A Study of

Senate Bill S-2600

A Report to the New Jersey State Senate by the

Mandated Health Benefits Advisory Commission

March 10, 2008

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Introduction

On November 21, 2007 the Mandated Health Benefits Advisory Commission (Commission) was asked to issue a report on Senate Bill 2600 (S-2600), a bill originating in the 2006-2007 legislative session. S-2600 was not prefiled for the 2008-2009 legislative session, nor has it been reintroduced. However, a similar bill, Assembly Bill 2123 (A-2123), is currently pending before the legislature, and was released from the Assembly Financial Institutions and Insurance Committee on 2/25/2008. This report addresses S-2600, not A-2123, because it is S-2600 that was referred to the Commission. A-2123 is similar, but not identical, to S-2600.

The Commission prepared this report using Department staff resources only, rather than engaging a consultant. The Commission understands that, as a general rule, the Legislature expects these studies to emphasize the financial impact on the market for health benefits, including the impact on price and on the availability of necessary medical services. However, in the case of S-2600, it should be observed that there would be an impact on other insurance markets because the provisions of S-2600 would apply to private passenger automobile personal injury protection and workers compensation insurance as well. This report summarizes the potential impact upon these other insurance markets, but does not attempt to estimate a financial impact on these markets

The Commission received comments on S-2600 from the Kessler Institute for Rehabilitation (Kessler), the Medical Society of New Jersey (MSNJ), the New Jersey Association of Health Plans (NJAHP) , New Jersey Manufacturers Insurance Company (NJM) and the Property Casualty Insurers Association of America (PCIAA). These comments are summarized in the report and attached as an Appendix.

Summary

Senate Bill 2600 applies to the State-regulated health benefits market. The regulated health benefits market includes individual and group contracts or policies sold in New Jersey by hospital, medical and health service corporations (e.g. Horizon Blue Cross Blue Shield), by insurance companies, and by health maintenance organizations (HMOs). The bill applies to contracts and policies sold in the Individual Health Coverage (IHC), Small Employer Health (SEH) and large group markets. There are about 2.4 million people covered by the State-regulated market of the 8.7 million people in New Jersey. This market has annual premiums of over $9 billion. The bill does not apply to the State Health Benefits Plan. However, the bill also applies to private passenger automobile personal injury protection (PIP) and workers compensation (comp) coverage.

S-2600 requires health insurance policies or contracts issued by health carriers that provide benefits for physical therapy (PT) to provide such coverage without use of prior authorization or referral requirements. The bill provides that benefits for PT be paid in an amount at least equal to the PIP fee schedule and requires carriers to accept assignments of benefits to out of network providers. It limits the types of providers to whom carriers may pay PT benefits to physical therapists, licensed health care facilities, and professional corporations owned by licensed physical therapists in New Jersey. S-2600 limits a carrier's ability to deny a claim for physical therapy services by requiring independent medical exams in certain situations, and by deeming denials based on medical necessity, deviations from generally accepted standards of physical therapy, and inappropriate documentation to be allegations of misconduct which are subject to final determination by the State Board of Physical Therapy Examiners.

On the other hand, S-2600 does not require that physical therapy be covered at all or to the extent that other medical services are covered.

Detailed Elements of Senate Bill 2600

S-2600 deals with the processing and payment of claims for physical therapy.

Section 1 of the bill defines health benefit plan as a hospital or medical expense insurance policy or other plan for hospital and medical care and explicitly includes workers' compensation insurance, motor vehicle medical payment and personal injury protection coverage provided by a motor vehicle or automobile insurance policy. (Note that most of the statutes and laws applicable to commercial health coverage specifically exclude worker's compensation and automobile coverage from the definition of health benefit plan.) This section also defines a physical therapy corporation as a professional corporation organized under N.J.S.A. 14A:17-3 under which physical therapy providers provide physical therapy. N.J.S.A. 14A:17-3 limits the ownership of a professional corporation to persons who are licensed or legally authorized to render the professional services in New Jersey. A physical therapy corporation (as defined by this bill) must therefore be exclusively owned by physical therapists authorized to practice in New Jersey.

Section 2 of the bill bans carriers issuing health benefit plans and the organized delivery systems with whom they contract from requiring prior approval (prior authorization, pre-certification, or provider referrals) for PT services. (Current law governing the professional practice of physical therapy already permits a patient to see a physical therapist without first seeing another licensed provider such as a physician. But, some health plans may require that the patient be referred by a provider or receive some other form of prior approval for purposes of reimbursement.)

Section 3 of the bill requires carriers to reimburse PT benefits at a rate at least equal to the PIP fee schedule and bans carriers from using network fee schedules to reimburse claims of out-of-network physical therapists. This appears to require that all physical therapy services be reimbursed at no less than the amounts in the PIP fee

schedule. The ban on reimbursing out-of-network at scheduled rates is characterized in the bill summary as blocking the use of so-called "silent" networks, where an out-of-network provider is reimbursed at a rate agreed to with another payer. However, the requirement to use the PIP fee schedule appears to effectively override the prohibition on using the network fee schedule to reimburse out-of-network physical therapists. This bill mandates a government payment schedule, which is highly unusual for covered benefits in a commercial health insurance product.

Section 4 requires carriers issuing health benefit plans and the organized delivery systems (ODS) with whom they contract to pay claims for physical therapy services to physical therapists, physical therapy corporations, health care facilities as defined at N.J.S.A. 26:2H-2 or covered persons, unless the covered person has assigned his benefits. This provision operates to exclude payments to entities that are not exclusively owned by New Jersey licensed physical therapists and that do not satisfy the definition of health care facility at N.J.S.A, 26:2H-2[1], such as clinics and hospital satellites. Although this definition appears to be all-inclusive, some facilities providing physical therapy may not fall within the scope of the definition. For instance, the Commission has been advised by the Dept. of Health and Senior Services that non-hospital facilities providing only physical therapy, occupational therapy, and/or speech therapy services have not been required to become licensed health care facilities unless they replace a hospital's outpatient therapy department.

Section 5 mandates that carriers honor assignments of benefits by covered persons to out of network physical therapists and physical therapy corporations.

Although section 2 bans prior approval, section 6 requires that carriers issuing health benefit plans and the organized delivery systems with whom they contract respond to prior authorization requests within three days. If prior authorization is granted or if the health carrier or ODS fails to timely respond to the prior authorization request, the claim cannot be denied for medical necessity unless there is fraud or the carrier or ODS pays for an independent medical exam by a physical therapist. The carrier's decision following the independent medical exam may be appealed under either the internal appeal process required by P.L. 2005, C. 352, to the Independent Health Care Appeals Program established by the Health Care Quality Act or to the private passenger automobile insurance personal injury protection dispute resolution process.[2] A subsequent appeal must then be filed with the State Board of Physical Therapy Examiners. This section also applies where prior authorization has been granted or a prior authorization request is timely processed and the carrier denies the claim based on the patient's ineligibility on the date of service. The Commission is concerned about the apparent conflict between sections 2 and 6. Section 6 establishes requirements for

[1] N.J.S.A. 26:2H-2 defines a health care facility as a facility providing services for the diagnosis or treatment of human disease, injury, deformity or physical condition, including, but not limited to a, general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential care facility and bioanalytical laboratory institution or central services facility

[2] Note that a denial by a health carrier or ODS based on medical necessity cannot be appealed through the provider dispute resolution established by P.L. 2005, C. 352 but must be addressed to the Independent Health Care Appeals Program under N.J.S.A. 26:2S-12.

responding to prior authorization requests and denial of claims for prior authorized services. But, such prior authorization is prohibited by Section 2.

Section 7 of the bill bans carriers issuing health benefit plans and the ODSs with whom they contract from changing the diagnostic codes on claims for PT services. The intent of this section is probably to prohibit carriers from denying claims by using programs that "bundle" or "downgrade" procedure codes based upon services performed.

Section 8 provides that any denial of a claim for physical therapy services submitted by a physical therapist, a physical therapy corporation or a covered person that is denied by a carrier issuing health benefit plans and the ODSs with whom it contracts based on medical necessity, deviation from generally accepted standards of physical therapy or inappropriate documentation is an allegation of misconduct which, following an internal appeal to the carrier, may be appealed to the State Board of Physical Therapy Examiners which shall issue a final decision following a hearing. The bill provides that said decision shall not be subject to appeal. Sections 9 through 15 of the bill amend the prompt pay laws applicable to hospital, medical and health service corporations, prepaid prescription service organizations, individual and group health insurance companies, and health maintenance organizations to make PT claims that are subject to appeal to the State Board of Physical Therapy Examiners pursuant to section 8 ineligible for the binding payment arbitration supervised by the Department of Banking and Insurance.

Section 16 amends the Health Care Quality Act to reiterate that all forms of prior approval, including a referral requirement, are not permitted with respect to PT services.

Section 17 amends the PIP dispute resolution statute (applicable to auto insurance claims only) to provide that decisions of the dispute resolution professional are not binding with respect to PT services that are subject to appeal to the State Board of Physical Therapy Examiners pursuant to section 8.

Sections 18 and 19 amend the PIP statutes (applicable to auto insurance claims only) to provide that PT treatment shall be covered as medical expense benefits without the need for a referral.

Section 20 changes the definition of physical therapist to include the designation of physical therapist physician. It also amends the definition of PT to include peer review and independent examination services.

Section 21 requires persons performing peer review and independent medical reviews in New Jersey to hold a PT license in New Jersey.

The Commission was unclear about the purpose of Section 22.

Section 23 states that sections 1-3 and 5-8 do not apply to general hospitals, comprehensive rehabilitation hospitals, pediatric rehabilitation hospitals or nursing homes. Thus, PT services provided in these facilities can be subject to prior authorization and referral requirements, can be paid at rates other than the PIP fee schedule, are not subject to mandatory assignment of benefits, can have diagnostic

codes changed on claims and can not appeal claim denials to the State Board of Physical Therapy Examiners.

Functional Summary of the Elements of S-2600

In order to analyze this bill, the Commission identified the following "dimensions":

1. Prior Approval

S-2600 prohibits carriers from requiring, as a condition of coverage of PT, prior approval. Examples of practices that would be prohibited are provider referral, pre-authorization, pre-certification, and prior notice[3]. Under present law, prior approval is very common in commercial coverage, and is either *common or universal* in auto (PIP) and worker's compensation coverage. (Section 23 states that these forms of pre-determination would still be allowed when the PT services are provided by a hospital or nursing home.) The law would prohibit such prior approval in commercial health, PIP, and worker's compensation coverage.

The law does not seem to change the current professional requirements which allow a patient direct access to PT without a physician referral. Although such access is permitted, physical therapists who see patients directly are required to refer the patient to another health care provider, or inform the patient's primary care provider about the current course of treatment in specific circumstances, such as failure of the patient's condition to improve or treatment continuing for more than 30 days.

2. Carrier Reimbursement

Carriers must use the PIP fee schedule developed for auto medical claims to determine the minimum contracted charge, or the allowable charge (before cost sharing such as deductibles and coinsurance) for reimbursement of all PT claims payable pursuant to commercial health, worker's compensation and automobile PIP coverage. (As in the case of pre-determination, Section 23 provides that this restriction would not apply if the provider were a hospital or nursing home.) This requirement appears to establish the PIP fee schedule as the minimum for reimbursement; it permits the carrier to pay more than the PIP schedule either in or out of network[4].

The bill sets a standard for what the carrier must pay the provider. It does not limit the amount an out of network provider can charge the patient (except in the case of PIP, where the provider must accept that amount). In out-of-network commercial coverage, there may still be balance billing of the patients by the provider.

This bill mandates a government payment schedule. As Governor Jon Corzine noted in his signing statement for PL 2007, c. 345 (mandating coverage for prosthetics

[3] These terms are not strictly defined and are often used interchangeably.
[4] The PIP fee schedule can be found in the Appendix to N.J.A.C. 11:3-29.

and orthotics) there is a concern that "this aspect of the bill [government setting the reimbursement levels] will limit insurers' ability to negotiate price reductions under circumstances that will not reduce access."

The bill prohibits the use of in-network reimbursement as the basis for setting out-of-network reimbursement. This requirement would appear to have little impact, because both in-network and out-of-network reimbursement would be subject to the PIP fee schedule at a minimum. However, the bill summary indicates that the legislative intent is that "silent networks" (contracted rates between the provider and someone other than the payer) not be used in determining out-of-network reimbursement. This might be operative in the case where a contract allows for reimbursement in excess of PIP.

3. Carrier Adjustment of PT Claims

The carrier cannot adjust the diagnostic codes (this probably means the procedure codes) in a PT claim. Section 23 implies this would not be the case for hospital and nursing home claims.

4. Review and Appeal of PT Claim Denials

S-2600 would specifically remove PT claim denials and appeals from a system put in place under the Health Claims Authorization, Processing and Payment Act, P.L. 2005, c. 352, specifying a different mechanism, which includes review by the State Board of Physical Therapy Examiners. Section 23 states that this would not be the case if the provider were a hospital or nursing home.

5. Mechanism of Payment

Carriers are required to honor assignment of benefits. Unless benefits are assigned, the law may block payment to certain institutions providing PT.

6. Definition of "Physical Therapist"

Section 20 defines a physical therapist as a specialty physician within the meaning of N.J.S.A. 45:9-37.11 et. seq. and allows the use of the term "Physical Therapist Physician."

Other Research

A concise but useful study was done by the Medicare Payment Advisory Commission (MEDPAC) in 2004.[5] (A copy of this study is attached as an appendix.)

[5] Medicare Payment Advisory Commission's December 30, 2004 report to Senate President Richard B. Cheney and Representative J. Dennis Hastert, delivered in accordance with section 647 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, studying the

This study was specifically about whether Medicare should continue to require that PT services be referred by physicians. The study addressed both the cost impact on Medicare and the health impact on Medicare beneficiaries. In the course of its study, MEDPAC looked at behavior in commercial insurance markets. It noted that various forms of prior review of PT are common in commercial insurance markets.

The MEDPAC recommendation was that referral by a physician continue to be required, on both medical and cost grounds. In fact, the recommendation went further and suggested additional steps beyond referrals to increase the efficiency of PT services. In particular, it noted the need for ongoing review of the necessity of PT services along the lines practiced by commercial insurers.

MEDPAC also noted that practitioners of other forms of therapy, notably Occupational Therapy, would argue for the same sorts of direct access.

The MEDPAC conclusion may not be directly translatable to this bill affecting the New Jersey commercial population. As the study notes, the Medicare population is older and sicker than the average commercial population. The MEDPAC concern that the overall medical needs of the patient be assessed in connection with PT may not be as critical in the case of younger, healthier patients with fewer comorbidities, or for whom the indications for PT may seem obvious. Furthermore, a generally younger and healthier population may bear out at least one study cited by MEDPAC indicating that cost savings from avoiding the initial physician visit could offset additional costs of unreferred PT.

On the other hand, a study by Mitchell and de Lissovoy[6] (is often cited as indicating that direct access might reduce the cost of care. This study of a commercially insured population models cost of episodes of care based on various factors. The study concludes that episodes in which there was no physician referral were less costly overall than episodes which there were physician-referrals. The study does attempt to control for seriousness of the episode (since more serious conditions could be considered more likely to be initiated by a physician).

Comments

The Commission received comments in opposition to the bill from five parties. No comments were received in support of the bill.

Kessler objects to the limitations in section 4 which restrict the entities to whom carriers can pay benefits for physical therapy services. This section excludes entities

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feasibility and advisability of allowing Medicare fee-for-service beneficiaries direct access to outpatient physical therapy and comprehensive rehabilitation facility services.

