Report to the Social Services Appropriations Subcommittee

Medicaid Coverage and Reimbursement

for

Outpatient Physical Therapy

and

Outpatient Occupational Therapy

Prepared by the Division of Medicaid and Health Financing

November 30, 2018

EXECUTIVE SUMMARY

This report is submitted in response to a request from Representative Raymond Ward for a report to be given to the Social Services Appropriations Subcommittee. The request to the Department of Health was for a report on:

1. *How [Medicaid] currently pay[s] for outpatient physical therapy and occupational therapy treatment, and*
2. *An estimate of what the costs and improvements in physical and occupational therapy availability and services might be if Medicaid were to drop the proprietary code that they currently use for reimbursing for outpatient therapy treatment, and instead change to reimburse for those services using the typical treatment codes that are used by other insurances and other state Medicaid programs.*

How they currently pay for outpatient physical therapy (PT) and occupational therapy (OT) treatment

Who is eligible to receive this service?

The Code of Federal Regulations designates PT and OT services as optional for medical assistance programs. The Utah Medicaid State Plan and R414-1 designate the categorically needy and medically needy as eligible for PT and OT benefits. The Physical Therapy and Occupational Therapy Services Manual also designates PT and OT as optional services but indicates they are mandatory for individuals under the Child Health Evaluation and Care (CHEC) program. CHEC is a part of the Utah State Medicaid Program for children ages 0-21 who qualify for Medicaid.

PT is available under home health services. OT in the home is limited to individuals under the CHEC program.

What limits are on the services?

The Physical Therapy and Occupational Therapy Services Manual places a limit of 20 PT sessions, per member, per calendar year for members who qualify for benefits as displayed on the Coverage and Reimbursement Lookup Tool. The same limit applies for OT. The lookup tool confirms this information in a special note, and also defines the limits of the non-traditional benefit (parents) as 16 combined PT/OT per year, in any arrangement. According to the special note, the yearly limit might be extended for those with benefits if the provider seeks prior authorization. The look-up tool grid shows PT and OT benefits as non-covered in the Primary Care Network (PCN) Program.

What is the Reimbursement rate?

Utah Medicaid reimburses outpatient PT and OT per encounter with use of HCPCS code T1015. The current rate is $20.88. This rate has been the same since 10/1/08. Prior to that, the rate had been $21.12, but was reduced as part of legislative budget cuts in 2008.

In a physician's office, PT and OT services for assessments and reassessments are allowed to be reported by separate CPT codes in addition to the encounter sessions reported by a single, all-inclusive HCPCS code.

PT assessments using CPT 97161, 97162, or 97163, are reimbursed at $62.65.
PT reassessments using CPT 97164 is reimbursed at $42.23.
OT assessments using CPT 97165, 97166, and 97167 are reimbursed at $67.44.
OT reassessments using 97168 is reimbursed at $45.76.

PT and OT sessions delivered in the home health environment are reported with HCPCS codes S9131 and S9129, respectively. The evaluations and sessions report with the same codes and reimburse $80.66.

How does the reimbursement methodology compare to Medicare and commercial?

Medicare and commercial payers reimburse claims that report modality codes 97010 - 97036 and therapeutic procedures codes 97110-97150, 97530, and 97533 from the Physical Medicine and Rehabilitation section of the CPT manual rather than the single, all-inclusive encounter code that is designated by Utah Medicaid. The modalities and/or therapies delivered during a session are reported which results in a claim with several codes and reimbursement of each. In addition to the assessment and reassessment codes already listed, if the modality/therapy codes were used by Utah Medicaid and the overall funding did not change the codes would reimburse:

97010 - $4.72
97012 - $11.14
97014 - $11.50
97016 - $11.76
97018 - $6.48
97022 - $14.00
97024 - $5.22
97026 - $4.72
97028 - $6.02
97032 - $11.64
97033 - $15.44
97034 - $11.31
97035 - $10.05
97036 - $26.06
97110 - $22.94
97112 - $26.06
97113 - $29.04
97116 - $22.68
97124 - $22.67
97139 - $10.31
97140 - $20.82
97150 - $13.74
97530 - $29.97
97533 - $25.51

How are these services reimbursed in the various settings?

