Medicare Basics:

Welcome to the World of Medicare
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I. Medicare Basics
Medicare History
In 1965, Congress established Medicare as Title XVIII of the Social Security Act. Medicare provides health insurance coverage for persons age 65 and over, persons with disabilities, and persons with end-stage renal disease. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) and consists of the Hospital Insurance Program (Part A), the Supplementary Medical Insurance Program (Part B), the Medicare Advantage Program (Part C) and the Medicare Prescription Drug Benefit (Part D). Medicare Part A covers hospital inpatient services, skilled nursing facility, and hospice care. Medicare Part B covers outpatient services in all settings, and physician and other professional services including OT services provided by private practitioners. Medicare Part C provides an array of managed care plan options to beneficiaries, while Part D establishes a prescription drug benefit for Medicare beneficiaries. The home health benefit is paid out of both Part A and Part B funding.

In 1983, the first prospective payment system (PPS) was implemented for inpatient acute care hospitals, based on a diagnosis related group (DRG) patient classification system under which each hospital is paid on a per discharge basis. The Balanced Budget Act of 1997 (BBA) created sweeping changes in the method of payment for other provider types and services, which were designed to balance the federal budget by 2002 and make the Medicare program solvent until 2010. The BBA required that as of January 1, 1999, all outpatient therapy (i.e., OT, PT, SLP) services provided by SNFs, hospital outpatient departments, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), clinics and by private practitioners be paid using the Medicare Physician Fee Schedule (MPFS). The major payment system changes currently in place include:

- The Skilled Nursing Facility Prospective Payment System (PPS) (effective July 1998);
- The Hospital Outpatient PPS (effective August 2000);
- The Home Health PPS (effective July 1998);
- The Inpatient Rehabilitation Facility/Unit PPS (effective January 2002);
- The Long Term Care Hospital PPS (effective October 2002, and implemented under the Benefits Improvement and Protection Act of 1999);
- The Inpatient Psychiatric Facility (IPF) PPS (effective January 2005, and implemented under the Balance Budget Refinement Act of 1999)

Occupational Therapy Services in Medicare
As shown in the following chart, occupational therapy practitioners provide services in nearly all Medicare settings. Rules for the provision of services and payment for services vary by setting. For detailed information about a specific payment system or setting, please see also the CMS website at http://www.cms.hhs.gov/home/medicare.asp

Medicare Payment Systems for Specific Provider Setting

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Payment System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital, Acute Care Inpatient</td>
<td>PPS – Effective 1983, per episode system based on DRGs (Diagnosis Related Groups); excludes psychiatric, rehabilitation, alcohol/drug, and distinct-part</td>
</tr>
<tr>
<td>Hospice</td>
<td>Cost-related prospective payment, subject to aggregate limit</td>
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</tbody>
</table>

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AOTA: Reimbursement and Regulatory Policy Department
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Medicare Payment Systems for Specific Provider Setting

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Payment System</th>
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<tbody>
<tr>
<td>Long Term Care (LTC) Hospital</td>
<td>PPS – Effective for cost reporting periods beginning October 1, 2002, per discharge system based on LTC-DRGs</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility (IRF)/Unit</td>
<td>PPS – Effective for cost reporting periods beginning January 1, 2002, per discharge system based on CMGs (case mix groups), subject to 75% rule (effective May 7, 2004)</td>
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<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Part A benefit: Per diem PPS based on RUG III (resource utilization groups) categories Part B benefit: MPFS</td>
</tr>
<tr>
<td>Home Health Agency (HHA)</td>
<td>Part A benefit: Effective October 2000, per episode PPS based on HHRGs (Home Health Resource Groups) Outpatient benefit: MPFS</td>
</tr>
<tr>
<td>Hospital Outpatient, Comprehensive Outpatient Rehabilitation Facility (CORF), Rehabilitation Agency, OT Private Practice</td>
<td>Medicare Physician Fee Schedule (MPFS)</td>
</tr>
<tr>
<td>Partial Hospitalization Program (PHP) in Hospital or Community Mental Health Center</td>
<td>Hospital Outpatient PPS, effective August 2000</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facility</td>
<td>Per diem IPF PPS, effective January 1, 2005, for inpatient hospital services furnished in psychiatric hospitals and units</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>Paid as incident to physician’s services based on MPFS</td>
</tr>
</tbody>
</table>

Medicare Coverage for Occupational Therapy

Generally, occupational therapy is considered a covered service under Medicare if it meets the following criteria:

