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Developing Outpatient Therapy Payment Alternatives (DOTPA): 2009 Annual Report

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CONTENTS

SECTION 1 INTRODUCTION	1
1.1 Background.....	1
1.2 Purpose and Organization of This Report.....	2
SECTION 2 OUTREACH SUMMARY	3
2.1 Technical Expert Panel	3
2.2 Open Door Forum	6
2.3 Other Outreach Activities	7
SECTION 3 DATA COLLECTION INSTRUMENT DEVELOPMENT	8
3.1 Initial Data Collection Instrument Development.....	8
3.2 Stakeholder Involvement Informing the “Final” Draft Tool	10
SECTION 4 KEY UTILIZATION FINDINGS	14
SECTION 5 PROJECT PROGRESS ON MEETING GOALS & OBJECTIVES.....	16
REFERENCES	R-1
List of Tables	
Table 1 Summary of outreach activities	4

SECTION 1 INTRODUCTION

1.1 Background

In 2007, the Centers for Medicare and Medicaid Services established a research project titled “Developing Outpatient Therapy Payment Alternatives” (DOTPA). The purposes of this project are to identify, collect, and analyze therapy-related information tied to beneficiary need and the effectiveness of outpatient therapy services. The ultimate goal is to develop payment method alternatives to the current financial cap on outpatient therapy services.

Outpatient therapy services are composed of physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP). Outpatient therapy services are billed under Medicare Part B and are provided in multiple settings including community-based, e.g., private practices, hospital outpatient clinics, and facility-based, e.g., skilled nursing homes, long term care facilities.

These services represent a small but growing share of the Medicare expenditures, accounting for about 3 percent of Medicare Part B spending in 2004. The past growth in Medicare expenditures led to increased attention to these services. Attempts to address the increased expenditures through payment policy changes led to the realization that CMS cannot adequately assess the appropriateness of utilization patterns or the impact of changes in payment policy without access to better information tied to patient need and the effectiveness of outpatient therapy services.

Significant changes in Medicare outpatient therapy payment policies began with the Balanced Budget Act (BBA) of 1997 with its attempts to “level the playing field” and pay therapy providers consistently across sites of care. Hospitals (including inpatient rehabilitation facilities (IRFs)), skilled nursing facilities (SNFs), and home health agencies (HHAs) have moved to new, case-mix adjusted prospective payment systems (PPS) for these services. However, the outpatient therapy providers were addressed separately from the outpatient PPS. First, outpatient therapy services furnished by providers were moved to fee schedules to be more consistent with other outpatient payment methodologies. Second, annual financial limits (“therapy caps”), already in place for physical therapy and occupational therapy private practice patients, were extended to all other outpatient settings except hospital-based services. Congress implemented temporary moratoria on the therapy caps for several years and in the Deficit Reduction Act of 2005 required CMS to establish in 2006 an exceptions process to allow the provision of medically necessary therapy services that would otherwise exceed the therapy cap. Subsequently, the Tax Relief and Health Care Act of 2006 extended this exceptions process for services furnished in 2007 and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the exceptions process for services furnished through June 30, 2008. The exceptions process is a refinement of the therapy caps, not an alternative. The cap and exceptions method of payment addresses cost containment but does not address the fundamental issue of assuring that appropriate therapy services are provided to the beneficiary efficiently. Therefore, developing payment alternatives that are tied to beneficiary needs and outcomes are a priority to the Agency as well as Congress.

1.2 Purpose and Organization of This Report

The purpose of the annual reports is to summarize progress on stakeholder involvement, instrument design, data collection, and analyses conducted to date. This report is organized as follows. Section 2 of this report summarizes stakeholder outreach conducted to date, including technical expert panels (TEPs), Open Door Forums (ODFs), presentations at association meetings, and other discussions with key stakeholders. Section 3 summarizes progress on the data collection tool development, including design principles for the data collection instruments, the initial draft instruments, summary of feedback received on the draft instruments, and a summary of the refinements to the draft instruments. Section 4 summarizes findings from the 2007 Utilization Report. Section 5 summarizes how well the project's progress to-date has met its goals.

SECTION 2 OUTREACH SUMMARY

This section summarizes outreach activities RTI has conducted in the past year. As shown in Table 1, RTI has conducted outreach activities with several organizations. These activities include in-person telephone meetings with organization staff as well as e-mail feedback. The remainder of this section describes the outreach activities in more detail.