[6] Mitchell, J.M., and G. de Lissovoy. A comparison of resource use and cost in direct access versus physician referral episodes in physical therapy, Physical Therapy, , vol. 77, no. 1, pp. 10-18 (1997).

that do not qualify as health care facilities and are not exclusively owned by physical therapists. Such restriction would prohibit payment to the various outpatient clinics owned by Kessler. Kessler is also concerned that use of a mandated fee schedule for physical therapy services will cause carriers to diminish the physical therapy benefit to the detriment of covered persons.

MSNJ states that S-2600 will increase premiums and medical costs by eliminating referrals and prior authorization. It states that physician referral for physical therapy services is needed to insure proper diagnosis and treatment. It states that use of the PIP fee schedule to determine physical therapy benefits in health benefit plans is inappropriate because PIP providers cannot balance bill patients unlike out-of-network health care providers. The Medical Society strongly objects to use of the designation "physical therapy physician" because physical therapists do not have the education required of physicians.

NJAHP believes that the definition of covered physical therapy benefit creates an unlimited PT benefit because it refers only to PT provided by a PT provider to a covered person rather than to PT services covered by a health benefits plan. NJAHP believes this definition overrides plan limits and exclusions related to PT. The Association also objects to the ban on referrals and prior authorization and the requirement to obtain an independent medical exam as costly and unnecessary in light of the right to an external appeal before the Independent Health Care Appeals Program. The Association objects to use of the PIP fee schedule to pay for PT services and notes that no other provider rates are set by the government. Moreover, it argues that the removal of physician authorization for PT will adversely affect health quality and notes that mandating carrier acceptance of assignments of benefits will remove the incentive for providers to join networks, thereby increasing premiums.

NJM objects to direct access to PT services due to the substantial risks associated with the treatment of injuries prior to obtaining a medical diagnosis or performing imaging tests to determine the nature and extent of the injury. NJM notes that direct access will cause over utilization of PT services which will increase premiums. Similarly, NJM states that the ban on prior approval will remove protections provided by the Automobile Insurance Cost Reduction Act of 1998 and require preferential treatment by carriers of PT providers. Finally, NJM notes that a legislatively imposed fee schedule for network providers is anti-competitive and results in additional costs with no countervailing benefit.

PCIAA objects to the elimination of the referral requirement because the physician is best able to review a patient's condition and determine the soundness of treatment. PCIAA notes that physical therapists do not have the education or training necessary to provide an overall diagnosis. Moreover, referrals protect against fraud, abuse and over-utilization. PCIAA objects to having the State Board of Physical Therapy Examiners decide physical therapist payment disputes because the Board does not have the resources or experience to perform this function and the PIP arbitration process functions well. PCIAA cites several studies of the Office of the Inspector General in the US Department of Health and Human Services finding that physical therapy services are unnecessary and excessive.

Cost Analysis

DOBI staff prepared a separate report on the estimated cost of this bill. The staff cost analysis is included as Appendix I to this report. One critical assumption of this cost analysis is that the amount of PT coverage remains the same. For example, if a plan currently covers a maximum of 30 visits, it is assumed that maximum will remain, even though subject to the provisions of the bill regarding referral, pre-authorization, payment, and denial of claims. In reality, a carrier or plan sponsor could choose to reduce (or more dramatically, eliminate) PT coverage as a result of this bill. This would moderate any cost increase. It might also have the opposite of the intended effect on coverage.

It was assumed that increased costs under this bill would arise from two sources: 1) additional services provided because of the ban on prior approval, and 2) higher costs for each service because of the use of the PIP fee schedule. Item 1), additional services provided, can be further divided into services that would have been denied under prior approval, and services that were never requested because of the prior approval barrier.

Although cost estimates varied widely (more widely than one might expect) a mid-range estimate would be that costs would increase by about 1% (before any offsetting reduction in the value of the PT benefit, such as a reduced maximum number of visits or days). This would correspond to an increase of about $40 a year per person based on the 2006 average premium per covered person of $3800 per year. This bill could result in a decrease of the insured population of from 4,800 to 14,400 people, depending on the response to price increases by purchasers, which is known as "elasticity". This assumes an elasticity of -0.2 to -0.6. This also assumes that all of the additional costs of the bill are passed on to consumers.

Conclusions

Nature of the Bill as a Mandate

This bill is not a "mandate" in the strictest sense of the term. It does not require that physical therapy be covered at all by a commercial health plan. If physical therapy is covered by a commercial health plan, it is not required to be covered to the same extent as other medical conditions. The bill is a mandate because it has standards on carrier control of access and carrier reimbursement.

Other bills studied by this commission were mandates in the strict sense. Coverage for a particular condition was required to be covered to an extent stated in the bill, often to the same extent as other medical conditions. However, some of these bills also contained provisions on access and reimbursement.

Consequences for the Effectiveness of Medical Care

There are at least two opinions on the consequences of this bill. One opinion is that the bill will lead to PT services being provided more quickly, and to a greater extent, than is the current case. The opposite opinion is that this bill will lead to an increase in unnecessary or inappropriate PT services. Perhaps the strongest concern of those holding the latter opinion is that lack of prior authorization will lead patients to forego necessary services from non physical therapy providers.

Cost Consequences

The report provides a cost estimate of about 1% of premium for commercial health coverage. The Commission warns that this is a rough approximation, but believes an estimate of the approximate size of the cost impact should be sufficient. The Commission notes that (as in all mandate discussions) a balance must be sought between the additional care made available, and the additional cost of health benefit coverages. The Commission notes a concern that the bill might have an excessive cost impact on individual coverage. Finally, because this is not a "true" mandate, employers purchasing group health coverage for their employees may respond to the additional cost imposed by this bill by reducing or eliminating the amount of PT that is covered.

As noted below, the Commission was not able to develop a cost estimate for PIP or Workers Compensation coverage.

Consequences for Consumers

One reason for prior authorization and provider referral under health plans is to reduce the possibility that the services will be deemed medically unnecessary (or otherwise not covered) at the time of claim review. The bill limits, but does not eliminate, medical necessity review. Therefore, an unintended consequence of the bill could be to increase the number of post-service denials.

Auto (PIP) and Worker's Compensation

This bill brings automobile personal injury protection and worker's compensation coverage within the scope of the regulation of commercial health coverage. These two systems have historically evolved with different systems of benefit determination, provider networks, and provider compensation than commercial health coverage. Both of these insurance systems are designed to respond to injuries in specific contexts. It is not clear that perceived difficulties in the commercial market (approval practices and reimbursement) exist for these other two systems, or that solutions appropriate to the commercial health market would be suitable for these other two systems. If there is a perception there are issues that need to be addressed regarding access to PT when services are reimbursed through automobile personal injury protection or worker's compensation coverage, legislation specific to the issues in the context of these two systems might be more appropriate.

Other Issues

The Commission considers some of the other aspects of the bill (designation of physical

therapists as physicians, specific mechanisms of appeal of claims, and prohibition of direct payment to some sorts of payers) to largely fall outside the concept of a "mandate" in even the widest sense. However, we draw the attention of the legislature to the comments of various parties. We have concern that involving the Board of Physical Therapy Examiners in the claims appeal process will create a burden for which that board has neither the expertise nor the capacity. The designation of physical therapists as physicians does not seem to have an impact on access to quality and affordable PT. Furthermore, physical therapists may be prohibited from using this title without meeting requirements of the Board of Medical Examiners.[7] The bill does not provide a rationale for identifying certain types of facilities (specifically, facilities that are not licensed by DHSS) for ineligibility for direct payment from a carrier. If the basis is either punitive or, as a matter of policy, to direct payment away from such facilities, that intention should be made clear in the bill.

[7] N.J.S.A. 45:9-18 seems to say that someone who uses a title implying they are practicing medicine is to be regarded as practicing medicine (for purposes of state law). But N.J.S.A. 45:9-37.14b says the physical therapist licensing act does not authorize physical therapists to practice medicine unless otherwise licensed.

APPENDIX I

STAFF COST ANALYSIS OF S-2600

Current Status of Coverage for Physical Therapy

Carriers state that almost all commercial contracts have some level of coverage for physical therapy. Generally, there are no minimum standards for the amount of PT that must be provided in New Jersey commercial health insurance coverage. An exception is the IHC market, where standard plans must provide 30 PT visits per year and Basic & Essential plans must provide a minimum of 20 visits per year. The SEH standard plans also have visit limits[1], but these may be reduced by rider. Carriers are permitted to require some form of prior approval for physical therapy.

In the large group health market, 30 PT visits per year is a typical benefit. Another typical benefit is 60 continuous days per condition. Purchasers can increase or decrease cost by adjusting these maximums, or by introducing deductibles and copayments. Costs can also be addressed by combining different sorts of therapy in the visit limit, for example, 60 visits per year for physical, occupational, speech, and cognitive therapy combined.

These two benefits appear to have about the same cost. For one large carrier, the typical PT benefit contributes, on average, about 0.65% to total benefit costs (before cost sharing). This translates to about $25 per year per covered person. On average, unlimited PT visits (with prior approval) increase cost by about 50%. A 20 visit limit on PT decreases costs by about 20%. A $20 copay per PT visit reduces costs by about 25% and a $40 copay reduces costs by about 50%.

Carriers analyzing their claims experience generally estimate that PT claims as a percentage of total claims were slightly higher than the above estimate based on the rate manual. One carrier estimated that PT claims as a percentage of total claims ranged from about 0.7% (for Small Group HMO/POS) to around 1.8% (for Large Group PPO). A second carrier estimated a range from 0.2% (HMO) to 3.4% (PPO) with an average of about 2%. A third carrier provided an overall estimate of about 2% of total claims coming from PT. Experience was available for individual business only for a fourth carrier. The percentages were 0.3% for HMO and 1.8% for PPO. This suggests that PT accounts for about 2% of total claims overall, but that the percentage of PT claims will be much lower in HMO (highly managed) contracts than in PPO contracts. (However, do not confuse this lower level of PT claims in HMO with the higher impact, to be discussed below, of the bill on HMO).

[1] SEH standard plans provide for a total of 30 PT and occupational therapy (OT) visits combined.

Finally, carriers indicate that prior approval is commonly used to control access to physical therapy. Referral from a provider is common in HMO contracts, and pre-authorization is common, although not universal, in PPO contracts.

Cost Impact

DOBI staff attempted to estimate the cost impact of this bill on the commercial insurance market of approximately 2.4 million people. The DOBI staff assumption was that the primary cost impacts would come from the removal of any form of prior approval (referral or pre-authorization), which would increase the number of covered visits, and from the requirement to use the PIP fee schedule in determining payments or allowed amounts, which would increase the cost per visit. Additional visits from the ban on prior approval would include visits that would have not been authorized, as well as visits that were never requested because of prior authorization requirements. DOBI staff did not think that the other aspects of the bill (such as prohibition of down coding, acceptance of assignment, prohibition of direct payment to certain carriers or the different procedures for appeals of denials) would have a measurable effect. DOBI staff was also only able to make this cost estimate for commercial health insurance. Cost estimates for automobile personal injury protection and worker's compensation coverage are outside of the scope of the Commission's responsibilities.

DOBI staff requested cost estimates from the six largest New Jersey health carriers. We requested separate estimates of 1) no prior approval and 2) reimbursement at the PIP fee schedule. Responses were received from 3 carriers.

Carriers were advised to evaluate the bill as if prior approval were not permitted Therefore, they were to overlook the references to pre-authorization in section 6. Furthermore, carriers were advised to assume that all PT was paid at the PIP fee schedule. They were to overlook the restriction that out-of-network could not use an in-network fee schedule.

Carriers may have made certain assumptions that would tend to increase the cost estimate. Carriers may have assumed that they would not be able to disapprove for medical necessity, because section 6 implies that such disapprovals would be before the Board of Physical Therapy Examiners. Carriers may not have considered that, as provided in section 23, covered physical therapy provided in some facilities would still have been subject to pre-authorization and could be paid at levels (contracted or otherwise) less than PIP.

Finally, the carriers provided estimates of the gross impact, before any reduction of benefits. The assumption is that purchasers do not offset the increased costs of the bill by reducing benefit levels (typically, the maximum amount of PT available) or (less likely) by eliminating PT entirely. This response is possible because the bill does not mandate that any level of PT services be covered.

The estimated impact of no prior authorization was generally higher for plans that required a physician referral (typically, HMO plans) than plans that required pre-authorization.

One carrier estimated that no prior approval would increase total claims by 0.1% to 0.7%, depending on whether pre-authorization (lower estimate) or referral (higher estimate) was involved. Another carrier estimated that the impact of no prior approval was higher, a range from 1% to 2%. A third carrier estimated almost no impact.

For the PIP fee schedule requirement, the first carrier estimated an impact of 0.6% and the second carrier estimated an impact of 1%. The third carrier was not able to estimate a cost impact of the PIP fee schedule.

Analysis

There was a wide range of cost estimates from 0.7% to 3% (realizing that one carrier found almost no cost impact). For purposes of analysis, DOBI staff suggests a total cost estimate of approximately 1% of premium. This is consistent with the total estimate of the midrange carrier. This could be further refined to an estimate of 1.3% for HMO/POS (strongly managed) plans and 0.7% for PPO (lightly managed) plans.

In the large group market of about 1.4 million covered lives, about 62% of the people are covered by HMO or POS plans where the impact is expected to be higher. In the small group market (900,000 covered lives), about 67% are covered by HMO or POS plans, and in the individual market (almost 90,000 covered lives) about 72% are covered by HMO or EPO in-network-only plans. Because of the approximate nature of the analysis, it's difficult to conclude that the bill will have a disparately high impact on the reform (individual and small group) markets. However, the higher proportion of people in highly managed plans in these markets does raise that concern.

Purchasers in the individual market are at an additional disadvantage. Coverage in the market is through plans with standard benefits, or with very few benefit options. Therefore, an individual will not have the option available to a large or small employer to compensate for the additional cost of the bill by reducing the value of the PT benefit (through a lower maximum or higher copayment, for example).

Appendix II

S-2600 Comments

February 4, 2008

To Neil Vance, NJ Mandated Health Benefits Advisory Committee:

Regarding **Bill S2600**, I would like to submit my comments, on behalf of Kessler Institute of Rehabilitation.

A.) Social Impact

a. Physical Therapy benefits have already undergone major changes in the limitations that are presented to the consumers and providers. Insurance companies often take it upon themselves to determine the appropriate number of visits needed for a diagnosis based on averages for diagnostic codes. Very rarely, if ever, do they take into account the consumer's personal traits (co-morbidities, pre-morbid status, living arrangements, functional capabilities with activities of daily living, age and general health condition).

b. By mandating a fee schedule, the insurance companies will continue to find a way to stay within their "budget" by adding additional riders to the benefits policy. We feel they will have this "work around" by decreasing the number of approved visits to Physical Therapy, a situation that is already common and impacting the consumers overall health and well being.

c. Currently many insurance companies are deeming an appropriate number of visits to get the consumers back to a level of function, they (insurance companies) feel is appropriate, and this is often just 80% of full function. This discharge criterion does not take into account the consumer's pre-morbid status or the ability to perform activities of daily living independently. Many consumers therefore are discharged before they reach their full potential and are then required to pay out of pocket to continue with Physical Therapy services, or do not continue on at all, leaving them in a state significantly below their level of full functional capabilities.

d. **In summary – all of the above would result in inadequate Physical Therapy health care coverage that may very well cause financial hardship to many consumers of NJ.**

D.) Balancing the Social and Economic Efficacy considerations

a. Over the last several years, we have continued to see co-pays rise. At this time, there are many insurance companies who require the consumer to pay well over 80% of the reimbursement in their co-pay. In other words, if the visit costs $50, often the consumer's co-pay is $40 and the insurance company is only responsible for $10 to the provider.

b. **This has a serious impact on the availability of services to consumers. The rising co-pays often put visits of 2-3 times a week (what is usually necessary to get people functionally**

better to return to work and life), out of reach for many. This in turn has caused people not to seek treatment at all and only causing further complications later on in their lives, which ultimately will cost the health care system, and the state more money down the line.