1. Services must be prescribed by a physician and furnished under a physician approved plan of care (developed by a physician or an occupational therapist).
2. Services must be performed by a qualified occupational therapist or occupational therapy assistant under the general supervision of an occupational therapist (or direct supervision (i.e., “in the office suite”) in the case of occupational therapy private practice), and
3. Services must be reasonable and necessary for the treatment of the individual’s illness or injury.
Occupational therapy is considered reasonable and necessary when it is expected that the therapy will result in significant improvement in the patient's level of function within a reasonable amount of time. CMS publishes Medicare manuals containing information for the provision of services in each treatment setting. The manuals can be accessed and downloaded from the CMS website or ordered through the Government Printing Office.

Local Medicare Contractors
CMS contracts with various third party payers around the country to administer Medicare claims and perform medical review services. Medicare Fiscal Intermediaries (FIs) are insurance companies that process claims for hospitals, SNFs, CORFs, and rehabilitation agencies. Five Regional Home Health Intermediaries (RHHIs) oversee all home health agency claims processing. Medicare Carriers adjudicate claims from physicians and OT private practitioners. Additionally, there are four Durable Medical Equipment Regional Carriers (DMERCs) that develop policy and process claims for durable medical equipment, prosthetics, orthotics and supplies. Under the Medicare Modernization Act of 2003 (MMA), CMS is currently working to consolidate the FIs, carriers, and DMERCs into entities called Medicare Administrative Contractors (MACs).

Medicare contractors have the authority to develop local coverage determinations (LCDs) to determine coverage for services except in cases where there is a conflict with national coverage policy. Coverage and reimbursement for OT services vary by contractor and sometimes vary for each state in which that payer administers claims. LCDs can be accessed either through the contractor’s website or by searching CMS’ Medicare Coverage Database at http://www.cms.hhs.gov/mcd/search.asp

Medicare Managed Care
Although Medicare managed health care options have been available to some Medicare beneficiaries since 1982, the BBA of 1997 established Medicare Part C, also called Medicare+Choice, which provided an array of managed care plan options to beneficiaries.

Recently, as part of the MMA, Congress introduced the Medicare Advantage program to replace the Medicare+Choice managed care program, and further expand beneficiary choice of health care plan options.

Under the Medicare Advantage program, persons entitled to Medicare Part A and enrolled under Medicare Part B, who live in specific service areas, can elect to receive services through three types of plan options:

1) coordinated care plans (including a “special needs plan” for dual eligible and institutionalized individuals);
2) private-fee-for-service plans; and
3) combination plans (combining a medical savings account plan and a contribution into an MSA). Medicare pays Medicare Advantage plans per capita rates, based on a specific formula. Under the Medicare Advantage program, plans continue to have great flexibility in making coverage determinations and provider contracting decisions.

Medicare Prescription Drug Benefit
The MMA also added a new outpatient prescription drug benefit known as “Part D” to the Medicare program. The drug benefit is provided by private entities, both stand-alone prescription drug plans and comprehensive managed care plans known as Medicare Advantage plans (formerly Medicare+Choice). These entities will assume part of the financial risk associated with offering the new Part D benefit. The MMA contains safeguards for ensuring the availability of plans and sufficient choice in all geographic areas.
II. Medicare 101: Understanding the Basics
Medicare 101
Understanding the Basics

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ABSTRACT
Medicare is the largest health care payer in the United States, covering more than 42 million people. A high percentage of occupational therapy practitioners provide services to Medicare beneficiaries. The Medicare benefit is available through several programs, each of which adheres to a different set of rules and payment policies. Occupational therapy services are covered in these programs at various settings under specific criteria. Occupational therapy practitioners must understand these rules and regulations in order to fully service their patients and promote their profession. Congress regulates Medicare, and when we understand the rules and regulations, we can better advocate for occupational therapy services or influence changes in the system.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Differentiate between the various Medicare programs.
2. Identify basic Medicare Part B billing requirements.
3. Identify the different Medicare contractors that administer and manage the Medicare claims process.
4. Identify general Medicare documentation requirements.

INTRODUCTION
As the largest health care payer in the United States, Medicare covered more than 42 million people in 2005. Approximately 35.4 million of those covered are 65 years of age or older, with the remaining 6.6 million under 65 with a permanent disability (Kaiser Family Foundation, 2005). A high percentage of occupational therapy clients have medical coverage through the Medicare program.