2.1 Technical Expert Panel

2.1.1 TEP Objective and Membership

One of RTI's principal outreach activities was convening a TEP to receive feedback on an early draft of the project data collection instrument (the instrument development process is described in more detail in Section 3). The meeting was held on July 8-9, 2008 at the Centers for Medicare & Medicaid Services (CMS) in Baltimore, Maryland. The objective of the TEP was to obtain expert opinions regarding the key features and tradeoffs necessary in the design of an assessment tool that would measure patient severity and outcomes and measures that could be used in a payment system alternative to the existing cap and exceptions method. Table 2 presents a list of TEP members.

In regulatory guidance to providers for documenting patient function information for therapy cap exceptions, CMS has recommended four instruments:¹

- ASHA's National Outcomes Measurement System (NOMS) instrument
- Focus On Therapeutic Outcomes, Inc.'s (FOTO's) Patient Inquiry® instrument
- Boston University's Activity Measure-Post Acute Care (AM-PAC) instrument
- Cedaron's/APTA's OPTIMAL instrument

Appendices A-1 through A-4 provide examples of each of these instruments (which were provided to the TEP members prior to the meeting). It is important to note, however, that in the case of the AM-PAC and FOTO these are paper-based short forms. The full AM-PAC and FOTO tools are computerized adaptive testing (CAT) instruments that adaptively draw on an item bank depending on earlier item responses.

TEP members prior to the meeting were asked to review these instruments, as well as: (1) a proposed new assessment instrument to be used in community-based settings; (2) the Continuity Assessment and Record Evaluation (CARE) tool; (3) additional assessment instruments used in therapy practice; and (4) a selection of related scientific literature. We asked this panel to advise on domains and specific items that may explain differences in severity and outcomes that could be used in a payment system.

¹ See Chapter 15 of the Medicare Benefit Policy Manual, Section 220.3. Note that CMS recommended these instruments for use in documentation of necessity for therapy, but did not mandate their use.

Table 1
Summary of outreach activities

Organization	Topic(s)	Mode(s)
American Physical Therapy Association (APTA)	Patient assessment Payment for therapy services TEP nominations	In-person Telephone E-mail
American Occupational Therapy Association (AOTA)	Patient assessment Payment for therapy services TEP nominations	In-person Telephone E-mail Presentation at meeting
American Speech-Language-Hearing Association (ASHA)	Patient assessment Developing assessment items Payment for therapy services TEP nominations	In-person Telephone E-mail
American Medical Rehabilitation Providers Association (AMRPA)	Patient assessment Payment for therapy services TEP nominations	Conference call E-mail
National Association for the Support of Long Term Care (NASL)	Patient assessment TEP nominations	In-person Conference call E-mail
American Health Care Association (AHCA)	Patient assessment Payment for therapy services TEP nominations	In-person Conference call E-mail
Tri-Alliance of Health and Rehabilitation Professions	Patient assessment Payment for therapy services	Conference call
Uniform Data System for Medical Rehabilitation (UDSMR)	Patient assessment TEP nominations	Conference call E-mail
Genesis Rehabilitation Services	Patient assessment Payment for therapy services TEP nominations	In-person Conference call E-mail
Alexian Rehabilitation Hospital	Patient assessment	In-person

2.1.2 Summary of TEP Discussion

Opening Orientation of TEP Panelists. The meeting began with a description of the objectives of the DOTPA project and provided an opportunity for TEP members to ask questions in order to clarify their understanding of the purpose for developing an outpatient therapy assessment instrument and voice their initial concerns.

Domains for patient severity and outcomes. Panel coordinators outlined the domains identified to date and asked for input. Panelists suggested many new domains, including assistive technology, personal drive/motivation, social context/living arrangements, ability to learn, supplement for those who use a wheelchair, supplement for ADLs and basic mobility, goal attainment, and caregiver availability. The group felt that items to capture the needs of, and resources used by, severely disabled individuals were lacking. Additionally, panelists suggested asking about full tasks, such as eating and dressing, and whether the patient is able to get out in society (E.g. “Are you able to participate in activities outside of your home that you choose to participate in?” “Are you able to travel outside your home as you want to?”).

Patient self-reported versus clinician-reported items. Panelists raised issues of health literacy, when to use patient proxies, who would determine whether a patient needs a proxy, and who would act as a patient’s proxy.