Respectfully submitted,

Beth Sarfaty, PT
Vice President Clinical Operations
Kessler Rehabilitation Center

S2600

Supplemental Comments on behalf of Kessler Institute for Rehabilitation

Presented to

Mandated Health Benefits Commission

In addition to the comments submitted on behalf of Kessler by Beth Sarfety, Kessler is concerned that Section 4 of S2600 would have a significant adverse impact on continued access by New Jersey residents to physical therapy services currently furnished by licensed health care facilities, such as Kessler, and Medicare-certified rehabilitation agencies owned by affiliates of Kessler. In effect, Section 4 seeks to limit payment by any health benefits plan for such physical therapy services to physical therapy providers owned exclusively by physical therapists. This provision therefore inappropriately favors one type of therapy service provider over another.

Currently, such services are offered also by other types of providers, including licensed hospitals and health care facilities and their affiliated entities and Medicare-certified rehabilitation agencies. If Section 4 is enacted, many New Jersey residents insured by a health benefits plan would not be able to access physical therapy services through these types of providers. In addition, the loss of ability to serve this population by these types of providers could force them to cease offering physical therapy services at all, resulting in further loss of access to services by New Jersey residents and loss of jobs.

MSNJ

609 896 1766 : 609 896 1347 : www.msn

2 PRINCESS ROAD LAWRENCEVILLE, NJ 08648-2302

January 30, 2008

Via E-mail @ MHBAC@dobi.state.nj.us
And Regular Mail

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, New Jersey 08625

Proposed Mandated Health Benefit: S2600 Sponsored by Doria/Karcher

Dear Committee:

The Medical Society of New Jersey would like to comment on S-2600 which reforms the review, processing and payment of health and other insurance claims relating to the provisions of physical therapy services by physical therapists. We believe this bill will be a cost burden on insurance policyholders and small businesses. MSNJ strongly objects to several provisions of the bill.

It is essential that New Jersey regulators and legislators continue to approve proposals that control skyrocketing medical costs. This bill, on the other hand, states a payer shall not require prior approval or a professional referral from another health care provider in order for a covered person to access a physical therapy service. Current law requires a referral if a patient is seeking insurance reimbursement. This referral is in place not just to save money, but a licensed plenary care physician needs to be involved in the diagnosis and treatment related to physical therapy. Referrals help control medical costs.

Under current law automobile accident victims are covered under personal injury protection (PIP) which is a component of our auto insurance policies. Generally, physicians are paid a higher premium under PIP because it is emergency care and there is no balanced billing. S-2600 states physical therapists must always be paid based on the PIP fee schedule! This is outrageous and I assure you every physician in the state of New Jersey wishes they were always paid under a PIP schedule! Last, again under PIP treatment this bill states a referral is not necessary.

The bill also states that for third party reimbursement a physical therapist may be referred to as a Physical Therapist **Physician.** Not only is this bill attempting to give away a title that should be earned via education, but it is also attempting to mandate direct insurance payments from all payors.

Physical therapy is a vital part of treatment for many patients in the state and access for treatment does exist and is already utilized by the population of New Jersey. Insurance coverage also exists when treatment is a component of a diagnosis by a physician. This bill is an attempt to override the inclusion of a doctor's diagnosis and therefore increase insurance costs for everyone. It is clear that if this bill becomes law, premiums will increase for all payors, policyholders, small businesses and automobile insurance carriers.

Considering the dire economic situation in New Jersey and the high cost of health insurance, MSNJ urges the Board to oppose this bill because of the financial burden it will place on every resident of the state. We finally have competitive automobile insurance carriers advertising and soliciting new policyholders. Do we want to drive them out of the state?

The Medical Society of New Jersey has a high regard for physical therapy and physical therapists, but we strongly disagree with this effort. I thank you in advance for considering our objections to S-2600, and this terrible effort to rewrite insurance law.

Sincerely,

Eileen Kean, Esq.

Eileen Kean, Esq.
Director of Government Affairs

skc

Testimony of Wardell Sanders, President
New Jersey Association of Health Plans
Before the Assembly Financial Institutions and Insurance Committee
On Assembly Bill 3790
February 8, 2007

Chairman Cohen, Vice Chairman Panter, Members of the Committee:

My name is Wardell Sanders, and I am the President of the New Jersey Association of Health Plans. My Association represents all of the commercial and Medicaid health plans in New Jersey. I appreciate the opportunity to testify before you today on A.3790, a bill addressing the review, processing and payment of certain health and other insurance claims relating to physical therapy services.

The Association respectfully and strongly **opposes** A.3790.

Currently, the review, process and payment of physical therapy benefits are largely treated the same as other claims. This bill would change that by making physical therapy benefits unique and affording them special protection and more. The bill statement makes clear that the intent of the bill is "to better ensure that claims for physical therapy benefits are reimbursable..." Well the bill would likely achieve that result, but it would do so at an extraordinary cost. One has to ask, what is the public policy rationale for conferring such benefits to physical therapists?

Consider the following special rules that would be unique to physical therapy benefits:

1. *"Covered physical therapy benefit":* The bill essentially defines a "covered physical therapy benefit" as a benefit that has been provided, regardless of any coverage exclusion or benefit limitation in the contract. Most contracts of insurance have limitations on the number of covered physical therapy visits. Under this bill, it requires a payer to provide "reimbursement to a claimant for **any** covered physical therapy benefit." It would appear that physical therapy benefits provided to a consumer that are clearly in excess of a contract's visit limits would nevertheless meet the definition of a "covered" physical therapy benefit." In effect, the bill makes coverage for physical therapy visits unlimited.
2. *Independent Examinations*: The bill would require an independent actual examination of the member at payer's expense if payer were to deny a claim or deny preauthorization for physical therapy benefits on the basis of a failure to

meet the standards of medical necessity. So, if the payer is clearly correct in its determination, the payer would need to order what is an unnecessary examination to validate its position at its own expense. All this is done, even though current law already provides for a right to internal carrier appeals and a review by an independent expert through the State's Independent Health Care Appeals Program. In short, the requirement that payers arrange and pay for additional examinations is costly and existing protections are already in place to correct carrier errors.

3. *Appeals to the State Board of Physical Therapy Examiners*: The bill would deem a reduction, delay or denial of a claim for reimbursement from a physical therapist by a payer, based on medical necessity into an allegation of licensee misconduct. In what appears to be a bizarre twist, the bill provides that a physical therapist may appeal a claim denial to the Board "pursuant to [the board's] duty to conduct hearings in to allegation of [the physical therapist's] misconduct." But, then the Board, pursuant to its right to conduct such hearings, then undertakes its real role, to act as a claims adjudicator. This task is well beyond the scope and mission of this, or really any, professional board.
4. *Minimum rates:* This bill would set minimum levels for physical therapy benefits based on DOBI's PIP fee schedule. Again, this would be unique to physical therapy services; no other service or supply provided under a health benefits plan is subject to a minimum benefit law or rule. This would certainly create challenges for a health plan's claims payment systems, which traditionally have used one standard for determination of out-of-network benefits levels (*e.g.*, Ingenix's PHCS fee profile, CMS fee profiles). This bill would require plans to use multiple systems.
5. *Removes Physician Authorization:* The bill would eliminate the requirement for physical therapy services to be authorized by a physician. In effect "physical therapy physicians" would be permitted to authorize physical therapy services without the intervention of a physician.
6. *Assignment of Benefits:* This bill would eliminate the ability of a carrier to refuse to accept assignment of benefits to a non-participating physical therapy provider. For a whole host of reasons, the NJAHP opposes arrangements which require carriers to accept assignment of benefits. Most significantly, forcing health plans to accept assignment of benefits limits fraud investigations and impedes network-building efforts.

This testimony does not catalogue all of the concerns that the NJAHP has with this bill. Rather, it highlights some of the key concerns that we have. Some of the provisions, we frankly do not understand. We would be happy to provide additional input and insight to the sponsors.

Again, thank you for your time.

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Before the Assembly Financial Institutions and Insurance Committee
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February 8, 2007

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Consider the following special rules that would be unique to physical therapy benefits:

1. *"Covered physical therapy benefit":* The bill essentially defines a "covered physical therapy benefit" as a benefit that has been provided, regardless of any coverage exclusion or benefit limitation in the contract. Most contracts of insurance have limitations on the number of covered physical therapy visits. Under this bill, it requires a payer to provide "reimbursement to a claimant for **any** covered physical therapy benefit." It would appear that physical therapy benefits provided to a consumer that are clearly in excess of a contract's visit limits would nevertheless meet the definition of a "covered" physical therapy benefit." In effect, the bill makes coverage for physical therapy visits unlimited.
2. *Independent Examinations*: The bill would require an independent actual examination of the member at payer's expense if payer were to deny a claim or deny preauthorization for physical therapy benefits on the basis of a failure to

meet the standards of medical necessity. So, if the payer is clearly correct in its determination, the payer would need to order what is an unnecessary examination to validate its position at its own expense. All this is done, even though current law already provides for a right to internal carrier appeals and a review by an independent expert through the State's Independent Health Care Appeals Program. In short, the requirement that payers arrange and pay for additional examinations is costly and existing protections are already in place to correct carrier errors.

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4. *Minimum rates:* This bill would set minimum levels for physical therapy benefits based on DOBI's PIP fee schedule. Again, this would be unique to physical therapy services; no other service or supply provided under a health benefits plan is subject to a minimum benefit law or rule. This would certainly create challenges for a health plan's claims payment systems, which traditionally have used one standard for determination of out-of-network benefits levels (*e.g.*, Ingenix's PHCS fee profile, CMS fee profiles). This bill would require plans to use multiple systems.
5. *Removes Physician Authorization:* The bill would eliminate the requirement for physical therapy services to be authorized by a physician. In effect "physical therapy physicians" would be permitted to authorize physical therapy services without the intervention of a physician.
6. *Assignment of Benefits:* This bill would eliminate the ability of a carrier to refuse to accept assignment of benefits to a non-participating physical therapy provider. For a whole host of reasons, the NJAHP opposes arrangements which require carriers to accept assignment of benefits. Most significantly, forcing health plans to accept assignment of benefits limits fraud investigations and impedes network-building efforts.

This testimony does not catalogue all of the concerns that the NJAHP has with this bill. Rather, it highlights some of the key concerns that we have. Some of the provisions, we frankly do not understand. We would be happy to provide additional input and insight to the sponsors.

Again, thank you for your time.

Testimony from
Wardell Sanders, President,
New Jersey Association of Health Plans
For the Assembly Financial Institutions and Insurance Committee
February 25, 2008

ASSEMBLY BILL 2123: Physical Therapy Benefits
NJAHP POSTION: OPPOSE

Chairman Cohen and Members of the Assembly Financial Institutions and Insurance Committee:

The New Jersey Association of Health Plans (NJAHP) is a non-profit association representing leading health care plans in the state. Our members include Aetna, AmeriChoice, AmeriGroup, AmeriHealth, Cigna, Horizon Blue Cross Blue Shield of New Jersey, HealthNet, University Health Plans, and United Health Care. Thank you for the opportunity to express our concerns about A2123, a bill concerning providing special preferences for claims related to physical therapy services. This bill appears to create an unlimited benefit for physical therapy services, sets government rates for payments of physical therapy services, bans the use of a referral process, bans the use of prior authorization, bans any review of a provider's determination of medical necessity, and requires carriers to accept assignment of benefits.

This bill has not yet been posted on GovNet or on the Legislature's website. My comments are based on an unofficial copy of the bill I received last week. The NJAHP respectfully **opposes** A2123.

Currently, the review, process and payment of physical therapy benefits are largely treated the same as other claims. This bill, however, would change that by making physical therapy benefits unique and affording these extraordinary protection and more. Consider the following special rules that would be unique to physical therapy benefits:

1. *"Covered physical therapy benefit":* The bill essentially defines a "covered physical therapy benefit" as a benefit that has been provided, regardless of any coverage exclusion or benefit limitation in the contract. Most contracts of insurance have limitations on the number of covered physical therapy visits. Under this bill, it requires a payer to provide "reimbursement to a claimant for **any** covered physical therapy benefit." It would appear that physical therapy benefits provided to a consumer that are clearly in excess of a contract's visit limits would nevertheless meet the definition of a "covered" physical therapy benefit." In effect, the bill makes coverage for physical therapy visits unlimited.

2. *Referrals and Prior Authorization:* The bill in Section 2 appears to ban the use of prior authorization, but then in Section 5 mandates that carries respond to requests for prior authorization within certain timeframes. These provisions are inconsistent. If the intent is to ban the use of prior authorization, we would object. Similarly, the bill appears to ban the use of a referral process. Again, we would object to a ban on the use of referrals.
3. *Independent Examinations*: The bill would require an independent actual examination of the member at payer's expense if payer were to deny a claim or deny preauthorization for physical therapy benefits on the basis of a failure to meet the standards of medical necessity. So, if the payer is clearly correct in its determination, the payer would need to order what is an unnecessary examination to validate its position at its own expense. All this is done, even though current law already provides for a right to internal carrier appeals and a review by an independent expert through the State's Independent Health Care Appeals Program. In short, the requirement that payers arrange and pay for additional examinations is costly and existing protections are already in place to correct carrier errors.
4. *Minimum rates:* This bill would set minimum payment levels for physical therapy benefits based on DOBI's PIP fee schedule. Again, this is quite unique; generally provider payments for services and supplies provided under a commercial health insurance plan benefits plan are not set by government. In addition to limiting cost-savings, this also creates challenges for a health plan's claims payment systems, which traditionally has used one standard for determination of out-of-network benefits levels (*e.g.,* Ingenix's PHCS fee profile, CMS fee profiles). This bill would require plans to use multiple systems.
5. *Removes Physician Authorization:* The bill would eliminate the requirement for physical therapy services to be authorized by a physician. In effect "physical therapy physicians" would be permitted to authorize physical therapy services without the intervention of a physician. We believe that this is a health care quality issue.
6. *Assignment of Benefits:* Providers contract with health plans, often at reduced rates, in return for direct payment and to steer a volume of patients to the provider. Requiring carriers to accept assignment of benefits removes a key incentive for providers to participate in networks, especially for smaller health plans. By limiting a health plan's ability to create robust networks, it increases costs to consumers through higher premiums and balanced billing for use of non-network services. The cost-containment value of anti-assignment provisions in group contracts has long been recognized as good public policy. This was summed up nicely by the New Jersey Superior Court in the Somerset Orthopedics case:

> "In other words, the anti-assignment clause has been deemed to advance the overarching public interest in limiting health care costs for, if the patient could assign his or her rights to payment to outside medical providers, it would undercut the pre-arranged costs with in-network providers that are relied upon by non-profit health

services corporations in deciding the premium amount. *See generally* Rocky Mountain Hosp., *supra*, 754 *P.*2d at 1182; *Kent General Hosp., supra*, 442 *A.*2d at 1371-72; *Augusta Med. Complex, supra*, 634 *P.*2d at 1126-27; *Obstetricians-Gynecologists, supra*, 361 *N.W.*2d at 556. Accordingly, these cases have held that the purported assignment of benefits to a non-participating medical provider, in the face of an anti-assignment clause in a group health care policy, is void and unenforceable against the insurer as contrary to public policy." Somerset Orthopedic Associates, P.A. v. Horizon Blue Cross And Blue Shield Of New Jersey 345 N.J.Super. 410, 785 A.2d 457 (App. Div. 2001).

This testimony does not catalogue all of the concerns that the NJAHP has with this bill. Rather, it highlights some of the key concerns that we have. Some of the provisions, we frankly do not understand. We would be happy to provide additional input and insight to the sponsors.

Again, thank you for your time.