Funding Medicare is an ongoing federal issue. Medicare was 13% of the federal budget in 2005, costing a staggering $325 billion. Hospital inpatients made up 37% of those costs, followed by physicians and other providers, including outpatient therapy services (25%), skilled nursing facilities (5%), and home health (4%) (Kaiser Family Foundation, 2005). These escalating costs often result in Congress writing such legislation as the Balanced Budget Refinement Act of 1999 (Public Law 106-113) or the Medicare Modernization Act of 2003 (Public Law 108-173) to help manage Medicare costs. Medicare legislation significantly affects our practice settings and service delivery. Occupational therapy practitioners provide services in most of the Medicare-approved settings. Certainly some clinicians work in settings that do not use Medicare funding; however, it is important to know and understand Medicare guidelines because many other insurance companies follow Medicare rules and apply the same coverage decisions when approving health care services. We must understand the Medicare system and related legislation so that we can optimize our opportunities to practice and ensure reimbursement for our practice, promote occupational therapy services, and serve our clients fully.

HISTORY OF MEDICARE
In 1965, Congress established two programs to cover the medical costs for elderly people and persons with disabilities. These programs, commonly referred to as Medicare, were included in Title XVIII of the Social Security Act Amendments of 1965 (Public Law 89-97). The “Hospital Insurance Benefits for the Aged and Disabled,” also known as Medicare Part A, was created to provide partial funding for inpatient hospitalization and other institutional care. The second program, “Supplementary Medical Insurance Benefits for the Aged and Disabled,” also known as Medicare Part B, was created to provide additional financial support for noninstitutional costs, such as physician and other health care provider services. The Medicare Part B benefit was created as a voluntary program that required additional monthly premiums to be paid by the recipient.

Medicare established a third, managed care program option under the Balanced Budget Act of 1997 (Public Law 105-33) called “Medicare+Choice,” now referred to as “Medicare Advantage” or Medicare Part C. This program is optional for Medicare recipients if they choose not to use the traditional Medicare fee-for-service model (CCH Editorial Staff Productions, 2006).

The final Medicare option is the newly developed Medicare Part D, the “Voluntary Prescription Drug Benefit Program.” The prescription drug program became available to Medicare recipients in January 2006 (CCH Editorial Staff Productions, 2006).

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To be eligible for any of the Medicare programs, one must be 65 years of age or older and eligible for Social Security benefits, survivor benefits, or railroad retirement benefits. People under 65 are eligible for Medicare if they are entitled to Medicare through a disability or end-stage renal disease.
to Social Security or railroad disability benefits or if they have end-stage renal disease or amyotrophic lateral sclerosis benefits. Those who do not meet any of the aforementioned categories and are 65 years of age or older can opt into the Medicare program by paying a monthly premium for Part A (CCH Editorial Staff Productions, 2006).

**TYPES OF MEDICARE BENEFITS**

**Medicare Part A**
The Medicare Part A benefit includes inpatient hospitalization, inpatient rehabilitation, inpatient psychiatric care, long-term-care hospitals (LTCHs), skilled nursing facilities (SNFs), home health care, and hospice. Medicare Part A is paid in these settings under a specific set of rules. Reimbursement is based on a prospective payment system (PPS), which is a comprehensive payment system that has an established rate for an episode of care based on initial diagnoses and presenting problems. A standardized set of criteria or assessments is used to determine the patient-related problems and to translate the results into a payment rate. Reimbursement fees and rates are established by Congress and may vary or be adjusted annually.

It is important for practitioners to understand how their services are paid, so they can be knowledgeable care providers. In the PPS, occupational therapy practitioners should understand the balance between patient care and the costs associated with service delivery. For example, most supplies (reachers, dressing sticks, theraputty, splints) are bundled in the PPS rate. If we understand the financial implication of our services, we can advocate for our clients from a position of knowledge and appreciation of the payment system. The following sections review the different Medicare Part A settings where occupational therapy practitioners work.

**Inpatient Hospitals**
In 1983, the Medicare payment system dramatically changed. President Reagan signed into law the Medicare Prospective Payment System as defined in the Social Security Act Amendments of 1983 (Public Law 98-21). Before this law, hospital services were paid by the costs, or fee for services. The new law established a per-case per diem rate based on diagnostic categories called diagnosis-related groups (DRGs). The DRG bundled rate includes room and board; nursing services; medication and supplies; diagnostic services; and other services, including occupational therapy. This flat rate also includes supplies that occupational therapy practitioners may issue to patients, such as activities of daily living (ADL) or exercise supplies.