Single versus setting-specific assessments. Many members were not enthusiastic about patients filling in assessment information if the information would be used to determine payments. Most TEP members felt that multiple assessments would be most appropriate and allow for a more appropriate assessment of different patient populations.

Medical conditions and reasons for therapy. Some of the panelists felt that the questions presented in the draft assessment focused more on issues related to physical therapy and that there were too few items related to speech-language pathology. Panelists raised the idea of brief screeners, leading to more in-depth questions for those that fit into certain categories. The clinicians suggested adding several conditions to the assessment that would describe populations that were not yet identified. Along these lines, most participants felt that there should be a physician and a therapy diagnosis noted on the form. Comorbid conditions were also mentioned as an important factor in outcomes that should be captured in an assessment.

One of the sub-contractors on the project discussed her experience testing the instrument in the field. She noted that many patients were happy to fill in the information and appreciated being asked many of the questions. While results were inconclusive as to the optimal scale, patients that were anxious preferred descriptors that allowed them to check off their answer.

Residence and environmental barriers. The necessity to understand the amount of assistance a patient needs in their daily life was an important factor in this discussion. Environmental barriers were noted as an important variable in the logistics of acquiring the appropriate equipment and the amount of training the patient may need. The group agreed to a question asking if a patient has trouble getting around their home. Falls were identified as an important variable to capture.

Pain, impairment, and cognitive status. In the discussion of pain, a large portion of panelists said they used a zero to ten scale for their patients to identify pain severity. An important factor to panelists for identifying the full range of beneficiaries with pain was the wording of pain questions. The group suggested adding words such as numbness, tingling, and funny feeling to best capture all patients with pain. The discussion of impairments included vision, hearing, and swallowing. All participants agreed these factors are important to cover, but each factor could have screener questions before more in-depth questioning into each function.

During the discussion of cognition, some panelists expressed concern about difficulties in collecting this information from the patient. Patients with memory problems, for example, may not report cognition accurately, and some who believe they have memory problems actually do not. Some panelists suggested using triggers to assess cognition, potentially based on diagnosis. The group recommended the Trails A and B test (Reitan, 1958; Corrigan and Hinkeldey, 1987) to assess patient's cognition.

Function items. The second day of the TEP began with a discussion of the function items proposed in the draft assessment. Some panelists felt that the context of the function items was important. For example, dressing is different to a man and a woman and eating could mean various things to people. Again, some panelists expressed an overall concern that there were not enough items at the lower end of the function scale to assess some patients appropriately. To address this concern, there was an agreement to add more questions that are more sensitive to those with lower function. A panelist suggested adding a supplement to the community-based instrument for those beneficiaries who use wheelchairs. An overarching question of the discussion was what should be included in the core and supplemental sections. General concerns included clinician time to fill in assessment, patient's ability to answer items, and accuracy of the answers.

Mood and self-efficacy. The group suggested adding items that ask about patients' ability to take care of themselves and their home, whether they are able to participate in activities they like to do, hopefulness, and whether they believe they will improve over the course of treatment. There was a general consensus that these types of items are important factors in predicting patient outcomes.

Miscellaneous topics. During the wrap-up the panel discussed several issues that had no conclusion to that point during the meeting. TEP panelists said that it is important to know whether a patient has an able caregiver or needs more than one, as well as whether the patient is a caregiver for someone else. The panelists discussed the timeframe for admission, proposing that the first 2-3 therapy visits act as the initial evaluation or allow the clinician to decide. The panel also raised the issue of how to assess patients who are only evaluated and will not be treated, and those that are treated, but do not return.

2.2 Open Door Forum

On August 6, CMS and RTI held an Open Door Forum in Baltimore to review and comment on the project and data collection strategy. This meeting provided a forum for feedback from a broad base of stakeholders, including providers, representatives of hospital associations, consumers, patients, family caregivers, and advocacy groups. The ODF was announced to all subscribers through appropriate CMS electronic lists, shared with stakeholder organizations, and announced on the CMS website. Participants in the ODF had the opportunity to ask questions about the project and the potential for participating in the data collection. The announcements for the ODFs included CMS and RTI e-mail address where interested parties were able to indicate their interest in the project and express concerns. Over 400 people attended the ODF. RTI recorded comments and is incorporating some of them into the data collection instrument revision process.