PT and OT services in a nursing home are considered ancillary to the daily rate paid. If a facility hired a therapist as an employee, the therapist could enroll as a Medicaid provider and bill directly for those services as they would if done in an outpatient setting. The therapist would report the same encounter code (T1015) as if the service were being delivered outpatient.

Home health encounters have already been described.

PT/OT services in an outpatient setting have also been described.

An estimate of what the costs and improvements in physical and occupational therapy availability and services might be if Medicaid were to drop the proprietary code that they currently use for reimbursing for outpatient therapy treatment, and instead change to reimburse for those services using the typical treatment codes that are used by other insurances and other state Medicaid programs.

What problem would be solved with additional funding?
According to the *CDC Guideline for Prescribing Opioids for Chronic Pain*[1], patients with pain should receive treatment that provides the greatest benefits relative to risks. The contextual evidence review found that many non-pharmacologic therapies, including PT, weight loss for knee osteoarthritis, PTs such as Cognitive Behavioral Therapy (CBT), and certain interventional procedures can ameliorate chronic pain. There is high-quality evidence that exercise therapy (a prominent modality in PT) for hip (*100*) or knee (*99*) osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2–6 months.

Increased funding will encourage providers of PT and OT services to more readily accept Utah Medicaid members in their practices. It is hoped these services will provide Utah Medicaid members with alternative methods of pain relief when historically they may have relied on:

- surgery and other costly, invasive medical procedures, or
- pain relieving medications (opioids).

The use of PT and OT in medicine is proven as a standard of care to reduce pain and increase mobility.

- InterQual criteria often sets request for PT as a precursor to approval of surgical events
- Surgical intervention as a remedy for pain might be avoided
- Other invasive, costly treatments as remedies for pain might be avoided
- Pharmaceutical interventions for pain (opioids) might be avoided
- Therapies following surgeries produce increased mobility and decrease pain
- Therapies can help prevent hospitalizations and re-hospitalizations
- Therapies help to optimize healing time and avoid causing further injuries
- Therapists will be motivated to create and focus the plan of care to the member's diagnosis, abilities, and co-morbidities

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1 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

What has been done to solve this problem with existing resources and what were the results?
Utah Medicaid reimburses PT and OT per encounter. PT and OT services have been funded with the same encounter rate for at least 10 years.

PT and OT service providers have been requesting a reimbursement update for several years saying the rate is not keeping current with the cost of services. Providers have more recently asked for reimbursement to be paid using a methodology similar to Medicare, the commercial sector, and other Medicaid programs. Without a rate increase, some providers are saying they will stop providing services to Utah Medicaid members (i.e., access to care issues are possible).

How will new funding, if appropriated, be utilized and what operational changes will be made to maximize new resources?
If additional funds are appropriated, Utah Medicaid will increase fee for service rates for PT and OT services. For services provided through ACOs, ACO rates will be raised. Medicaid ACO contracts are being revised to require ACOs to reimburse at a minimum at the Medicaid fee schedule.

In addition, Utah Medicaid will implement use of modality codes in the same way they are reimbursed by Medicare and commercial payers.

- Use of CPT codes to report each service delivered in a session
- Knowledge of services delivered promotes accountability

What are the anticipated results or outcomes of how the new funding will be utilized?
An increased percentage of Utah Medicaid members will rely on PT/OT to treat chronic pain rather than rely on opioid prescriptions.

A study published in the Journal of the American Board of Family Medicine in 2017 found that among Medicaid recipients with new-onset lower back pain, a referral to physical therapy and subsequent physical therapy participation was associated with reduced opioid prescriptions during follow-up. The study sample was identified from claims data of enrollees in the University of Utah Health Plans (UUHP) Medicaid Managed Care Plan.[2]

What are potential negative effects if the funding is not received?
Low reimbursement creates an environment where providers are less willing to deliver service to Utah Medicaid members. This environment could:

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[2] http://www.jabfm.org/content/30/6/784.long

- Limit access to care
- Limit modalities/treatments at each encounter
- Result in additional PT and OT providers not serving Utah Medicaid members

What additional appropriation would be needed?

If this change were to begin on July 1, 2019, Medicaid would need an additional $821,000 in on-going General Fund ($2,723,200 Total Funds).