The Medicare Part A benefit allows for 90 days of hospitalization per “spell of illness.” The beneficiary pays a deductible for the first 60 days of inpatient per spell of illness, and a copayment is required for Days 61 to 90. Additionally, each beneficiary has 60 days “hospital lifetime reserve days,” which can be at any time. When a beneficiary chooses to use these days, there is a per-day copayment fee (CCH Editorial Staff Productions, 2006).

**Inpatient Rehabilitation Facilities**
Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation. Generally, patients receive 3 hours of combined therapy services (occupational therapy, physical therapy, speech-language pathology) a day plus other inpatient services. Beginning in January 2002, IRFs were required to follow a PPS. This program uses a per-discharge system based on case mix groups (CMGs), which are functional-related groups. A modified version of the FIM™ is used to assess the patient and assign the CMG. The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is used to determine the category. The instrument gathers information in nine key areas, including patient identification; demographics; medical information; patient safety; and patient functional abilities, including cognition. The IRF-PAI is completed twice during the patient’s stay, once on admission and again at discharge. These two combined assessments establish the payment (CCH Editorial Staff Productions, 2006).

IRFs also are faced with adhering to the “75% rule.” This rule requires that 75% of the patients in a cost-reporting year meet certain treatment categories (Medicare Program: Changes to the Medicare Claims Appeal Procedures, 2005). Some of these patients include those with stroke, spinal cord injury, amputations, multiple trauma, brain injury, and two major joints with severe osteoarthritis. Facilities had a 3-year phase-in period in which to comply with this regulation. Full implementation is expected for July 2007.

**Inpatient Psychiatric Facilities**
The Balanced Budget Refinement Act of 1999 created a new per diem PPS for inpatient psychiatric facilities. This system uses a standard base rate that is adjusted by various factors. This PPS uses the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes (Centers for Disease Control and Prevention & National Center for Health Statistics, 2006) (not Diagnostic and Statistical Manual of Mental Disorders, 4th ed. [American Psychiatric Association, 1994]) to establish the patient’s DRG. Adjustments to the payment rate are made based on age and for patients who have 1 or more of 17 comorbidities in addition to the diagnosed psychiatric condition. Payments also are adjusted based on length of stay. The highest day rate is the first day because of the number of assessments given. Payments from Days 2 through 21 are reduced, and further reductions are made from Day 22 onward (CCH Editorial Staff Productions, 2006).

**Long-Term-Care Hospitals**
LTCHs treat patients who are very clinically complex and need 25 or more days of skilled service. These patients have...
very acute or chronic conditions that require extended services, including rehabilitation, respiratory therapy, pain management, traumatic brain injury treatment, and close medical management. Payment is based on a DRG system on a per-discharge basis. The LTCH PPS also considers patient demographics, discharge status, principal diagnosis, and an additional eight diagnoses and six medical procedures in order to determine the rate. These all contribute to classifying the patient in 1 of more than 500 LTCH DRGs (CCH Editorial Staff Productions, 2006).

**Skilled Nursing Facilities**

Medicare defines specific criteria that a beneficiary must satisfy to receive the Medicare Part A benefit in an SNF. The beneficiary must (a) be referred by a physician, (b) have a 3-day qualifying stay in a hospital, (c) be admitted to the SNF within 30 days of the qualifying stay, and (d) require daily nursing or rehabilitation services at least 5 days a week. The Medicare Part A SNF benefit allows for 100 skilled days of service per spell of illness. The first 20 days of care do not cost the beneficiary. Days 21 through 100 require a beneficiary copayment. Any days beyond 100 are covered under Medicare Part B.

This PPS was introduced into the skilled nursing setting in 1998. Payment is based on a case mix–adjusted payment system. The Minimum Data Set (MDS 2.0) is used to screen multiple aspects of data on the patient (e.g., diagnosis, time spent in therapy, functional status, complicating medical factors, medication). All these elements contribute to the overall payment category. The payment categories are called Resource Utilization Groups (RUGs). The RUGs system has 53 payment categories, and rehabilitation is defined in the highest paying RUGs levels. This payment is based on the time spent in therapy services and the number of disciplines delivering services. The MDS 2.0 is completed at specific intervals during the patient’s stay in order to adjust the RUGs level and payment rate as appropriate.

**Home Health Care**

To qualify for the Medicare Part A home health benefit, the patient must be homebound; be under the care of a physician; and need skilled nursing or therapy services, which must be certified by a physician. The plan of care is reviewed and recertified every 60 days. The Medicare Part A home health benefit covers up to 100 visits per “spell of illness.”