2.3 Other Outreach Activities

During the past year, RTI engaged in a variety of other outreach activities, as shown in Table 1. Many of the outreach activities have involved the three main therapy associations. RTI has had in-person meetings at each of the therapy discipline association's headquarters. These meetings included discussions of: (1) members' concerns about Medicare payment, both current and future; (2) recommendations on important assessment domains to cover in project data collection instruments; and (3) possibilities for further outreach activities related to this project.

RTI has engaged in additional outreach activities with these associations. With AOTA, Edward Drozd gave a presentation on the project data collection instrument design process to AOTA's annual meeting in Houston. With ASHA, RTI has had numerous discussions related to data collection instrument content, including working with ASHA staff to develop a number of assessment items specifically for patients receiving services from SLPs, including both patient- and clinician-reported items. In addition, RTI sought representatives from all 3 of the therapy associations for membership in an advisory workgroup to help develop the data collection instruments.

RTI engaged in outreach activities with organizations in addition to the 3 main therapy associations. RTI has held conference calls with representatives from AMRPA, AHCA, and NASL to understand concerns their members have regarding Medicare payment for outpatient therapy, including alternatives to the current therapy caps and assessment information that could be used in payment systems. RTI attended a meeting at CMS in September, 2008 with representatives from NASL and AHCA to discuss findings from a study they have funded to help them offer alternative payment approaches for outpatient therapy provided in nursing facilities. RTI has also had conversations with leadership of a few providers, including Rehabilitation Institute of Chicago, Alexian Rehabilitation Hospital, and Genesis Rehabilitation Services, to gain their perspectives on Medicare payment for outpatient therapy and to gauge their interest in potentially participating in data collection.

RTI has set up electronic means for stakeholders to relay their concerns and interest in the project. There is a project e-mail address (optherapy-comments@rti.org) that is monitored daily for messages giving interest and comments. It has been used by providers to express interest, and RTI is keeping track of all interested providers with whom to follow up during data collection recruitment.

RTI set up a project Web site (<http://optherapy.rti.org/>) that provides information about the project and provides a means of giving comments or suggestions, and showing interest in the project. The website is updated as new material of interest becomes available, such as PDFs of presentations made to provider associations or news about the project. In addition, versions of the draft instruments included in the Paperwork Reduction Act request for comment materials will be posted to the Web site.

SECTION 3 DATA COLLECTION INSTRUMENT DEVELOPMENT

This section provides a summary of RTI's activities to date to develop primary data collection instruments for the project. RTI's proposed data collection instruments can be found in the appendices to this report: Appendices B-1 and B-2 contain the admission and discharge instruments for community-based settings, and Appendices C-1 and C-2 contain the admission and discharge instruments for use in nursing facilities.

3.1 Initial Data Collection Instrument Development

3.1.1 Design Principles for the Study Patient Assessment Tool

RTI's proposed draft patient assessment tool incorporates the following basic design principles:

1. Use a uniform assessment tool, possibly conditional on setting (community-based versus nursing facility), rather than use multiple tools depending on the treating clinician's discipline or the patient's principal impairment.
2. Use a core-plus-supplemental approach to structure the tool rather than requiring that all items be completed on all patients.
3. Feature patient self-reported items (that can be completed by a proxy if necessary) in the core assessment items to reduce provider burden.
4. Use assessment items that are intended to measure patient case-mix complexity, not just severity of individual impairments.

RTI's goal was to develop a single tool that can be completed by or for any outpatient therapy patient regardless of the types of therapies they receive. Consistency in assessment across settings is in fact a Congressional requirement in the Benefit Improvement and Portability Act (BIPA).

However, RTI has created separate instruments for community-based versus nursing facility settings because a single data collection instrument would have resulted in either an overly-long instrument or one featuring assessment items subject to ceiling and floor effects—the instrument's scope would not have allowed for the expression of the extreme upper and lower ranges of function across all beneficiaries receiving outpatient therapy. Although there is significant overlap in the function, impairment and complexity of the population receiving outpatient therapy, RTI developed separate assessments to allow better sensitivity in the extreme ranges of function. RTI simplified the comparability problems created with two instruments by using as many common items as feasible in both instruments.

RTI's data collection tools feature a core-and-supplemental approach. Core items are reported by or for all patients, and supplemental items are used as needed to refine assessment information for particular subsets of patients. To minimize reporting burden, we attempt to limit assessment completion time for the study tool to 15 to 30 minutes (total) per patient. The core items would provide standard information on all outpatient therapy patients. The supplemental items would provide more refined information about specific limitations and impairments.