Assembly Financial Institutions and Insurance Committee

Statement in Opposition to A – 3790

New Jersey Manufacturers Insurance Group is a unique, policyholder focused property-casualty insurer domiciled in the State of New Jersey. It is by far the largest writer of Workers Compensation insurance in New Jersey, covering more than 19,500 businesses and their employees, and also the state's leading automobile insurer.

We are strongly opposed to A3790 which, if enacted, would – with respect to physical therapy services – effectively undo the cohesive care management systems that are currently in place for Workers Compensation (WC) insurance and the Personal Injury Protection (PIP) mandated under New Jersey automobile insurance policies.

In New Jersey, every employee enjoys the full benefit of workers compensation insurance – fully paid by his/her employer – which provides unlimited medical coverage and wage replacement indemnity payments for work-related injuries. Workers compensation is designed to provide the most efficient, dignified and certain form of financial and medical benefits for the victims of work-related injuries. Since its statutory inception in 1911 this system has served New Jersey well - enabling prompt and effective care for injured employees while also ensuring that employers, through their insurers, have the ability to reasonably and appropriately control such care and thus its incumbent costs. In administering this system, insurers rely upon the medical diagnoses and care management recommendations of skilled physicians.

A3790 would eliminate this important control for physical therapy services and also require that any reduction, delay or denial of a physical therapy claim be supported -- in advance – by an independent medical exam (IME) by a physical therapist A3790 would also negate existing fees negotiated between insurers and health care providers by tying all physical therapy reimbursements to the Auto PIP fee schedule. We believe that these changes will significantly increase the cost of physical therapy claims for all workers compensation insurers -- an outcome which will result in higher premiums for New Jersey's businesses.

As respects auto-related injuries covered under PIP, we similarly believe that medical diagnoses and treatment determinations are properly reserved for licensed and skilled physicians. Under current statutes this is, in fact, the practice. A3790, however, would eliminate the need for physician referral for physical therapy treatment. As with workers compensation claims, A3790 would also require that the PIP insurer pay for an IME by a physical therapist selected by the injured person before reducing,delaying or denying payment for physical therapy services. We believe these changes are likely to compromise care management and increase claim costs - thus further increasing the PIP premiums paid by New Jersey drivers.

We urge you to oppose this legislation.

PCI Property Casualty Insurers Association of America
Shaping the Future of American Insurance

February 19, 2008

VIA E-MAIL

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, New Jersey 08625

Re: Physical Therapist legislation (S-2600)

Dear Advisory Commission:

We understand that the Commission has been charged to review and issue a report to the State Legislature concerning S-2600/A-3790 by March 10, 2008, legislation that pertains to access to physical therapists' services. We participated at the Commission's last meeting and offered to provide the Commission with our views and comments about this legislation. We understand that the legislation has been reintroduced in the 2008/09 legislative session as A-2123.

As we stated at the last meeting, the Property Casualty Insurers Association of America is a national trade organization representing the major property-casualty insurers throughout the United States including New Jersey. We represent over 1,000 major property-casualty insurers. We are pleased to be able to offer our help in the Commission's deliberations about this issue.

As part of our responsibilities, we have been reviewing and commenting on S-2600/A-3790 since its introduction last session. We have expressed our opposition to the legislation for a number of reasons. We are particularly concerned with the elimination of the referral process. We believe that a licensed physician can best provide the ability to review the conditions of the patient and determine the overall soundness of treatment.

While we respect and work very closely with physical therapists, we believe that the licensed physician provides the critical role of diagnosis of the patient that the physical therapist is not trained to do. We submit that the physical therapist is not synonymous with the role and education of other medical officers trained to provide an overall body diagnosis or other similar duties.

Under the legislation, we would also question how a patient may want to or could challenge the treatment? Would a patient be allowed to go to a licensed physician or would it simply be a matter of seeking out another physical therapist?

We also believe that the referral process provides an important check and balance to the possibility of insurance fraud, abuse, and over-utilization of the system. Through the referral process, there is general oversight about the treatment and the need for treatment that is critical for a patient's care. This process also provides important assurances to the patient of the need for the treatment.

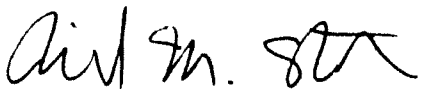
This bill also has another side note of concern to us that the Committee should be concerned with: This bill would shift the dispute resolution over auto accident-related physical therapist bills to the Physical Therapist Board of Examiners. This is a monumental change and could significantly impact how we handle PIP arbitration proceedings. We do not believe the Physical Therapist Board of Examiners is equipped to handle this responsibility nor does the Board have the experience.

As we promised in the Commission's meeting, PCI is happy to offer our expertise on the property-casualty side of this issue. We have previously prepared an analysis of S-2600/A-3790 for our review of this legislation. We offer this document as something the Commission can use in its deliberations.

Our study indicates that a licensed physician referral is important in the diagnosis of treatment for patients. Also, we believe that a referral provides the best check on treatment, especially as it relates to over-utilization of services. Finally, our review indicates that a referral process does not jeopardize timely and appropriate treatment for patients. We include a copy of our study for your records.

We would be pleased to provide any further information the Commission may need regarding this legislation as it pertains to the property-casualty insurance industry. Thank you again for the opportunity to provide you our views.

Sincerely,



Richard M. Stokes, Esq.
Regional Manager and Counsel

PCI Property Casualty Insurers Association of America
Shaping the Future of American Insurance

NEW JERSEY A-3790: ANALYSIS OF PHYSICAL THERAPY PRACTICES WITHOUT A PHYSICIAN'S REFERRAL

New Jersey A-3790 proposes that a licensed physical therapist (PT) may provide service to a patient without having to wait for a referral from a licensed physician and other health care professionals (specifically mentioned are dentist, podiatrist, and chiropractor). Furthermore, these types of PT services shall be covered as a medical expense benefit under an accident, disability income or liability (e.g., general liability, motor vehicle liability, or workers' compensation) insurance policy at the PT rate established in the New Jersey medical fee schedule.

This analysis discusses the importance of obtaining a physician's referral before the start of physical therapy and provides insight into the growing cost of claims that would result if referrals were no longer needed, using private passenger auto personal injury protection (PIP) data. Direct access to PT would increase insurance losses, leading to higher insurance rates.

Reasons for a physician's referral prior to physical therapy include the following:

- An examination by a licensed physician is required to accurately evaluate and diagnose a patient. A physician's review and referral are intended to prevent treatment that is of little or no value and instead help individuals get services that are necessary and appropriate for their medical conditions.

- Because patients at times have multiple medical conditions, physicians are in the best position to consider their overall needs. Continued supervision would enable the physician to evaluate the patient's response to therapy relative to the medical treatment as a whole.

- Without a physician's referral, therapy treatment would be used more often and result in higher costs and, hence, insurance rates. Studies have shown that medically unnecessary services are often provided regardless of physicians' orders. Costs would be compounded, since charges for PT treatments in the New Jersey medical fee schedule are generally about two times more than chiropractic treatments and five times more than oral evaluations.

- There is no evidence to show that physician referrals result in more costly physical therapy treatments (for the same types of injury), nor have referrals caused delays in treatment.

- Eliminating the physician's referral for PT services would create a precedent for other types of medical care, such as occupational therapy, home health services, skilled nursing facilities, medical supplies and pharmaceuticals, and durable medical equipment.

Physician Referrals Provide Accurate Evaluation and Diagnosis

Initially, physicians generally have their patients undergo certain examinations before making a diagnosis. Such an evaluation helps determine whether physical therapy is necessary and whether it

will benefit the patient. Continued monitoring enables the physician to observe the progress of the patient in the context of his or her overall condition. Since patients sometimes have more than one health concern, a physician's ongoing supervision is a reasonable way to administer proper medical care. It is important that health care needs are correctly evaluated, referred for appropriate treatment and monitored over time by a licensed physician.

Unnecessary Therapy Treatment is Sometimes Provided

Medical therapy services are often furnished when they are not needed. In different studies on the level of physical and occupational therapy services administered to patients, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) found the following:

- Five to 26 percent of treatment provided in skilled nursing facilities was unnecessary.[1]
- The majority of contractors (75 percent) hired to review therapy claims found that therapy treatment in skilled nursing facilities was medically unnecessary and excessive. Reasons for their findings include the following comments:
  - "the services were not skilled;"
  - "the treatment goals were too ambitious for the patient's condition;" and
  - "the frequency of the service provision was excessive given the patient's condition."[2]
- About 12 percent of PT services furnished to patients in skilled nursing facilities were medically unnecessary, primarily because the services did not match the patients' conditions or the treatment goals.[3]
- Forty (40) percent of claims stemming from services provided by outpatient rehabilitation facilities were considered "not reasonable and medically necessary for the patient's condition."[4]

The OIG determined that physical therapy treatments were sometimes administered to people who did not warrant them, or skilled services were furnished in lieu of more appropriate routine maintenance. In other instances, services were continued although patients' goals were already met or treatment plans were not reevaluated. The General Accountability Office found similar results with respect to unnecessary therapy and lack of physician oversight. "It is possible that unnecessary services are provided more frequently in settings where there is even less physician supervision."[5]

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[1] OIG (HHS), 2001a; Physical, occupational and speech therapy for Medicare nursing home patients: Medical necessity and quality of care based on treatment diagnosis, Report # OEI-09-99-00563

[2] OIG (HHS), 2000a; Monitoring Part B therapy in skilled nursing facilities (SNF) patients, Report # OEI-09-99-00550

[3] OIG (HHS), 2001b; Physical, occupational and speech therapy for Medicare nursing home patients: Medical necessity, cost and documentation under the $1,500 caps, Report # OEI-09-99-00560, and Office of the Inspector General, op. cit., 2001a

[4] OIG (HHS), 2000b; Six-state review of outpatient rehabilitation facilities, Report # A-04-99-01193

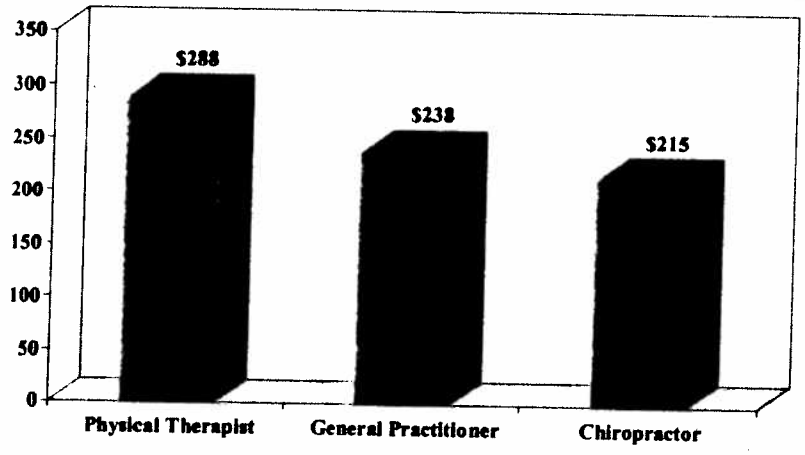
[5] December 30, 2004 letters from Glenn M. Hackbarth, J.D., Chairman of the Medicare Payment Advisory Commission, to Richard B. Cheney, President of the Senate, and J. Dennis Hastert, then Speaker of the House

Although some claim that elimination of physicians' referrals would increase the cost effectiveness of health care, unnecessary or more expensive physical therapy treatment adds to health care costs. In some cases, unwarranted therapy may even prove to be harmful to the patient. If a physician recommends another course of action (other than therapy), the patient may actually receive better and more cost-effective medical care, since extraneous (and most likely expensive) care would be avoided.

Lack of Physician Referrals Would Increase Treatment Costs

Adoption of A-3790 eliminating the need for a physician's referral would increase the number of visits to a physical therapist. Although the number of initial visits to a physician or chiropractor would be reduced, the overall insured health care cost would be substantially greater. Using 2002 New Jersey private passenger auto personal injury protection claims data compiled by the Insurance Research Council, the average charge per visit to a physical therapist is higher than the average charge per visit to both a general practitioner and a chiropractor ($288 – PT vs. $238 – GP and $215 – chiropractor).[6]

New Jersey PIP Claimants
Average Charge Per Visit for Medical Professional



Source: Insurance Research Council, 2002

Pursuant to A-3790, claims would follow the New Jersey Medical Fee Schedule which lists costs for various treatments. According to this schedule, the amount under "Fee Schedule North" for different chiropractic manipulative treatments ranges from $37.77 to $67.95. A periodic oral evaluation performed by a dentist ranges from $32 to $41. In contrast, a physical therapist evaluation alone is $110.02, while PT home visits cost between $65.57 and $159.50.[7] Based on these amounts, it may be inferred that claims for services provided by therapists would cost much more than claims for services provided by chiropractors and dentists. Thus, an already higher fee charged for PT treatments accompanied by a larger number of PT claims, due to referrals no longer being needed, would result in higher costs of insurance claims.

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[6] Insurance Research Council, *Auto Injury Claims: Countrywide Patterns in Treatment, Cost and Compensation*, December 2003

[7] 39 N.J. Reg. No. 23, current through December 3, 2007; because the types of services provided by a general practitioner are too varied, no costs for this particular provider are offered here.

A simplistic hypothetical example illustrates the difference in costs before and after A-3790:

Prior to A-3790: Assume 1,000 claimants went to physicians at an average fee of $50, so the total physician cost would be $50,000; and 400 claimants went to physical therapists at an average fee of $100, so the total PT cost would be $40,000. The sum of visits to both physicians and PTs would cost $90,000 overall.

If A-3790 passed: Assume 250 of the 1,000 claimants above bypassed their physicians and went directly to physical therapists without a referral. There would now be 750 (i.e., 1,000 – 250) claimants going to physicians at an average fee of $50, or a total cost of $37,500; and 650 (i.e., 400 + 250) claimants would be going to PTs at an average fee of $100, or a total cost of $65,000. The sum of visits to both physicians and PTs would cost $102,500 overall.

In this case, health care costs would rise 13.9 percent (from $90,000 to $102,500) because referrals were no longer needed. Clearly, direct access to PTs compounded with more expensive costs for their particular services would mean increased insurance losses and, hence, increased insurance rates.

Treatments are Not Necessarily More Costly with Physicians' Referrals

Those who favor elimination of the referral requirement assert that the cost effectiveness of health care would increase. Although proponents of removing physicians' referrals allege that therapy care provided to patients without referrals is shorter in duration and is about half the cost of care initiated with referrals, it was determined that the severity of patients' conditions differed. Researchers who compared the cost of treatment with and without referrals acknowledged that the cost of care with referrals generally reflected patients who had more serious injuries from the start.[8]

Physician Referrals Have Not Caused Delays in Physical Therapy Treatment

Proponents of eliminating physician referrals also argue that delays in obtaining PT service would be reduced without doctors' orders, hence allowing for faster recovery times for patients. According to the 2004 chairman of the Medicare Payment Advisory Commission (MedPAC), however, the vast majority of Medicare beneficiaries (85 percent) report that they do not have problems obtaining therapy services (PT, occupational therapy and speech-language pathology services).[9] From 2000 to 2003, the share of beneficiaries who reported no problems increased, and the reporting of both "big" and "little" problems declined over this period. The lack of problems indicates that access to therapy, even with physician referrals, is available without delay.

The Property Casualty Insurers Association of America (PCI) is a trade association comprising over 1,000 insurers of all sizes and types that represent 51.4 percent of the total auto business and 37.6 percent of the workers compensation business in the nation. In New Jersey, PCI members represent 65.8 percent of the total auto market and 53.9 percent of the workers compensation market.