For occupational therapy to be involved, a nurse, physical therapist, or speech-language pathologist must open the case. After the case is opened, occupational therapy can be a stand-alone skilled service and recertify the patient. The home health PPS began in October 2000. This PPS uses the Outcomes and Assessment Information Set (OASIS) to calculate payment rates. The OASIS gathers data on the patient’s discharge needs; ADL; living arrangements; support systems; equipment management; medications; diagnosed conditions; psychosocial status; and physical status, including sensory, skin, and neurological. Based on the data submitted from the OASIS, grouper software determines the appropriate Home Health Resources Group for payment. The OASIS is completed at specific Medicare-defined intervals to establish the payment rate. The Medicare Part A benefit does not have a deductible or copayment (Centers for Medicare & Medicaid Services [CMS], 2006b).

**Hospice Care**

Medicare Part A hospice care is a unique program intended for beneficiaries whose physicians have certified that they have a terminal condition with a life expectancy of 6 months or less. When a patient opts into the hospice program, he or she is agreeing to palliative care. Unlike many of the other Medicare Part A services, hospice care does not limit the number of days of the benefit. At any time a patient can choose to stop the hospice benefit and return to traditional Medicare. Hospice care offers numerous benefits to the patient and caregivers, including counseling, social services, pain control, home health aide services, homemaker services, medical supplies, inpatient respite care, and therapy services. Occupational therapy services are limited and generally related to comfort, safety, quality of life issues, and caregiver education and training.

Hospice services are based on a cost-related prospective payment. Payment rates are based on four categories: routine home care, continuous home care, inpatient respite, and general inpatient care.

**Medicare Part B**

Medicare Part B is the supplementary medical insurance program. This voluntary program usually requires the beneficiary to pay monthly premiums and a 20% copayment based on the Medicare physician fee schedule (MPFS). Medicare Part B covers outpatient occupational therapy, physical therapy, and speech-language pathology; physician visits; durable medical equipment (e.g., wheelchairs), prosthetics, orthotics, and supplies (DMEPOS); outpatient hospital services; outpatient mental health services; and clinical laboratory (e.g., blood tests) and diagnostic tests. Payments for occupational therapy services are based on the MPFS. The MPFSs and coding are discussed later in more detail.

Outpatient occupational therapy services are provided in various settings (CMS, 2006d), including:

- Private practice: Occupational therapist private practitioners (OTPPs) are required to have a National Provider Identifier number to bill for services
- Clinic, rehabilitation, or public health agencies
- Hospital outpatient clinics
- SNFs: Services are provided for beneficiaries who have exhausted the Medicare Part A benefit or are residents of the facility who did not have a 3-day qualifying hospital stay.
- Physician office: Therapy incident to physician services or
as OTPPs in physician groups.

- Home health care: This includes visits over the 100-day Part A limit or when the patient does not meet the home health Part A benefit criterion.

- Comprehensive outpatient rehabilitation facilities (CORFs): CORFs provide a wide range of comprehensive and coordinated rehabilitation services. At a minimum, these include physician, therapy, and psychosocial services.

Medicare Part C
The Medicare Advantage Plan (also referred to as Medicare Part C) replaced the Medicare+Choice program in 2006. Medicare assigns contracts to private insurance companies to manage the beneficiary’s Medicare benefits. These plans include both Medicare Part A and Medicare Part B services and many include a prescription medication benefit. Often, the copayment for services under a Medicare Part C plan are lower for the beneficiary. However, these insurance companies also are gatekeepers of service delivery and may require prior approval before services are rendered, limit the beneficiary to a specific network of providers, or both.

The new Medicare Advantage Plan includes the following options: Medicare preferred provider organizations, Medicare health maintenance organizations, Medicare private fee-for-service, Medicare Special Needs Plan, and Medicare medical savings account (CCH Editorial Staff Productions, 2006). Occupational therapy practitioners must effectively communicate with these plan providers. We need to identify the skilled services we provide and how these services will benefit the patient. Resources such as the Medicare National Coverage Determinations (i.e., the procedures and services Medicare will cover) (CMS, 2006e), The American Occupational Therapy Association’s (AOTA’s) Scope of Practice (2004), and the evidence-based practice resources on the AOTA Web site (www.aota.org) can be used to explain occupational therapy and the effectiveness of the services we offer.