Where possible (on the community-based data collection instrument), RTI has utilized both self-report (either by the patient or by a proxy) and clinician assessment as the modes of data collection. A standard protocol for determining whether a proxy or assistant should be used is on the first page of the community-based data collection instrument. The nursing facility instrument is only clinician-reported.

3.1.2 Using a Modified AM-PAC as the Basis for Function Assessment in the Study Tool

RTI is using a modification of the Activity Measure for Post Acute Care (AM-PAC) Adaptive Short Form (ASF) as the basis for the draft version of the study assessment tool. ASF versions of the AM-PAC consist of specific items from the AM-PAC item bank administered to all patients (in contrast to the full AM-PAC system, which uses computerized adaptive testing so that different patients may answer different questions). AM-PAC ASFs are divided into three sections associated with different domains of function (mobility, daily activities, and applied cognitive function). By using a modification of the AM-PAC Adaptive Short Form instrument as the initial draft study assessment tool, the project's assessment instrument can cover a broad range of function with a relatively small subset of items. In addition, the AM-PAC is a functional assessment instrument recommended by CMS for documenting necessity of services and the need for a therapy cap exception, and the AOTA is reportedly considering endorsing the AM-PAC as a patient functional assessment tool for use by occupational therapists.

3.1.3 Consistency with the CARE Tool

Under separate CMS contracts, work is already underway to develop a common assessment instrument for post-acute care settings (long term care hospitals [LTCHs], inpatient rehabilitation facilities [IRFs], skilled nursing facilities [SNFs], and home health agencies [HHAs]). This instrument, the Continuity Assessment and Record Evaluation (CARE) tool, is intended to replace the existing assessment instruments used in the prospective payment systems for IRFs, SNFs, and HHAs. Four major domains are included in the tool: medical, functional, cognitive impairments, and social/environmental factors. These domains either measure case-mix severity differences within medical conditions or predict outcomes such as discharge to home or community, re-hospitalization, and changes in functional or medical status. To the extent appropriate, RTI has maintained a reasonable degree of consistency between the CARE tool and the data collection instruments created for this project to ease the incorporation of useful items into any successor of the current CARE tool to meet Congressional (BIPA) requirements for assessment consistency across settings. Demographic, pain, and impairment items from the CARE tool have been incorporated in the starting point community-based instrument.

3.1.4 Using a Modified CARE Tool in Nursing Facility Settings

In the future CMS may make more extensive use of the CARE tool (under development and not yet approved for payment and other programmatic use) for Part A-covered SNF stays (and other post-acute settings). For many patients needing the level of care provided in a skilled nursing setting, the only relevant difference between these patients and patients in other settings is their Medicare coverage for the stay, not clinical need. In many cases, the same clinicians provide services under both Part A and Part B. As a result, if the CARE tool is appropriate for

patient assessment for a Part A-covered inpatient SNF stay, it is likely to be appropriate for patients in a SNF receiving Part B-covered therapy.

Using a modified CARE assessment in facilities versus a new tool in community based settings can complicate comparisons between these groups of patients. As a result, making items as comparable as possible, conditional on the items reflecting the range of functional or other limitations of the respective patient populations, is quite desirable. RTI has included in the starting-point tool as many comparable items from the CARE tool as might be appropriate for community-based populations. Conversely, the modified CARE tool uses as many items from the community-based tool as possible, including diagnosis, pain, and communication function items.

3.2 Stakeholder Involvement Informing the “Final” Draft Tool

As noted in Section 2, an important part of stakeholder outreach was soliciting suggestions and feedback on the development of the project data collection instruments. This includes review from TEP members, feedback from the ODF, and other interactions with stakeholders. The data collection assessment instrument development process proceeded significantly more slowly than originally anticipated. However, we believe the instruments were greatly improved by taking the additional time to receive feedback and to gain support from a wide range of stakeholders. RTI anticipates that many fewer changes will be needed during the mandated Paperwork Reduction Act public comment and review process as a result of the intensive involvement with stakeholders.