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[8] December 30, 2004 letters from Glenn M. Hackbarth, J.D., Chairman of the Medicare Payment Advisory Commission, to Richard B. Cheney, President of the Senate, and J. Dennis Hastert, then Speaker of the House

[9] MedPAC analysis of the Consumer Assessment of Health Plans Survey

Appendix III

S-2600 Other Research

MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chair
Mark E. Miller, Ph.D., Executive Director

December 30, 2004

The Honorable Richard B. Cheney
President of the Senate
U.S. Capitol
Washington, D.C. 20515

Dear Mr. Vice President:

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Congress mandated MedPAC to study the feasibility and advisability of allowing Medicare fee-for-service beneficiaries to have "direct access" to outpatient physical therapy (PT) services and comprehensive rehabilitation facility services.[1]

Current Medicare coverage rules require a beneficiary to be referred by and under the care of a physician for outpatient PT services to be covered by Medicare. Physical therapists would like these requirements removed so that Medicare would cover outpatient PT services even when the care was not referred or reviewed by a physician.

Proponents of eliminating the physician requirements for outpatient PT services contend that it would improve beneficiary care by shortening delays before therapy began. They also argue that eliminating the physician referral requirement would result in more cost-effective care and enhanced patient choice. Opponents argue that a physician examination is required to correctly assess and diagnose a patient's medical condition before the initiation of physical therapy. They also state that ongoing medical supervision ensures that a patient's response to treatment is considered within the context of his or her total medical care.

The physician referral and review requirements are a necessary but not sufficient mechanism to help beneficiaries get outpatient PT services that are needed and appropriate for their clinical conditions. Beneficiaries often have multiple medical conditions and physicians can consider their broad medical care needs. Like Medicare, private insurers usually control service provision, by requiring physician referrals and/or imposing limits on service use. Medicare's physician requirements do not appear to impede access—the majority of beneficiaries report no problems accessing these services. Eliminating the physician requirements for physical therapy services could establish a precedent for other services that currently have similar Medicare coverage requirements.

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[1] The language of section 647 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is found in Attachment A.

While we find no compelling reason to change Medicare's current requirements for physician referrals and care review, we note that other steps, in addition to the physician requirements, need to be taken to help ensure that service provision is appropriate. First, providers need to be made more aware of coverage rules for beneficiaries for example, through increased educational initiatives by the professional associations, the claims contractors, and facilities in which physical therapists practice. Second, better data are needed about the efficacy of physical therapy for older patients. Evidence-based research needs to be undertaken on when and how much outpatient PT benefits older patients. Finally, this information would assist in the development of evidence-based guidelines that are disseminated to physicians and physical therapists so that their practices deliver the best value to beneficiaries.

Background

Physical therapy is the range of service provided by a physical therapist to restore and maintain physical function and to treat or prevent impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries. Primarily through therapeutic exercise and functional training, physical therapy services include strengthening and improving a patient's mobility. Physical therapists have received a post-baccalaureate degree from an accredited education program and have passed a state-administered national examination. State licensure is required in each state in which a physician therapist practices and must be renewed on a regular basis.

Physical therapy services covered by Medicare. Medicare covers outpatient physical therapy services as long as the services are furnished by a skilled professional, are appropriate and effective for a patient's condition, and are reasonable in terms of frequency and duration. Further, a physician must refer the patient; review a written plan of care every 30 days; and, for longer-term treatment (extending beyond 60 days), reevaluate the patient. In addition, providers must have a physician on call to support emergency medical care. Beneficiaries are expected to improve significantly in a reasonable period of time. Medicare does not cover physical therapy designed to maintain a level of functioning or serve as a general exercise program. Finally, services are not covered when the expected patient gains from therapy are insignificant in relation to the therapy required to reach them or when it has been decided that a patient will not realize treatment goals.

Though Medicare's coverage policies are fairly broad, the local contractors that review and pay the claims submitted to Medicare often issue more specific medical review policies, thereby making the coverage requirements more specific.

Providers of outpatient physical therapy. Physical therapy services are furnished in many different settings. The largest (in terms of Medicare payments and patients treated) are hospital outpatient departments and skilled nursing facilities (SNFs).[2] Other settings include physicians'

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[2] Outpatient PT services may be furnished by a SNF to a beneficiary who does not qualify for a Medicare-covered SNF-stay under part A (for example, because he or she was not hospitalized prior to entering the SNF or does not require skilled services). Though provided in an inpatient setting, the PT is billed as an outpatient service and covered under part B. SNFs also furnish PT to beneficiaries who live in the community but use the SNF as a provider of outpatient PT services.

offices, physical therapists in private practice, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies (Attachment B). CORFs differ from other outpatient PT providers in two ways: (1) they must offer psychological or social services and the services of a physician who specializes in rehabilitation medicine, and (2) they are authorized to provide (and be paid separately for) nontherapy ancillary services (such as respiratory therapy, drugs that cannot be self administered, and nursing services) when medically necessary. Across all these settings, about 9 percent of beneficiaries receive PT services.

Medicare payments. Medicare covers all outpatient PT services under part B, the Supplementary Medical Insurance Trust Fund.[3] Payments are established for each outpatient PT service in the physician fee schedule, regardless of where the services are provided.[4] As with most services covered under part B, Medicare pays 80 percent of the payment amount and the beneficiary is responsible for a 20 percent coinsurance. In 2000, Medicare payments for outpatient therapy totaled almost $2.1 billion, two-thirds of which were for physical therapy (the other third paid for occupational and speech therapies.)

No limit currently exists on the amount of medically necessary outpatient PT a beneficiary may receive, but this has not always been the case. Limits on the amount of outpatient therapy furnished by therapists in independent practice were first implemented in 1972 and subsequently increased three times. The Balanced Budget Act of 1997 extended the cap to all nonhospital therapy providers and raised the cap to $1,500. Hospital providers were excluded from the cap to allow beneficiaries with high care needs to continue to receive services.[5] These caps were in effect for calendar year 1999 and then suspended by the Congress for three years. Due to delays in implementation, the inflation-adjusted limits ($1,590) were not reimposed until September 2002 and were again suspended beginning December 8, 2003, by the MMA. This latest suspension lasts through December 31, 2005. As a result, there are currently no monetary limits on the amount of outpatient PT that can be provided by physical therapists to patients.

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[3] Part B is an optional program that covers physician and other outpatient services that beneficiaries may buy into through monthly premiums. About 92 percent of beneficiaries participate in Part B.

[4] Until 1999, payments to institutional providers (hospital outpatient departments, SNFs, CORFs, and ORFs) were cost based. The Balanced Budget Act of 1997 replaced the cost-based method with a uniform fee schedule that established payments for all providers of outpatient PT and, as an interim savings measure for 1998, reduced payments to institutional providers.

[5] Maxwell, Stephanie et al. 2001. *Part B therapy services under Medicare 1998–2000: Impact of extending fee schedule payments and coverage limits.* Washington, DC: Urban Institute.

Physician requirements help ensure beneficiaries receive medically appropriate care

Since the beginning of the program, Medicare has relied on physicians to determine which services are reasonable and necessary.[6] Before referring a patient for physical therapy, physicians generally examine the patient and, if necessary, order and evaluate the results of diagnostic services such as radiological exams and laboratory tests to establish an initial diagnosis. Patient diagnoses and comorbidities are considered in assessing whether physical therapy services will be beneficial to a patient and, if so, how much therapy a patient could tolerate. Once therapy has begun, the physician recertifies that the plan of care continues to match the beneficiary's care needs and, in the case of longer-term therapy, periodically reexamines the patient. Given the multiple, often chronic, medical care needs of many beneficiaries, the physician oversight requirements are a reasonable way to help beneficiaries receive medically appropriate care.[7]

Without these physician requirements, the medical appropriateness of starting or continuing physical therapy services would be more uncertain. Under Medicare, physical therapists are not allowed to order the diagnostic services that may be critical to identifying the patient's underlying medical conditions. In some cases, physical therapy would not be beneficial to the patient and would raise program and beneficiary costs. In other cases, underlying medical conditions that look similar to other musculoskeletal conditions would go undetected. For these beneficiaries, overlooked medical conditions could result in delayed medical attention that could result in harmful or negative outcomes. While physician referral requirements do not ensure the medical appropriateness of services furnished, they help to prevent the provision of services of marginal or no clinical value.

Physical therapists counter that their training and practice ensures that patients are adequately screened for medical referrals. During each patient's examination, the physical therapist assesses whether the patient's condition is consistent with the diagnosis provided by the physician and whether the patient needs to be referred back to a physician for further medical attention. Physical therapists note that the physician referral may provide little clinical guidance regarding the services to be furnished. One study found that physician referral forms do not consistently include specific clinical diagnoses.[8] Physical therapists also contend that general instructions such as "evaluate and treat" require the same assessment skills and responsibilities that they would assume under their proposal to eliminate the physician referral requirement.[9]

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[6] Tunis, Sean. 2004. Why Medicare has not established criteria for coverage decisions. *New England Journal of Medicine* 350, no. 21 (May): 2196–2198.

[7] About 78 percent of beneficiaries had at least one chronic condition and 63 percent had two or more. Medicare Payment Advisory Commission. 2004a. *Report to the Congress: New approaches in Medicare.* Washington, DC: MedPAC. Chapter 2.

[8] One study found that fewer than 30 percent of claims included differential diagnoses information. Clawson, AJ, et al. 1994. Content of physician referrals to physical therapists at clinical education sites in Indiana. *Physical Therapy* 74, no. 4 (April): 356–360.

[9] General instructions may reflect a lack of oversight on the part of the physician or a high degree of confidence the physician has in the physical therapist.

Medicare's requirement that physical therapy services be under the care of a physician is similar to those for other services and practitioners. Physician referrals or orders are required for home health care, skilled nursing facility stays, durable medical equipment, medical supplies, outpatient drugs, oxygen, and occupational therapy. Medicare has similar coverage rules for physician assistants and nurse practitioners—these providers can bill Medicare independently but must practice under physician supervision or in collaboration with physicians. For home health services, physicians are also subject to civil monetary penalties when they falsely certify eligibility for beneficiaries they know to be ineligible for services. Other practitioners—podiatrists, optometrists, and chiropractors—are included in Medicare law's definition of physicians and do not require physician referral or oversight.

Changing the physician requirements for outpatient PT services is likely to have repercussions for other services. In a letter to MedPAC, the American Occupational Therapy Association (AOTA) notes that rehabilitation services—including physical and occupational therapies (OT) and speech-language pathology—are treated the same under Medicare.[10] It asserts that if changes were made to the requirements for physician certification and recertification requirements for PT, then changes should be made to OT and speech-language pathology. The position of the AOTA regarding the physician requirements is under consideration. Last year, AOTA noted that there were important public policy reasons to ensure that physicians review the therapy plan of care and attest to a continuing medical need for therapy services.[11]

Private payers use multiple strategies to control service use

Private payers generally use a combination of "front end" and "back end" mechanisms to control PT service use, particularly given their younger populations who may have less proven need for PT services. At the front end, managed care organizations, self-insured plans, and the national Federal Employees Health Benefit Programs (FEHBP) often require physician referrals. Blue Cross Blue Shield Association (BCBSA) plans vary in their requirements for physician referrals, depending on the plan and the employer. Their managed care plans are most likely to require physician referrals, whereas their preferred provider plans are less likely to require some form of prior authorization. Five BCBSA plans (Arizona, Delaware, Maryland, Montana, and North Dakota) do not require physician referrals, though representatives from the Blue Cross Association told us that many physical therapists prefer to have a physician referral before they begin treating patients.

Most private payers have adopted some kind of "back end" controls to limit PT service use. Many payers restrict coverage to a predefined number of days or visits per year, such as 60 calendar days from the beginning of an "event" or 30 visits. Some private plans also attempt to control the provision of individual services by paying for a "bundle" of therapy care on a "per visit" basis. For these visits, payments are uniform, regardless of the number of services furnished during the visit.

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[10] American Occupational Therapy Association. 2004. Letter to MedPAC, September 28.
[11] American Occupational Therapy Association. 2003. Comment letter to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, January 23. http://www.cms.gov/faca/ppac/writ_aota.pdf.

Some private payers also use practice guidelines that have been developed by clinical experts in combination with a review of the current medical literature.[12] These guidelines are sometimes used to establish eligibility for coverage but more often to perform utilization review. For a specific diagnosis, the guidelines typically include a brief description, indicators of the condition (such as the presence of pain), recommended treatment (for example, therapy or exercise), and the average or suggested number of visits. Guidelines sometimes describe the amount of improvement that can be expected from a given course of treatment and suggested end points based on range of motion, the amount of pain, and a patient's ability to work.

Consistent with the private payers, Medicare should have a control in place to consider the medical appropriateness and necessity of the services furnished. If Medicare removed the physician requirements, its only control mechanism, as a prudent purchaser it would need to establish an alternative method to control service use.

Many state laws restrict physical therapy practices

Although state laws relating to physical therapy vary considerably, only two states (Iowa and Montana) explicitly allow the provision of physical therapy services without a physician referral (Table 1). Another fifteen states implicitly allow physical therapists to see patients without a physician referral because their laws are silent on the issue. In these 15 states, the coverage policies of the insurers may still require physician referrals. More common are laws that in some way limit the services a physical therapist can deliver to patients. These restrictions include: allowing physical therapists to evaluate, but not treat, patients; placing time limits on how long a physical therapist may treat a patient before a physician must be seen; and limiting the types of services physical therapists can provide without a physician referral. For example, in Washington, interventions related to musculoskeletal conditions do not require referrals but providing orthotics for feet do. Four states explicitly require physician referrals.

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[12] Maxwell, Stephanie, and Cristina Baseggio. 2000. *Outpatient therapy services under Medicare: Background and policy issues*. Washington, DC: Urban Institute.

Table 1
State laws differ on physician referral requirements for physical therapy services

Provision	States
Referrals not required (2 states explicitly granted and 15 states implied through omission)	Iowa and Montana (explicitly granted) Alaska, Arizona, California, Colorado, Idaho, Maryland, Massachusetts, Nebraska, Nevada, North Carolina, North Dakota, South Dakota, Utah, Vermont, West Virginia (implied through omission)
Referrals not required for specific services (3 states)	Arkansas, Washington, Wyoming
Referrals not required for a limited period of time (11 states)	Delaware, Florida, Maine, Minnesota, New Hampshire, New Jersey, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina
Referrals not required to evaluate patients (16 states)	Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New Mexico, New York, Oklahoma, Tennessee, Texas
Physician referral required to evaluate and treat (4 states)	Alabama, Indiana, Virginia, Wisconsin

Note: Implied through omission: State laws do not explicitly mention physician referral requirements for either evaluation or treatment.
Referrals not required for a limited period of time: Physical therapists can evaluate and treat patients without a physician referral for a specific number days (for example, 21, or 30 days) before a physician must be consulted.
Referrals not required to evaluate patients: Physical therapists can evaluate patients without a physician referral but referrals are required to treat patients.

Source: Analysis of state laws as compiled by the American Association of Orthopedic Surgeons (in correspondence to MedPAC, 2004) and the American Physical Therapy Association, 2004. Establishing the Feasibility and Advisability of Direct Access to Physical Therapists: A Report to the Medicare Payment Advisory Commission. Alexandria, VA: APTA.

Two studies examining the experience of physical therapists practicing in states that do not require physician referrals found that between 34 and 45 percent of the therapists surveyed had practiced without physician referrals. Of those, between 10 and 35 percent of their cases were seen through direct access. Direct access was not more common among patients because either their employers or insurers required physician referrals or the therapists preferred to treat patients by referral.[13]

[13] Crout, K.L. et al. 1998. Physical therapists' opinions and practices regarding direct access. *Physical Therapy* 78, no.1 (January): 52–61 and Domholdt, E., and A.G. Durchholz. 1992. Direct access use by experienced therapists in states with direct access. *Physical Therapy* 72, no. 8 (August): 569–574.