Medicare Part D
Medicare Prescription Drug Coverage (Medicare Part D) is an optional program for beneficiaries. There are two ways to receive this benefit. First, the beneficiary can opt into a Medicare Part C program that offers a medication benefit. Second, the beneficiary can opt to enroll in the Medicare Part D program, which generally requires a monthly premium. More information on the Medicare Prescription Drug Coverage program can be found at the Medicare Web site (www.medicare.gov) or by calling 1-800-MEDICARE.

Medicare Supplemental Insurance
Medicare supplemental insurance, commonly referred to as Medigap, is additional private insurance that covers certain Medicare deductibles, copayments, and out-of-pocket expenses. This private insurance is federally regulated by Congress to avoid fraud or abuse of those beneficiaries they insure. The costs in any Medigap Plan A through L are the same for any insurance company; however, the costs to the beneficiary may vary (CMS, 2006a).

PHYSICIAN FEE SCHEDULE AND CODING
Medicare Part B occupational therapy services are reimbursed under the Medicare PFS. The PFS sets the payment for each billing code. Legislation established a payment system for services delivered across service providers based on geographic regions. The Resource Based Relative Value Scale is the system for measuring physician and provider input in medical services for the purpose of calculating a PFS. The relative value unit (RVU) is the standard for measuring the value of medical services provided by the health care provider compared with other medical services provided by other health care providers. The RVU for each service has three components: work, practice, and malpractice. The work component represents skilled time spent for setting up, preparing for, and delivering the service. For occupational therapy codes, this component represents 55% of the total code value. Considerations in defining the work component value include the technical skill and physical effort (skill, education, scope of practice intervention), mental effort and judgment (the complexity of the medical diagnosis, possible treatment options, medical urgency), and psychological stress (the risk of significant complications, morbidity, mortality). The practice component makes up approximately 40% of the total code value. The practice component includes overhead expenses of providing the service—including calculations for rent, utilities, office staffing, and equipment and supplies—that might be apportioned to the delivery of service. The malpractice component represents professional liability coverage, which is very low in therapy codes.

To establish the PFS (code value), the RVUs (for work, practice, and malpractice expenses) are each multiplied by a geographic adjustment factor (GAF) and the national uniform Medicare conversion factor (CF). The GAF makes adjustments for geographic location, and the CF converts the geographically adjusted RVUs to a dollar amount, with considerations for inflation. The Medicare PFS can be found on the CMS Web site (www.cms.hhs.gov/PhysicianFeeSched).

Occupational therapy practitioners must bill for Medicare Part B services using Current Procedural Terminology (CPT™) coding. CPT codes are used to describe the clinical contact between the patient and treating clinician. In 1983, CMS adopted CPT coding into a system called Healthcare Common Procedural Coding System (HCPCS), which contains two types of codes: Level I identifies CPT codes, and Level II represents supplies and equipment. The Level I CPT codes that CMS accepts are divided into six major categories; occupational therapy practitioners primarily use the Medicine/Physical Medicine and Rehabilitation section codes.

CPT codes are described as timed or nontimed codes. For codes calculated by time, the practitioner must consider the
time spent in that procedure when billing the service. An example of timed codes includes self-care/home management and/or training (97535), neuromuscular reeducation (97112), and contrast bath (97034)*. For nontimed codes, only one unit per day can be billed by the occupational therapy practitioner, regardless of the total time spent in providing that service. An example of nontimed codes includes occupational therapy evaluation (97003), occupational therapy reevaluation (97004), and unattended electrical stimulation (GO283)*.

When billing Medicare Part B, it is essential to adhere to the billing guidelines, especially knowing and understanding the billing requirements and proper application of the “8-minute rule” (see Table 1). All the time spent delivering timed codes are aggregated. The aggregated time will establish how many units of timed codes can be billed. Units are assigned based on the codes you spent the most time providing. For examples and further instructions for assigning units, refer to Chapter 5 of the Medicare Claims Processing Manual (CMS, 2006c).

Medicare requires the practitioner to record the total amount of time spent providing timed codes. The units billed for timed codes must be consistent with the amount of time spent in service. Medicare also requires the practitioner to record the total amount of time spent delivering both timed and nontimed services. Medicare regulations do not require the therapist to record the amount of time spent delivering each CPT code, just the aggregated time (CMS, 2006b).