3.2.1 Changes Made to the Community-Based Instrument

In response to the concerns, questions, and comments made, RTI made the following changes to the community-based instrument:

- Created separate admission and discharge instruments to reduce form complexity.
- Requested names and NPIs of all therapists completing the form because multiple therapists may contribute to the care of a patient in some settings.
- Included a detailed protocol on the front page of the instrument to determine whether a proxy or assistant for the patient should complete the patient-reported items and the reason for the assistant or proxy.
- Added a set of items comprising a global rating of change to the patient-reported section of the discharge form.
- Added screening items to the patient-reported function items so that those items can be skipped if a patient reports not having difficulty with a particular domain.
- Added items specific to wheelchair mobility in the patient reported mobility function items.

- Added a set of items based on the International Classification of Function (ICF) coding to collect the clinician-reported primary reason(s) for why the patient needs therapy.
- Substantially shortened the medical condition (primary and secondary) item lists to fit on a single page. They were also refined to tie better to ICD coding.
- Added items from the CARE tool related to vision, hearing, swallowing, cognitive status, communication, and continence impairments in the clinician-reported section. Also added screening items which clinicians only need to use to assess the patient if these items if relevant.
- Added an item asking whether the patient has one or more stage II (or unstageable) pressure ulcers, and if so, whether they interfere with therapy.
- Added a set of items derived from the NOMS instrument to assess swallowing, communication, and cognitive function assessed by clinicians treating or evaluating the patient on these domains. ASHA staff, with assistance from Alan Jette, developed these items to assess patients on these domains in a more structured fashion than in the NOMS instrument. This will hopefully improve consistency of response, particularly from clinicians not familiar with the NOMS.

3.2.2 Modifications to the CARE Tool for Use in DOTPA Data Collection

The workgroup composed of project staff, consultants, and outside advisors made several modifications—mostly deletions of items—to the most recent (as of September 9, 2008) version of the CARE tool for data collection for this project. Some items were deemed not needed for measuring case mix or outcomes for therapy use (as opposed to nursing care) or are needed only for continuity of care. Among the changes were:

- Used check boxes rather than written number codes with item responses to facilitate paper-based data collection.
- Clarified admission and discharge to refer to Part B therapy specifically.
- Deleted patient nickname; SSN; Medicaid number; medical record number; and payer information in the Administrative Items section.
- In the Admission Items section,
 - Deleted residence prior to the recent illness; patient’s ZIP code; and structural barriers in the home.
 - Modified item “Admitted from” by adding “MR/DD facility and assisted living facility” and “other medical services in the last 2 months”.

- Modified “Diagnosis in previous setting” to separate “two or more falls” versus “fall with injury” by converting “history of falls” to a checklist and specifically asking about persistent vegetative state.
- Added whether the patient was in the facility prior to receiving Part B therapy; and why the patient is receiving Part B therapy.
- In the Current Medical Information section,
 - Deleted the items: major procedures; medications; allergies and adverse drug reactions; and physiologic factors.
 - Modified primary and other diagnoses by substituting the medical condition checklist used on the community-based instrument.
 - Modified pressure ulcers by adding an item from the community based instrument on whether the pressure ulcers interfere with therapy.
 - Added primary reason(s) for why the patient needs therapy from the community-based tool based on the International Classification of Function (ICF) coding.
- In the Cognitive Status, Mood & Pain section,
 - Modified: pain item to add the location and description of pain items from the community-based instrument.
 - Added: NOMS-derived cognitive function items from the community-based instrument.
- In the Impairments section,
 - Deleted: bowel and bladder need for assistance; indwelling device prior to current illness; and grip strength.
 - Modified: swallowing disorder signs or symptoms, to add history of dysphagia/aspiration pneumonia.
 - Added: swallowing function item and the communication function items from the community-based instrument.
- In the Functional Status section, all items were left unchanged.
- Deleted the Overall Plan of Care/Advance Care Directives section.
- In the Discharge Status section,

- Deleted: attending physician; discharge care options; and all discharge location information items.
- Modified: discharge location to use response items from new admission source checklist.
- Deleted the procedure code items from the Medical coding section.