Medically unnecessary physical therapy services could increase if physician requirements were eliminated

Another concern with eliminating the referral and oversight requirements is that unnecessary use of outpatient PT services would increase. Long-standing concern about appropriate use has prompted the examination of these services furnished to Medicare beneficiaries. The studies have consistently found that despite the physician requirements, medically unnecessary therapy services were frequently furnished.

Amount of medically unnecessary PT services. The Office of Inspector General (OIG) of the Department of Health and Human Services examined the provision of outpatient physical and occupational therapy services provided in skilled nursing facilities (SNFs) and found considerable and widely varying shares of medically unnecessary services. One study found that from 5 to 26 percent of services was unnecessary, depending on the patient diagnosis.[14] Another OIG study found that three quarters of the contractors hired to review and process claims for payment commonly found medically unnecessary and excessive therapy claims.[15] The services were medically unnecessary because:

- the services were not skilled,
- the treatment goals were too ambitious for the patient's condition, and
- the frequency of the service provision was excessive given the patient's condition.

The appropriateness of care provided at CORFs and ORFs has also prompted examination. In its study of ORFs, the OIG found that about 40 percent of the claims reviewed were for services that were not reasonable and medically necessary for the conditions of the patient.[16] The Government Accountability Office (GAO) examined CORFs in Florida and found that on a per patient basis, Florida CORFs' payments were two to three times higher than payments to other facility-based therapy providers and that the differences were not explained by patient characteristics such as diagnosis.[17]

These studies indicate that unnecessary therapy is frequently provided and that the current requirements alone do not eliminate unnecessary service provision, even in settings supervised by physicians, such as SNFs and CORFs. The studies may also reflect low levels of physician oversight provided in some institutional settings. It is possible that unnecessary services are provided more frequently in settings where there even less physician supervision. Finally, the findings may illustrate a poor understanding of Medicare coverage by physicians and physical therapists.

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[14] Office of the Inspector General, Department of Health and Human Services. 2001a. Physical, occupational, and speech therapy for Medicare nursing home patients: Medical necessity and quality of care based on treatment diagnosis. Washington, DC: OIG. Report no. OEI-09-99-00563.

[15] Office of the Inspector General, Department of Health and Human Services. 2000a. Monitoring Part B therapy in SNF patients. Washington, DC: OIG. Report no. OEI-09-99-00550.

[16] Office of the Inspector General, Department of Health and Human Services. 2000b. Six-state review of outpatient rehabilitation facilities. Washington, DC. Report no. A-04-99-01193.

[17] General Accounting Office. 2004. Comprehensive outpatient rehabilitation facilities: High Medicare payments in Florida raise program integrity concerns. Washington, DC: GAO. Report no. GAO-04-709.

The OIG and GAO have recommended that CMS ensure that its contractors expand and conduct adequate medical reviews of PT claims. The OIG also recommended educating facilities and their staffs about Medicare's medical necessity guidelines and local medical review policies. It also encouraged national therapy and nursing home associations to disseminate information about coverage rules and proper documentation.

Service provision during and after the outpatient therapy caps. Service provision also appears to increase as Medicare payment policies become less restrictive. After the implementation of the outpatient therapy caps in 1999, total part B therapy expenditures decreased 34 percent between 1998 and 1999, mostly as a result of lower per beneficiary payments.[18] Then, when the constraints imposed by therapy caps were lifted, spending increased 36 percent between 1999 and 2000, again due primarily to increases in per patient spending.[19] The OIG found that even under the restrictive therapy caps, about 12 percent of physical therapy services provided to SNF patients were not medically necessary, primarily because the services furnished did not match the patients' conditions or the services provided did not match treatment goals.[20] In some cases, the patients were not candidates for PT services; in others, skilled services were provided when routine maintenance would have been more appropriate to the patients' conditions. Regarding the fit between services provided and treatment plans, in some cases, services continued to be provided even though patients had met their goals; in others, the patients were not meeting their goals but their treatment plans were not revaluated.

Variation in service spending. Variation in spending may be another indicator of unnecessary service provision. In 2000, there was a five-fold variation in Medicare payments per patient for outpatient PT services across states.[21] Although a large share of this variation is probably due to differences in health status, local prices, and provider mix, some of this difference in practice patterns may suggest overutilization.[22] But even for similar diagnoses, payments varied three-fold suggesting that either different types of providers treat patients of varying severity or that considerable variation in treating similar cases exists.[23] One study found that after controlling for differences in diagnosis and illness severity, orthopedic surgeons were more likely than primary care physicians to refer patients to physical therapy and that PT supply also explained differences in PT referral rates.[24] A better understanding of the reasons for the wide variation in outpatient

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[18] Olshin, Judith M. et al. 2002. *Study and report on outpatient therapy utilization: Physical therapy, occupational therapy and speech-language pathology services billed to Medicare Part B in all settings in 1998, 1999, and 2000.* Columbia, MD: Advance Med. http://www.cms.hhs.gov/medlearn/therapy and Maxwell, Stephanie et al, op. cit., 2001.

[19] Over the two year period (from 1998 to 2000), spending decreased 10 percent, in part reflecting the implementation of the fee schedule for institutional providers and budget-savings reductions taken in 1998.

[20] Office of the Inspector General, Department of Health and Human Services. 2001b. Physical, occupational, and speech therapy for Medicare nursing home patients: Medical necessity, cost, and documentation under the $1,500 caps. Washington, DC: OIG. Report no. OEI-09-99-00560 and Office of the Inspector General, op. cit., 2001a.

[21] Olshin, Judith M. et al, op. cit. Note that state measures do not accurately account for services that beneficiaries receive in nearby states.

[22] MedPAC estimates that across all health care spending, about 40 percent of the variation is attributable to differences in local prices and health status. Medicare Payment Advisory Commission. 2003. *Report to the Congress: Variation and innovation in Medicare.* Washington, DC: MedPAC. Chapter 3.

[23] Maxwell, Stephanie, op. cit., 2001.

[24] Freburger, Janet K. 2003. Physician referrals to physical therapy for the treatment of musculoskeletal conditions. *Archives of Physical Medicine and Rehabilitation* 84 (December): 1839--1849.

PT services is essential to activities aimed at increasing the appropriateness of service use, such as practice guidelines and practitioner profiling.

Amount of medical review. Stepped-up medical review of physical therapy services could help reduce medically unnecessary services. The Congress required the Secretary to focus attention on the medical appropriateness of outpatient PT, especially that provided in SNFs.[25] Currently, most of the contractors that review and process claims for payment do some kind of review, but in aggregate fewer than two percent of all therapy claims are examined. This scale of activity is unlikely to ensure that the PT services provided, and the beneficiaries receiving them, meet coverage rules. This lack of aggressive medical review is an additional factor to consider in relaxing restrictions on PT requirements.

Need for evidence-based research. Stepped up medical review is not, by itself, a solution to problem of unnecessary service provision. Lacking evidence on when older patients benefit from PT, it will be difficult for contractors responsible for medical review to determine which services were appropriate without conducting chart review. Evidence-based research to establish the clinical effectiveness of PT services for older patients could be used to educate physicians and physical therapists about best practices, which should begin to narrow the variation in practice patterns. Practice guidelines could also form the basis of Medicare's medical reviews of the appropriateness of PT services. Until evidence-based research has established when and how much PT services benefit the typical beneficiary, retaining the physician requirements is one, albeit imperfect, way to curtail unnecessary services.

The American Physical Therapy Association (APTA) has two initiatives underway that will help disseminate information about the effectiveness of physical therapy services. First, it developed an electronic patient record that includes an outcomes instrument, which it will market in the spring 2005. These data are intended to lead to the development of a national outcomes data base. Second, it has established and made available to its membership an information repository of 1,600 articles summarizing the peer reviewed literature on treatment effectiveness. Expanding the availability of this information to those physicians who refer many patients to PT would help them assess when and how much therapy is likely to benefit patients.

Physician requirements may not increase the cost of care

Proponents of eliminating the physician requirements claim that eliminating the requirement for physician referrals would increase the cost effectiveness of care. They say that the program would save money on physician office visits and beneficiaries would save on the associated copayments.

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[25] In the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999, the Congress required that CMS recommend a mechanism to assure the appropriate utilization of outpatient therapy services and conduct focused medical review of part B therapy claims, in particular SNF claims for 2000 and 2001. A year later, in the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, it extended the requirement for focused review of SNF therapy claims until 2003.

Sometimes, however, the patient comes to the physician's office with a medical complaint and the physician does not recommend physical therapy as part of the treatment plan. For this patient, the requirement for a physician referral results in better medical care that may be more cost effective. The physician referral requirement may lower the amount of unnecessary care that is provided and result in net savings to the program. Other beneficiaries have multiple health conditions that require medical attention. Even if the referral requirement were lifted, these beneficiaries would still see their physicians for their other medical conditions. For these patients, their physician office visits would not be eliminated and there may be no savings, depending on what remaining physician services are furnished.

Supporters point to a study done of Maryland Blue Cross Blue Shield claims comparing the cost of care for patients with and without a physician referral for physical therapy. This study, funded by APTA, found that the care provided to patients without a physician referral was shorter in duration and about half the cost of care initiated with a physician referral.[26] However, the authors acknowledge that differences in severity between patients seen by physical therapists and physicians could explain the differences in the cost of care. Direct measures of severity were not included in the analysis. Further, because the study did not include Medicare beneficiaries, it is not clear if similar cost differences would be observed in an older and sicker population.

Beneficiary access to physical therapy services appears good

Proponents of removing the physician referral requirement assert that the elimination of delays associated with getting a physician referral would promote quicker recoveries for beneficiaries who would benefit from physical therapy.[27] Yet, most beneficiaries report that they do not encounter problems in getting special therapy services (which include physical and occupational therapies and speech-language pathology services.)[28] In 2003, 85 percent of beneficiaries reported having no problems, an increase over the share in 2000 (Table 2). Across all beneficiaries, the share of beneficiaries reporting "big" and "little" problems decreased, with 6 percent reporting "big" problems and 8 percent reporting "little" problems in 2003, though these problems may not be related to the physician referral requirement. Almost all of the subgroups of beneficiaries reported fewer problems in 2003 than in 2000. Access to special therapy services is not uniform across all subgroups of beneficiaries, similar to differences noted for other health care services.[29] But even among subgroups reporting the most problems getting special therapy services, over 70 percent of beneficiaries report no problems.

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[26] Mitchell, Jean M., and Gregory de Lissovoy. 1997. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy. *Physical Therapy* 77, no. 1 (May): 10-17.

[27] For example, in 2000, one third of beneficiaries waited a week or more for an appointment for a specific problem. Trude, Sally, and Paul B. Ginsburg. 2002. *Growing physician access problems complicate Medicare payment debate*. Washington, DC: Center for Studying Health System Change. These delays are not, however, specific to waiting times associated with obtaining a referral for PT services.

[28] Beneficiaries may report access problems to services that are not medically appropriate or necessary. Ideally, our access measures would reflect beneficiaries' ability to get appropriate care.

[29] Medicare Payment Advisory Commission. 2004b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. Chapter 1.

Table 2
Most beneficiaries report no problems getting special therapy services

Beneficiary group	2000	2003
Beneficiaries reporting no problems	83%	85%
Urban	82	85[a]
Rural	84	87[a]
Under age 65	72[b]	71[b]
65–74	85[b]	87[b]
75 and older	85[b]	89[b]
Dual eligible	75[a]	77[a]
Nondual eligible	85[a]	87[a]
White	84[c]	87[c]
African American	76[c]	79[c]
Other race	72[c]	73[c]
Beneficiaries reporting "big" problems	8	6
Urban	9[a]	7[a]
Rural	8[a]	5[a]
Under age 65	16[b]	16[b]
65–74	7[b]	5[b]
75 and older	7[b]	4[b]
Dual eligible	13[a]	1[a]
Nondual eligible	7[a]	5[a]
White	8[c]	6[c]
African Americans	13[c]	10[c]
Other race	13[c]	12[c]
Beneficiaries reporting "little" problems	9	8
Urban	9	9[a]
Rural	8	7[a]
Dual eligible	12[a]	13[a]
Nondual eligible	8[a]	8[a]
Under age 65	9[b]	7[b]
65–74	12[b]	12[b]
75 and older	8[b]	7[b]
White	8[c]	7[c]
African Americans	11[c]	11[c]
Other race	15[c]	15[c]

Note: Special services include physical and occupational therapy and speech and language pathology services. There is some overlap between these subgroups. Dual eligible beneficiaries are disproportionately under age 65, African American, or Hispanic (included in the "other race" category).

[a] Differences between the subgroups are statistically significant.
[b] Differences between the subgroups of older beneficiaries (age 65–74 and 75 and older) and the under age 65 subgroup are statistically significant.
[c] Differences between the African American and the other race subgroups are statistically significant from the white subgroup but not from each other.

Source: MedPAC analysis of the 2000 and 2003 Consumer Assessment of Health Plans Survey.

Another measure of access is the number of beneficiaries receiving outpatient therapy services. Access appears to be stable, although this measure does not consider if the services were appropriate. Between 1998 and 2000, the number of Medicare beneficiaries receiving outpatient therapy services increased 2 percent, identical to the increase in the number of beneficiaries.

Conclusions

Several compelling reasons argue for retaining Medicare's current requirements that physicians refer beneficiaries to PT services and oversee their care. These requirements are in place so that beneficiary health care needs are correctly diagnosed, referred for treatment, and followed up. Given many beneficiaries' multiple and chronic health problems, the requirements encourage coordination of the medical care beneficiaries receive. The current requirements do not appear to impair access for most beneficiaries. Most private payers also restrict their coverage of outpatient physical therapy services, either by requiring physician referrals or setting service limits, or both. Were Medicare to eliminate its only method of controlling service use, it would need to consider alternative ways to screen services so that unnecessary care—already a problem with the current requirements—does not increase. Finally, lifting the referral requirements for physical therapy services would set a precedent for other services with similar coverage requirements.

While the current requirements are necessary, MedPAC acknowledges that they are not as effective as they might be at controlling unnecessary service provision. Provider education—for the physicians making the PT referrals and the therapists furnishing the services—is a key component to eliminating services of marginal value to beneficiaries. Evidence-based practice guidelines would help establish when and for how long beneficiaries would typically benefit from physical therapy services, thereby reducing the amount of inappropriate and medically unnecessary care. MedPAC encourages the physical therapy profession to help develop this body of evidence and use it to establish credible guidelines for outpatient physical therapy services furnished to older patients. These guidelines could then be used to educate physical therapists and physicians about PT service provision that is likely to be effective for beneficiaries.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Identical letter sent to the Honorable J. Dennis Hastert

Enclosures

Study mandate

Sec. 647. MedPAC study on direct access to physical therapy services of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(a) Study—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the feasibility and advisability of allowing medicare [sic] fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.)