To avoid inappropriate billing of bundled codes, CMS implemented a policy in 1996 known as the Correct Coding Initiative (CCI). The purpose of the CCI is to develop correct coding methodologies to curtail improper “ unbundling” of services for Medicare Part B claims. The CCI applies “ edits” that are used to review claims and to identify potential misuse and inappropriate billing of code pairs. Beginning January 1, 2006, CCI edits applied to all providers billing Medicare Part B. CCI edits are applied to services billed by the same provider for the same beneficiary on the same date of service. If you are billing in an SNF, a CORP, or a rehabilitation agency using a single provider number for all therapies, the edits will apply among disciplines (occupational therapy, physical therapy, speech-language pathology). For example, if you work in an SNF and the physical therapist provides gait training (97116) to Mrs. Smith on the same day the occupational therapist provides her with therapeutic activities (97530), these codes are edited and the physical therapist would need to modify the gait training code (97116) to get paid. Based on the CCI edit rules, a modifier (“-59”) can be applied to the code when services are distinctly different and permitted to be billed together. The previous example is a good demonstration of two codes billed on the same day using the modifier -59. If you are the sole provider as an independent practitioner using your own provider number, other discipline services do not influence your coding. Therapeutic activities (97530) and self-care/home management (97535) are examples of codes that are considered bundled under the CCI edit rules. For these codes to be billed together on the same day, they need to be provided at separate time intervals that were distinctly different. For example, a patient might receive therapeutic activities (97530) for balance training from 1:00 p.m. to 1:15 p.m. and then participate in self-care/home management (97535) for lower-body dressing using adaptive equipment from 1:15 p.m. to 1:45 p.m. These services were distinctly different and can be billed together using the -59 modifier on self-care/home management (97535). It is important to know the CCI edits because some codes can never be billed together on the same day. For example, OT evaluation (97003) and OT re-evaluation (97004) can never be billed together on the same day; only one of the two codes would be paid (OT re-evaluation, 97004).

CMS updates the CCI edits code pair list every quarter. CCI edits are available at no cost by downloading them from the CMS Web site (www.cms.hhs.gov/physicians/cciedits/default.asp). Note that there are two different types of National Correct Coding Initiative (NCCI) edits based on the practice setting. OTPPs use the NCCI Edits for Physicians. Other practice settings use the NCCI Edits for Hospital Outpatient Prospective Payment System. For more information on understanding and applying CCI edits go to www.cms.hhs.gov/NationalCorrectCodInitEd.

The second type of coding used to bill for services is HCPCS Level II, which are alpha-number codes that include equipment and supply codes for dressings (A codes), DME (E codes), orthotics or prosthetics (L codes), and G codes (e.g., unattended electrical stimulation, GO283). To use the L codes for billing orthotics, the OTPP or practice setting must be a Medicare DME provider with an approved number. Recently, Medicare has required that all suppliers of DME, prosthetics, and orthotics must obtain accreditation by an approved accreditation organization to obtain reimbursement under Medicare Part B.

**LIMITATIONS ON THERAPY SERVICES**

The Balanced Budget Act of 1997 placed annual financial limitations on therapy services, known as the “therapy caps.”

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**Table 1. Counting Minutes for Timed Codes in 15-Minute Units**

<table>
<thead>
<tr>
<th>Number of Units</th>
<th>Number of Minutes</th>
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<tbody>
<tr>
<td>1</td>
<td>≥ 8 through 22</td>
</tr>
<tr>
<td>2</td>
<td>≥ 23 through 37</td>
</tr>
<tr>
<td>3</td>
<td>≥ 38 through 52</td>
</tr>
<tr>
<td>4</td>
<td>≥ 53 through 67</td>
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<tr>
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*Note: From CMS (2006b).*

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**Earn .1 AOTA CEU** (one NBCOT PDU / one contact hour, see page CE-7 for details)
The therapy caps were in effect in 1999, and briefly in both 2003 and 2006. The therapy caps apply to all Medicare Part B settings except outpatient hospitals, which are exempt by law. In February 2006 Congress passed the Deficit Reduction Act of 2005 (Public Law 109-171), allowing patients to receive services beyond the $1,740 limitation if they meet specific criteria. This exception process is either automatic by using a modifier (KX) on the claim when it is billed, or manual, which requires written communication with the contractor for approval.

On December 7, 2006, after significant lobbying efforts by the therapy community and other stakeholders, the therapy cap exception process was extended to apply from January 1, 2007 to December 31, 2007, through a provision in H.R. 6111, the Tax Relief and Health Care Act of 2006. As of January 1, 2007, the annual financial limitation will be $1,780 for occupational therapy services.