SECTION 4 KEY UTILIZATION FINDINGS

The purpose of the 2007 Utilization Report is to provide a high-level analysis of the utilization of and expenditures for Medicare outpatient therapy services in CY2007. These analyses update and expand upon the previous utilization analyses conducted by CSC for data between 1998 and 2006 (Ciolek and Hwang 2006, 2008). The key observations in our 2007 Utilization Report are:

- Medicare expenditures for outpatient therapy were over \$4.3 billion in CY 2007. This represents a 6.6 percent increase from CY 2006. Almost three-quarters (74 percent) of the CY 2007 expenditures were for physical therapy (PT), followed by 19 percent for occupational therapy (OT) and 7 percent for speech language pathology (SLP).
- PT users were on average younger than OT and SLP users. Mean expenditures per user increased with the age of the beneficiaries. Overall, average per user expenditures increased from \$934 in 2006 to \$994 in 2007.
- Outpatient therapy users in 2007 were disproportionately female, a pattern similar to that found in 2006 and earlier years. While 56 percent of Medicare FFS beneficiaries were female, almost two-thirds of outpatient therapy users were female.
- Medicare expenditures for outpatient therapy varied considerably across different states, which could reflect regional differences in supply of therapy provider, or regional differences in practice patterns, or regional differences in case-mix of patients.
- The distribution of the settings providing outpatient therapy has shifted in the last few years away from facilities (hospitals, etc.) and physician offices and toward therapists in private practice (PTPP and OTTP). From 2006 to 2007, there was an over 16 percent decrease in the number of CORF and HHA facilities, while the number of PTPPs and OTTPs increased by 8 percent.
- Facility settings still account for the greater proportion of outpatient therapy expenditures, with skilled nursing facilities (SNFs) accounting for almost one third of payments in 2007. The demographic characteristic differing most by setting is age, with older patients, who have higher therapy expenditures on average, being more likely to be treated in facility-based settings.
- Over 80 percent of outpatient therapy users received only one type of therapy (PT, OT, or SLP) in 2007. Therapy users seen in SNFs and CORFs were the most likely to receive two or more types of therapy in the year.
- Almost 95 percent of all outpatient therapy claim lines and Medicare payments in both CY 2006 and CY 2007 were represented by just 15 Healthcare Common

Procedure Coding System (HCPCS) codes.¹ The importance of each of these procedures varied across provider settings.

- Comparing outpatient therapy episodes by the twenty most common primary diagnoses, there were important differences in the average number of treatment days and the average Medicare expenditures. Comparing episodes across setting types, the longest and most expensive outpatient therapy episodes (for all three therapy types) occurred in SNFs, CORFs, and ORFs.

¹ HCPCS is a standardized coding system for claims processing used by Medicare and other insurers primarily to identify products, supplies, and services not included in the CPT codes. See <http://www.cms.hhs.gov/MedHCPCSGeninfo/>

SECTION 5 PROJECT PROGRESS ON MEETING GOALS & OBJECTIVES

During the first project year, RTI had the following main goals and objectives:

- Engage key stakeholders to solicit feedback on and support for the project.
- Acquire and conduct preliminary analyses on Medicare datasets relevant to outpatient therapy services.
- Submit the first annual utilization report.
- Develop primary data collection instrument(s) for collection of patient assessment data.
- Submit the data collection instrument(s) and associated Paperwork Reduction Act materials for CMS for review and public comment.

RTI has achieved most of the goals and objectives for this first year. Project staff have visited the offices of the three principal therapy associations and have had numerous meetings with staff from these and other associations. RTI has also given presentations about the project at an Open Door Forum and at the annual meeting of the American Occupational Therapy Association.

RTI has also successfully acquired Medicare claims data for outpatient therapy services for 2006 and 2007 as well as data from the National Plan and Provider Enumeration System (NPPES). However, work with these data, particularly the NPPES data, proceeded more slowly than expected and also suggests challenges using these data for project needs. Because of concerns about data privacy, a great deal of time was spent establishing that RTI can only use the publicly-available NPPES data. Furthermore, RTI had planned on using the NPPES data as a crosswalk between National Provider Identifiers (NPIs) and legacy identifiers (particularly Unique Physician Identification Numbers, or UPINs). However, it seems that problems with the legacy identifiers on the NPPES file will greatly reduce its usefulness.

RTI has nearly completed the construction of “final draft” data collection instruments for the Paperwork Reduction Act package. Unfortunately, this process took considerably longer than originally anticipated. This was due primarily to deeper than expected involvement with the stakeholders, particularly with the American Speech-Language-Hearing Association. However, the result should be a better set of data collection instruments and improved stakeholder buy-in that could reduce the burden of response to public comments during OMB review and improve recruitment for data collection. Therefore the time for quality tradeoff is only likely to increase the likelihood of achieving the overall project goals. Unfortunately, the additional time spent on data collection instrument development has delayed the PRA package submission. However, RTI anticipates it will be submitted during May.

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