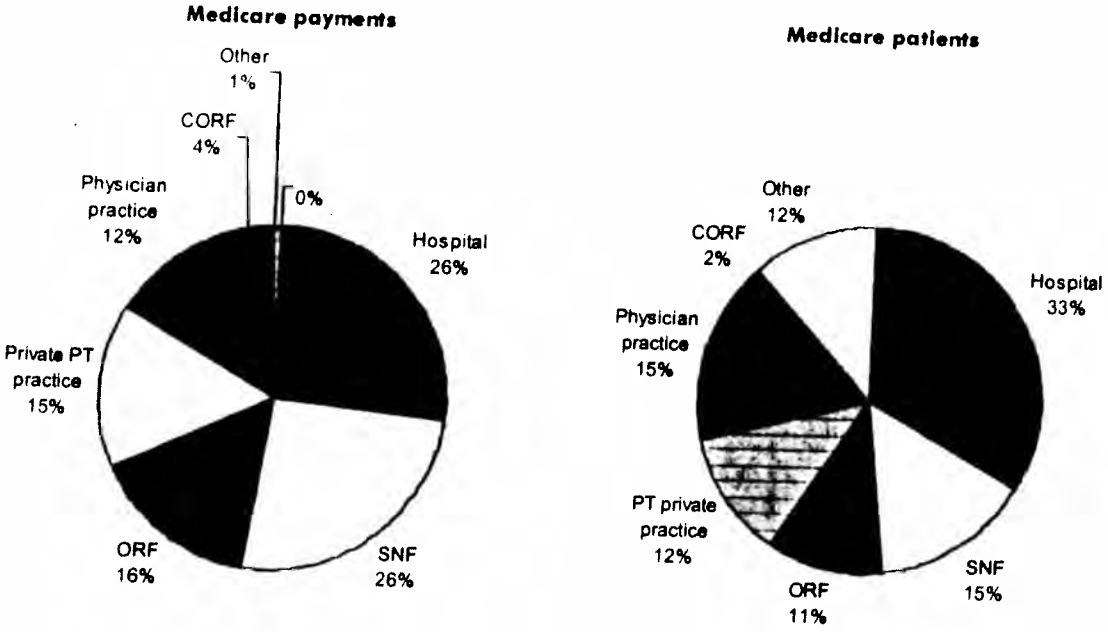
(b) Report—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

c) Direct Access Define—The term "direct access" means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage and payment for services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

1. without regard to any requirement that—
   - A. an individual be under the care of (or referred by) a physician; or
   - B. services be provided under the supervision of a physician; and
2. by allowing a physician or qualified physical therapist to satisfy any requirement for—
   - A. certification and recertification; and
   - B. establishment and periodic review of a plan of care.

Attachment B

Medicare payments and Medicare patients in 2000, by setting



Note: CORF (comprehensive outpatient rehabilitation facility), PT (physical therapy), ORF (outpatient rehabilitation facility), SNF (skilled nursing facility). Other includes other institutions such as home health agencies and ambulatory surgical centers.

Source: Olshin et al. 2002. Study and Report on Outpatient Therapy Utilization: Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Billed to Medicare Part B in All Settings in 1998, 1999, and 2000. Columbia, MD: Advance Med, 2002. Table 14 and Figure 20.

Research Report

A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy

Background and Purpose. Access to physical therapy in many states is contingent on prescription or referral by a physician. Other states have enacted direct access legislation enabling consumers to obtain physical therapy without a physician referral. Critics of direct access cite potential overutilization of services, increased costs, and inappropriate care. Methods and Results. Using paid claims data for the period 1989 to 1993 from Blue Cross-Blue Shield of Maryland, a direct access state, we compiled episodes of physical therapy for acute musculoskeletal disorders and categorized them as direct access (n=252) or physician referral (n=353) using algorithms devised by a clinician advisory panel. Relative to physician referral episodes, direct access episodes encompassed fewer numbers of services (7.6 versus 12.2 physical therapy office visits) and substantially less cost ($1,004 versus $2,236). Conclusion and Discussion. Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. There are several potential reasons why this may be the case, such as lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in overutilization of services or will increase costs appears to be unwarranted. [Mitchell JM, de Lissovoy G. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy. *Phys Ther.* 1997;77:10–18.]

Key Words: *Direct access, Episode of care, Physical therapy, Physician referral.*

Jean M Mitchell

Gregory de Lissovoy

In many states, the practice of physical therapy is contingent on the prescription or referral by a physician, a requirement that effectively limits access to physical therapy services. Other states have enacted legislation permitting direct access—the ability of a health care consumer to freely visit a physical therapist without first securing referral from a physician. In these states, licensed therapists may evaluate patients without referrals and make autonomous decisions about subsequent clinical management.[1]

Although direct access in the United States dates back to 1957, the majority of states with direct access statutes have permitted physical therapists to treat and evaluate patients without physician referral only since the 1980s.[2] No published research has evaluated the impact of physician referral versus direct access on utilization and costs of care for persons undergoing physical therapy. This exploratory study compared the utilization of health care resources and third-party medical expenditures for persons receiving physical therapy under direct access versus those referred for such services by a physician.

We begin this report by providing some background on direct access to physical therapy. Next, we describe a study method based on the analysis of episodes of physical therapy created using Blue Cross-Blue Shield claims data. The final section discusses empirical results, study limitations, and implications for public policy.

Background

Thirty states allow physical therapists to treat and evaluate patients without physician referral, and an additional 14 states allow physical therapists to evaluate, but not treat, patients without referral.[2] Twenty states and the District of Columbia require physician referral as a prerequisite for treatment by a physical therapist.[1]

Advocates for physical therapists to have direct access argue that direct access extends consumers' choice of health care providers, improves access to services that promote prevention and rehabilitation, and reduces delays before commencing therapy. Proponents further argue that direct access may result in cost savings by avoiding the referring physician's fees and related ancillary services (eg, roentgenograms, laboratory tests). Supporters of direct access also point out that other nonphysician providers, such as chiropractors and clinical psychologists, do not require physician referrals or screening evaluations.[1,3]

Critics of direct access argue that physical therapists may overlook serious medical conditions and for this reason contend that all patients should be screened initially by physicians.[1,3] The American Medical Association (AMA) contends that although allied health care professionals are useful as physician extenders, they would not serve the public as well in an autonomous role.[4] The AMA and the American Academy of Orthopaedic Surgeons oppose independent practitioner status for physical ther-

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apists because of concerns about improper diagnosis, inappropriate care, and the potential for increased costs.[5] State medical societies and chiropractic groups have also been major adversaries of direct access. A common concern is that direct access legislation may lead therapists to diagnose and treat beyond their level of competency, thus erroneously assuming the role of physician.[6,7]

Previous research on direct access to physical therapy has considered the incidence of direct access practice,[1,8,9] patient and provider satisfaction with physical therapy received under direct access,[2,10] and physical therapist and patient opinions about direct access to physical therapy.[11–13] The limited available evidence from these published studies indicates that direct access has had only a minimal impact on physical therapy practice.[1,8–10] In some of these studies,[1,10] however, physical therapists expressed greater job satisfaction and patients preferred the more expeditious treatment received.[1,10]

Method

The Data

The study is based on health insurance claims data furnished by Blue Cross-Blue Shield of Maryland. This insurer has been reimbursing for physical therapy provided under direct access since 1986, so the coverage is well established. Group insurance paid claims represent a broad cross section of the employed population and their dependents. Because these individuals obtained health insurance through employer-sponsored plans, the effect of adverse selection, which characterizes persons with individual policies (or no insurance), is minimized. Although the data encompassed a number of different employer groups, the range of services covered and the level of reimbursement among groups in the sample were virtually identical. The plans covered only working-age adults and their children; persons eligible for Medicare (age 65 years and over) were not examined.

The data set included all paid claims for the calendar years 1989 through mid-1993. The initial file contained 1.7 million claims in four categories: professional fees, outpatient services (ie, radiology, laboratory, and ancillary services), prescription drugs, and hospitalization. Each record contained a unique beneficiary identification number, date of service, type of service, submitted charge, amount reimbursed by Blue Cross-Blue Shield, and subscriber copayment amount. Claims for professional services also included a designation of clinical specialty (eg, licensed physical therapist, orthopedic physician, chiropractor), Current Procedural Terminology (CPT) code for type of service, and ICD-9-CM (*International Classification of Diseases, 9th Revision, Clinical Modification*) diagnostic code for the condition.

Analytical Framework—Episodes of Physical Therapy

Health insurance claim files comprise a series of discrete transactions that document beneficiary encounters with the medical care system. Claims records can be grouped sequentially to construct "episodes of care" that encompass a series of temporally contiguous health care services related to treatment of a specific illness or health condition.[14] Recent studies have used the episodes framework to examine the decision to seek medical care, subsequent utilization of services, and expenditures.[14–20]

The main advantage of using claims data for health services research is that observations on a large number of individuals over an extended period of time can be obtained at relatively low cost. When compared with audits of medical records, this method for assessing medical care has limitations. First, only sparse information is available for each encounter, and this information has been collected for administrative rather than clinical purposes. Second, the validity of episode construction is contingent on algorithms created by the investigator. Error may arise from either the inclusion of irrelevant transactions or the exclusion of transactions actually related to the condition of interest. Third, a subject's health history and clinical status at the start of an episode must be inferred from the pattern of prior claims. Similarly, outcome of treatment following an episode must also be deduced from the presence (or absence) of subsequent claims. Finally, medical expenditures paid directly by the patient, such as charges for over-the-counter drugs, are not documented (although this is also true of medical records).

Episodes of physical therapy were constructed with guidance from an advisory panel of five licensed health care professionals practicing in Maryland. Panel members were selected from a list of candidates provided by the Maryland Physical Therapy Association in response to a request for names of active practitioners specializing in physical therapy and orthopedic medicine. The panel consisted of three physical therapists and two physicians (an orthopedic surgeon and a physical medicine/rehabilitation specialist). Additional insight on the idiosyncracies of the claims data was provided by the medical director of Maryland Blue Cross-Blue Shield. Panel functions were to develop criteria for constructing episodes of care and to establish rules for classifying episodes as either direct access or physician referral.

An episode of physical therapy should encompass all services provided in relation to a specific illness or condition during a suitable time period.[14] At the time of this study, physical therapy performed by a licensed

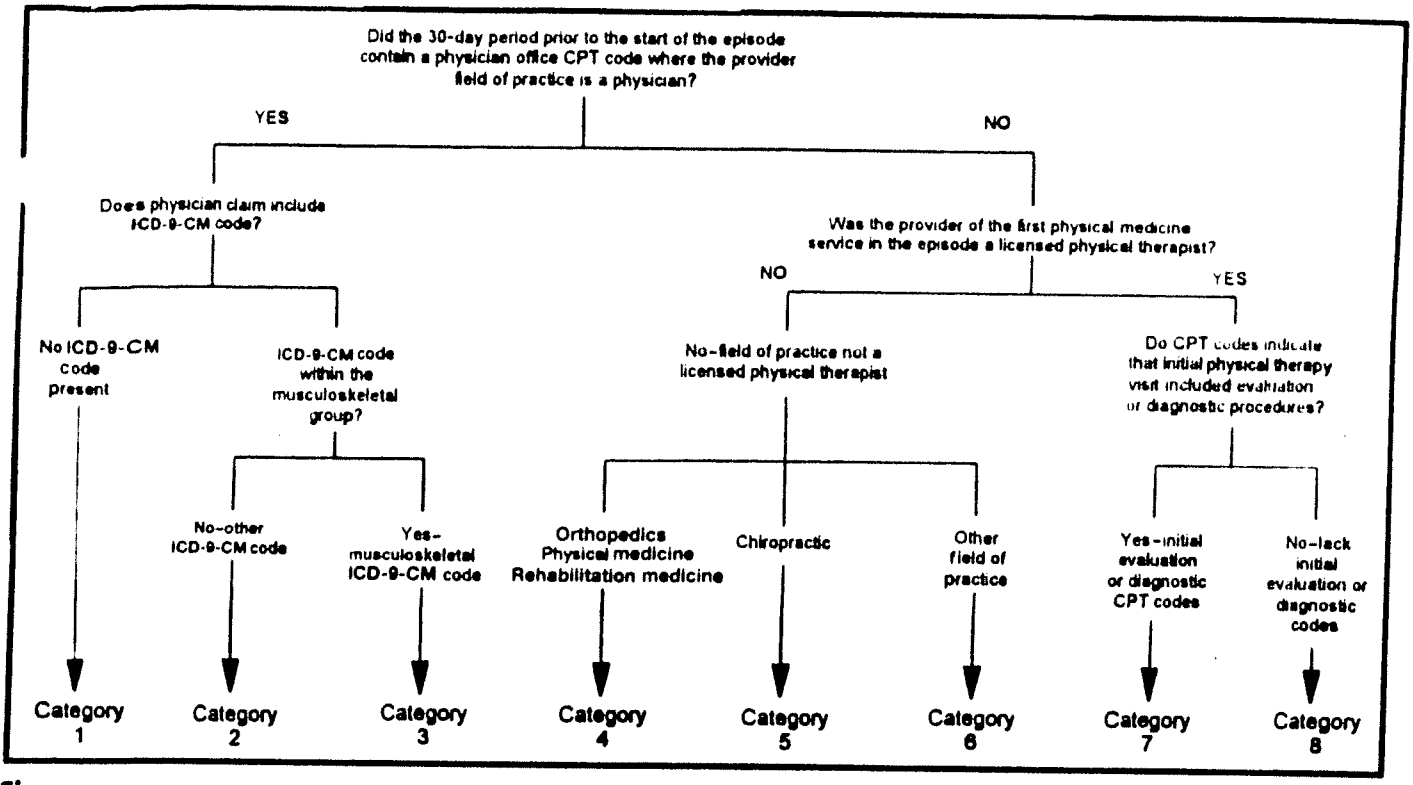

Figure.
Algorithm for categorization of episodes of care (CPT=Current Procedural Terminology, ICD-9-CM=*International Classification of Diseases, 9th Revision, Clinical Modification*). Note: musculoskeletal ICD-9-CM codes include 710–739 and 840–848.

physical therapist was billed under "physical medicine" procedure (CPT) codes. Other health care professionals such as physicians and chiropractors also utilize these CPT codes for services performed, even though they are not licensed physical therapists and thus may not be performing identical services. For purposes of classification, we refer to episodes of care defined by physical medicine procedures as physical therapy, irrespective of the health care provider who rendered the service.

We first identified all individuals who had at least one physical therapy claim during period January 1990 through December 1991. Approximately 11,600 individuals met this criterion. We then sorted each individual's claims for the period 1989 through 1993 in chronological order by date of service and created a window of observation extending from 12 months prior to the date of the first physical therapy service to 12 months after the last physical therapy service. This window contained all or part of one or more episodes of care.

Criteria for marking an episode's beginning and end points were devised by the advisory panel. We examined the 30-day period prior to the first physical therapy claim that occurred during the period January 1990 through December 1991. If no physical therapy claim occurred during the 30 days preceding the first physical therapy service, this date marked the beginning of an episode of care. If a physical therapy claim did occur within that 30-day period, the next 30-day period prior to that claim was reviewed. This process was repeated for each preceding 30-day period until reaching the initial transaction in the data set (January 1, 1989).

We then identified the last physical therapy service that occurred during the period January 1990 through December 1991. The panel recommended examining a 45-day period subsequent to this encounter. If no physical therapy claims were recorded during this 45-day period, then the last physical therapy service marked the end of the last episode. Alternatively, if a physical therapy service was recorded during this subsequent 45 days, the episode was deemed incomplete and the next 45-day period following the physical therapy service was examined. Again, this procedure was repeated until reaching the end of the data set (December 31, 1992). Using this approach, we created a new file containing observations on approximately 3,500 persons who had at least one episode of physical therapy that began and ended during the period 1989 through 1992.

These beginning and end points could actually mark different episodes. For this reason, we next examined the 45-day period occurring after the date established as the commencement point of the episode denoted by the first physical therapy service in order to distinguish among multiple episodes. If a physical therapy encounter occurred within 45 days after the commencement of

Table 1.
Comparison of Mean Values for Resource Utilization and Cost in Direct Access Episodes Versus Physician Referral Episodes

Variable	Direct Access (n=252)	Physician Referral (n=353)	Difference*
Physical therapy claims	20.2 (82.9)	33.6 (39.0)	13.4
Physical therapy office visits	7.6 (9.1)	12.2 (12.8)	4.6
Physical therapy claims paid ($)	566 (716)	890 (941)	324
Drug claims	1.47 (4.0)	3.13 (7.72)	1.66
Drug claims paid ($)	36 (109)	78 (223)	42
Radiology claims	0.32 (1.03)	1.02 (1.86)	0.70
Radiology claims paid ($)	44 (190)	175 (541)	131
Hospital admissions	0.25 (0.80)	0.64 (1.17)	0.39
Hospital admissions paid ($)	83 (402)	397 (1,003)	315
Total claims paid ($)	1,004 (2,030)	2,236 (2,827)	1,232

*$P < .01$.

an episode, the two encounters were considered part of a single episode. This procedure was repeated for all subsequent physical therapy services. If a period of 45 days occurred in which there was no physical therapy service, then the date of the last physical therapy service prior to the 45 days in which no physical therapy services were rendered marked the end of the episode. If another physical therapy service was observed beyond this 45-day posttreatment period, then this date marked the commencement point of another episode.

