees, elbow to avoid contractures or decreased mobility of the joints. Rehabilitative

services may include the development of a range of motion plan of care for maintenance of function achieved as a result of skilled therapy services.

Reasonable and Necessary - Services that are of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

Rehabilitation - An organized treatment approach designed to maximize an individual's recovery process in physical function lost due to an acute illness, trauma or injury.

Rehabilitative Therapy - The process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible. For example, rehabilitation after a stroke may help the patient walk again and speak clearly again. (Webster's New World Medical Dictionary).

Skilled - Therapy services must be provided by a qualified professional or qualified personnel and must require the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently.

Traumatic Brain Injury - A brain injury sustained in an accident, fall or assault involving a blow to the head or penetrating wound as in a gunshot. Rehabilitative services are often provided to assist individuals that have sustained traumatic brain injuries to learn to walk again or perform basic hygiene tasks.

Unskilled - Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, to maintain function after the recipient has maximized the benefits of skilled services. Unskilled services are delivered in accordance with a maintenance plan of care developed by a therapist incident to hygiene and grooming task provided by unskilled care givers.

APPENDIX B: REHABILITATIVE THERAPY PROCEDURE CODES

92506	Evaluation of speech, language, voice, communication, and/or auditory processing
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation);group, two or more individuals, one unit = one visit
92610	Evaluation of oral and pharyngeal swallowing
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston diagnostic aphasia examination) with interpretation and report per hour
97001	Physical therapy evaluation, one unit= one visit
97002	Physical therapy re-evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97010	Application of a modality to one or more areas; hot or cold packs
97012	Traction, mechanical
97014	Electrical stimulation (unattended)
97016	Vasopnuematic devices
97018	Paraffin bath
97022	whirlpool
97024	Diathermy, (e.g. microwave)
97026	Infrared
97028	Ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97035	Contrast baths, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Aquatic therapy with therapeutic exercises
97116	Gait training (includes stair climbing)
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one-on-one), patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (e.g. activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by the provider, each 15 minutes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g. high pressure water jet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per sessions; total wound(s) surface area less than or equal to 20 square centimeters
97750	Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes
G0151	Services of physical therapist in home health setting, each 15 minutes
G0152	Services of occupational therapist in home health setting, each 15 minutes
G0153	Services of speech and language pathologist in home health setting, each 15 minutes
S9128	Speech therapy , in home per diem
S9129	Occupational therapy, in home, per diem
S9131	Physical therapy; in home, per diem