Classification of Episodes

After creating episodes of physical therapy, the next task was to classify episodes as either direct access or physician referral. Because claims data do not differentiate direct access episodes from those that were referred, we adopted decision rules recommended by the advisory panel. The classification algorithm, depicted in the Figure, differentiated eight categories of episodes.

We first examined the 30-day period prior to the first physical therapy service within each episode to determine whether there was a claim for a physician service with either ICD-9-CM codes or CPT codes indicating a condition that could reasonably lead to the provision of physical therapy. The panel recommended a focus on only acute and sporadic musculoskeletal-related disorders (ICD-9-CM codes 710–739 and 840–848). The 30-day period was deemed conservative because a typical person receiving a prescription for physical therapy could likely schedule an initial appointment within 2 weeks. We then determined whether claims for physical therapy services within the episode were rendered by a licensed physical therapist in order to exclude physical therapy services rendered by other providers (eg, chiropractors). If these criteria were met, the episode was classified as a physician referral (category 3).

Episodes for which there was no indication that a physician encounter occurred in the 30-day period preceding the first physical therapy service were then examined to determine whether services were provided by a licensed physical therapist. Category 7 contained episodes in which claims for diagnostic or evaluation procedures were recorded for the first encounter with the physical therapist. Criteria for category 8 were identical to those for category 7 except that no initial claims for diagnostic evaluation were observed. Categories 7 and 8 were grouped together and comprise the direct access episodes. Other categories (1, 2, 4, 5, and 6) did not meet the criteria for either direct access or physician referral and were excluded from the analysis.

We then visually inspected the set of transactions comprising episodes in categories 3, 7, and 8. Following recommendations of the advisory panel, we excluded episodes that involved claims for chronic musculoskeletal conditions (eg, arthritis, cancer, multiple sclerosis, osteoporosis). We also excluded episodes in which the patient appeared to have multiple comorbidities. These episodes tended to contain visits to a number of different providers for a range of health problems, making it impossible to determine whether physical therapy received by the patient represented treatment for the initial encounter with a musculoskeletal diagnosis. The final analysis file comprised 252 direct access and 353 physician referral episodes.

Statistical Analyses

We first compared the mean values of utilization and cost variables for direct access versus physician referral episodes using a two-tailed test for differences between means, with a null hypothesis of no difference (Tab. 1). Because simple comparisons do not control for confounding factors, we also used multiple regression analysis to compare direct access and physician referral episodes with respect to utilization (number of physical therapy visits) and costs. Definitions of variables used in the analysis are presented in Table 2. Summary statistics for the dependent and explanatory variables follow each definition.

Table 2.
Definitions of Variables Used in Regression Analyses

Variable	Definition
Dependent	
Logarithm-physical therapy visits	Natural logarithm of the count of physical therapy office visits during the episode ($\bar{X}$=1.78, SD=1.12)
Logarithm-physical therapy paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for physical therapy services received by patient during the episode ($\bar{X}$=6.03, SD=1.26)
Logarithm-total paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for all services received by patient during the physical therapy episode ($\bar{X}$=6.61, SD=1.48)
Independent	
Direct access	Dichotomous variable: 1 if episode was direct access (category 7 or 8), 0 if episode was physician referral (category 3) ($\bar{X}$=0.58, SD=0.49)
Female	Dichotomous variable: 1 if the beneficiary gender was female, 0 if male ($\bar{X}$=0.63, SD=0.48)
Age	Beneficiary age (in years) ($\bar{X}$=42.19, SD=12.5)
Drugs	Dichotomous variable: 1 if the episode contained any claims for prescription drugs, 0 if otherwise ($\bar{X}$=0.42, SD=0.49)
Hospital	Dichotomous variable: 1 if the episode contained any claims for inpatient or outpatient services provided by an acute care general hospital, 0 if otherwise ($\bar{X}$=0.25, SD=0.44)
Radiology	Dichotomous variable: 1 if the episode contained any claims for diagnostic radiology services provided by a physician or freestanding imaging center, 0 if otherwise ($\bar{X}$=0.29, SD=0.46)
Direct access-drugs	Interaction of "direct access" and "drugs": 1 if a direct access episode contained prescription drug claims; 0 if otherwise ($\bar{X}$=0.12, SD=0.32)
Direct access-hospital	Interaction of "direct access" and "hospital": 1 if a direct access episode contained claims for hospital services; 0 if otherwise ($\bar{X}$=0.55, SD=0.23)
Direct access-radiology	Interaction of "direct access" and "radiology": 1 if a direct access episode contained diagnostic radiology claims performed at a physician office or freestanding imaging center, 0 if otherwise ($\bar{X}$=0.55, SD=0.23)

The total cost of each episode of physical therapy was computed as the sum of all paid claims for services and drugs provided during the episode. A logarithmic transformation was performed on the dependent variables to adjust for observed right-skewed distribution, which is typical of medical utilization and expenditure data.[21] The primary explanatory variable of interest was referral status. The dichotomous variable "direct access" identified episodes in categories 7 and 8 while category 3 (physician referral) served as the reference category. Three dichotomous variables were constructed to identify episodes that contained any claims for hospital services (hospital), pharmaceuticals (drugs), and diagnostic imaging rendered via a physician's office or freestanding center (radiology). All three categories of service must be prescribed by a physician and thus suggest greater severity of illness than episodes not including these services. To further distinguish episodes involving any or all of these services by referral status, we constructed interaction terms. These terms identified direct access episodes that involved claims for hospital services (direct access-hospital), pharmaceuticals (direct access-drugs), and imaging procedures (direct access-radiology). Additional variables controlled for age and gender.

Results

Table 1 shows simple comparisons using tests for differences between means. Physician referral episodes were characterized by 13.4 (67%) more physical therapy claims and 4.6 (60%) more office visits than direct access episodes ($P<.0001$). Reimbursements for physical therapy services were, on average, $324 (57%) more expensive for physician referral episodes when compared with direct access episodes ($P<.0001$). Total paid claims averaged $2,236 for physician referral episodes and $1,004 for direct access episodes; this $1,232 difference signifies that the cost to Blue Cross-Blue Shield for physician referral episodes exceeded the cost for direct access episodes by about 123% ($P<.001$).

Table 3 displays the results of regressions where the dependent variables were the number of physical therapy visits, paid claims for physical therapy services, and total paid claims for all services and drugs. In each case, the dependent variable has been transformed and is expressed as its natural logarithm. Adjusted multiple regression (R^2) values indicate that models account for about 25% of the variation in the logarithm of physical therapy visits and for about 21% for the logarithm of physical therapy claims. The regression explains 48% of

Table 3.
Regression Estimates for Number of Physical Therapy Visits, Paid Claims for Physical Therapy Services, and Paid Claims for All Services[a]

Independent Variable	Number of Physical Therapy Visits (Log)	Paid Claims for Physical Therapy Services (Log)	Total Paid Claims for All Services and Drugs (Log)
Direct access[b]	−0.503** (0.111)	−0.519** (0.134)	−0.864** (0.125)
Drugs	0.361** (0.10488)	0.346** (0.124)	0.425** (0.116)
Hospital	0.268* (0.121)	0.274* (0.142)	0.934** (0.134)
Radiology	0.479** (0.117)	0.534** (0.138)	0.853** (0.130)
Direct access-hospital[c]	0.127 (0.251)	0.106 (0.295)	0.133 (0.269)
Direct access-drugs[c]	0.601** (0.178)	0.644* (0.210)	0.685** (0.198)
Direct access-radiology[c]	−0.298 (0.248)	−0.107 (0.292)	0.249 (0.272)
Female[b]	0.112 (0.083)	0.161 (0.098)	0.149 (0.092)
Age	−5.643 (0.003)	−0.002 (0.004)	−0.002 (0.004)
Constant[c]	1.504** (0.155)	5.756** (0.184)	6.191** (0.173)
Adjusted R^2	.247	.212	.479
F statistic	22.94	17.34	61.79

[a] Standard errors of regression coefficients are in parentheses. Single asterisk (*) indicates $P < .05$, double asterisk (**) indicates $P < .01$.
[b] Reference category for "direct access" is "physician referral"; reference category for "female" is "male."
[c] Interaction term between "direct access" and named variable.

Table 4.
Percentage of Difference in Utilization and Cost for Direct Access Episodes Relative to Physician Referral Episodes[a]

Model Dependent Variable	Difference Relative to Physician Referral Episode
Number of physical therapy visits	−65%
Paid claims for physical therapy services	−68%
Total paid claims for all services and drugs	−137%

[a] Based on regression results shown in Table 3.

the variation in total paid claims for all services and drugs.

In each model, the coefficient for the variable "direct access" was negative ($P<.01$), implying that episodes of physical therapy classified as direct access involved fewer visits and lower costs relative to episodes classified as physician referral. Coefficients for the variables identifying episodes of physical therapy that included claims for drugs, hospitalizations, or radiology were positive and significant at $P<.01$. These findings imply that physician referral episodes with claims for any or all of these services are characterized by more physical therapy visits, higher paid claims for physical therapy services, and higher total costs per episode relative to physician referral episodes that do not involve drugs, hospitalizations, or imaging procedures.

Interaction terms that identified direct access episodes involving hospital inpatient services or imaging were not significant, implying that such services have little bearing on use of physical therapy or episode costs. By contrast, direct access episodes that contained one or more claims for pharmaceuticals were associated with more physical therapy visits, higher paid claims for physical therapy, and higher total episode costs. The variables controlling for gender and age had negligible effects on both utilization and costs.

Because log-transformed results cannot be interpreted directly, the coefficients for the direct access variables have been converted to percentages (Tab. 4). Relative to physician referral episodes, those episodes classified as direct access involved 65% fewer physical therapy visits and 68% lower paid claims for physical therapy services.

The lower utilization rates for all services that characterized direct access episodes is best seen by examining total episode costs. When measured in terms of paid claims, direct access episodes were 137% less expensive than those classified as physician referral.

Discussion

Thirty states have legislation enabling patients to obtain physical therapy services without physician referral (direct access). The public policy objective for direct access statutes is to give the consumer the ability to select the most appropriate source of care. Consumers, however, should be protected against underprovision of care that could occur if physician services were not provided when medically necessary.

Using Blue Cross-Blue Shield claims data from Maryland (a state with direct access statutes), we compared episodes of physical therapy categorized as direct access relative to those classed as physician referral and found substantial differences. Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classed as physician referral. Some direct access episodes included claims for inpatient hospital care, drugs, or outpatient radiology—all services requiring physician prescription. The use of hospital services or imaging procedures during direct access episodes had a negligible relationship with the number of physical therapy visits or episode costs. In contrast, direct access episodes that contained claims for drugs were associated with greater use of physical therapy and higher costs. Physician referral episodes that included any or all of these three items were associated with higher utilization and costs.

Because our study was based on health insurance claims data, these findings must be interpreted with caution. The method relied on sorting algorithms to identify episodes of care and to distinguish direct access from physician referral. We cannot be certain that resource use attributed to episodes and their classification accurately identified each patient's course of therapy. In addition, we have no way of knowing whether the lower cost of direct access episodes was due to underprovision of care or whether the greater resource intensity and cost of physician referral episodes reflects overprovision of care.

Conclusions

We conclude that direct access episodes, on average, are short in duration and relatively inexpensive. Potential explanations why this may be the case include lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in overutilization of services or will increase costs appears unwarranted. The fact that some direct access episodes included physician-prescribed services indicates that physical therapists are making referrals to physicians. Thus, our study offers evidence that public policy objectives for direct access to physical therapy services are being achieved.

Acknowledgments

We acknowledge the invaluable guidance provided by advisory panel members Richard Hinton, MD, Cindy Juris, MD, Annette Iglarsh, PhD, PT, Rod Schlegel, PT, and Mark Valente, PT. Insight on use of Maryland Blue Cross-Blue Shield claims data was provided by Alan Wright, MD. Chuanfa Guo provided expert computer programming in construction of episode-of-care files. Emily Tobias Shumsky assisted in the detailed inspection of final-analysis files. Comments on an earlier version of this manuscript were provided by Jack Hadley, Vivian Hamilton, and Robert Hurley.

References

1 Domholdt E, Durchholz AG. Direct access use by experienced therapists in states with direct access. *Phys Ther.* 1992;72:569–574.

2 *Physical Therapy Practice Without Referral: Direct Access.* Alexandria, Va: American Physical Therapy Association, Department of Government Affairs; July 1992.

3 Overman SS, Larson JW, Dickstein DA, Rockey PH. Physical therapy care for low back pain: monitored program of first-contact nonphysician care. *Phys Ther.* 1988;68:199–207.

4 Physical therapists and patient access without physician referral. *Medical World News.* 1987;28(17).

5 Barr J. It's time to be direct about direct access. *Physical Therapy Today.* Spring 1991.

6 Durant TL, Lord LJ, Domholdt E. Outpatient views on direct access to physical therapy in Indiana. *Phys Ther.* 1989;69:850–857.

7 Dorste T. Physical therapists: green light on direct access. *Hospitals.* 1987;61(15):113.

8 Jette AM, Davis KD. A comparison of hospital-based and private outpatient physical therapy practices. *Phys Ther.* 1991;71:366–381.

9 Dennis JK. Decisions made by physiotherapists: a study of private practitioners in Victoria. *Australian Journal of Physiotherapy.* 1987;33:181–191.

10 James JJ, Stuart RB. Expanded role for the physical therapist: screening musculoskeletal disorders. *Phys Ther.* 1975;55:121–132.

11 Domholdt E, Clawson A, Flesch P, Taylor T. *Direct Access to Physical Therapy.* Alexandria, Va: American Physical Therapy Association; 1991: chap 4.

12 Hamouz L, Barron A, Porter RE. Indiana physical therapists' attitudes toward direct access legislation. *Phys Ther.* 1989;69:393. Abstract.

13 LeMasters A, Domholdt E. Direct access opinions of physical therapy students. *Phys Ther.* 1989;69:392–393. Abstract.

14 Hornbrook MC, Hurtado AV, Johnson RE. Health care episodes: definition, measurement, and use. *Medical Care Review.* 1985;42(2):163–218.

15 Hillman BJ, Joseph CA, Mabry MA, et al. Frequency and costs of diagnostic imaging in office practice: a comparison of self-referring and radiologist-referring physicians. *N Engl J Med.* 1990;323:1604–1608.

16 Hillman BJ, Olson GT, Griffith PE, et al. Physicians' utilization and charges for outpatient diagnostic imaging in a Medicare population. *JAMA.* 1992;268:2050–2054.

17 Keeler EB, Rolph JE. The demand for episodes of treatment in the health insurance experiment. *Journal of Health Economics.* 1988;7:337–367.

18 Garnick DW, Luft HS, Gardner LB, et al. Services and charges by PPO physicians for PPO and indemnity patients: an episode of care comparison. *Med Care.* 1990;28:894–906.

19 Keeler EB, Manning WG, Wells KB. The demand for episodes of mental health services. *Journal of Health Economics.* 1988;7:369–392.

20 Haas-Wilson D, Cheadle A, Scheffler R. Demand for mental health services: an episode of treatment approach. *Southern Economic Journal.* 1989;56:219–232.

21 Manning WG, Newhouse JP, Duan N, et al. Health insurance and the demand for medical care. *American Economic Review.* 1987;77:251–277.