**MEDICARE DOCUMENTATION**

To qualify for occupational therapy services under the Medicare benefit, services must be medically necessary. Each of the Medicare provider settings (e.g., SNF, home health, inpatient hospitalization, outpatient) may have some unique requirements for medical necessity or for documentation; however, many of the criteria are similar. Medicare Part B has the most prescriptive requirements for documentation, which have been revised several times in the past year. For the most current requirements, refer to Chapter 15 of the Medicare Benefit Policy Manual (CMS, 2006b).

In all cases, the patient must have a condition that requires the skills of a therapist. The patient is under the care of a physician who certifies and recertifies the plan of care. A qualified person (e.g., a person qualified to provide occupational therapy services in that given state) must provide services. The intervention is within an accepted standard of practice for occupational therapy. Services are provided within a reasonable frequency, intensity, and duration for the condition. There is an expectation that the patient will improve in a reasonable amount of time.

It is important that as practitioners we clearly document the patient’s previous level of functioning, current medical condition, functional limitations, and how skilled occupational therapy services are necessary to return the patient to his or her highest practicable level of functioning. Do not assume that the medical reviewer understands the level of sophistication of our skilled services. Use the following AOTA materials to support that the services you are providing are within the standard of practice for your profession: standards of practice for occupational therapy, practice guidelines, specialized knowledge and skills papers, and evidenced-based practice resources. Clearly document the progress the patient is making toward his or her goals and the remaining functional limitations and skilled therapy needs. Present a clear and concise picture of the patient and the occupational therapy services.

Documentation requirements may vary slightly; however, in general an evaluation and plan of care, certification and recertification, progress notes, and encounter notes are necessary (Brennan & Robinson, 2006). A treatment encounter note is written after each occupational therapy treatment session. Medicare requires documentation for every treatment day; at a minimum, this documentation identifies the skilled service provided and the identity of the qualified professional (therapist, assistant) providing the service. For more information on documentation, refer to your practice setting’s chapter of the Medicare Benefit Policy Manual; Medicare Part B outpatient services requirements are found in Chapter 15 (CMS, 2006b).

**MEDICARE CONTRACTORS AND DENIALS MANAGEMENT**

Medicare has private insurance organizations that administer and pay Medicare claims. Currently, Medicare Part A claims generally are administered by fiscal intermediaries; however, home health care is managed by regional home health intermediaries. OTPPs, rehabilitation agencies, and outpatient rehabilitation facilities are billed under Medicare Part B, which is administered by a Medicare carrier. DMEPOS are billed under Medicare Part B DME regional carriers. By September 2011, Medicare administrative contractors will replace all fiscal intermediaries and carriers; once this change is completed, there no longer will be a distinction between Medicare Part A or B contractors.

Medicare contractors use Medicare program manuals to help guide medical review. In addition to these manuals, contractors use their own guidelines for medical review called local coverage determinations. To be proactive in the medical review process, know the Medicare program manual for your practice setting, Medicare National Coverage Decisions (CMS, 2006e), and review your Medicare contractor’s local coverage determinations. Medicare redesigned the claims appeal process in 2005; now the claims process is largely the same for both Medicare Part A and Medicare Part B. There are specific time frames for response for each level of appeal; therefore, it is essential to respond immediately to an additional development request and timely to all levels of the appeals (Medicare Program: Changes to the Medicare Claims Appeal Procedures, 2005). For more information on documentation and the denial process, refer to Brennan and Robinson (2006).

**FUTURE CHANGES**

Medicare rules and regulations are changed or modified frequently. Some changes on the horizon include return to the therapy cap; pay for performance; competitive bidding; suppliers of DMEPOS accreditation; and therapy certification for power wheeled mobility devices. To follow these issues and other possible changes, refer to the Reimbursement page on the AOTA Web site for up-to-date information and resources (www.aota.org/members/area5/links/link01.asp).
CONCLUSION
Occupational therapists and occupational therapy assistants work in the majority of settings that service Medicare beneficiaries. These various Medicare programs cover more than 42 million individuals. Each of these programs has its own set of rules, regulations, and requirements. By understanding these requirements we can better serve and advocate for our patients and our profession. Legislation establishes and drives the Medicare rules, and as practitioners we must be proactive by communicating with our congressional representatives about issues and concerns regarding Medicare and other related health care legislation. In addition, we must be proactive in advocating for Medicare coverage of the full scope of occupational therapy practice with CMS and its contractors.

ACKNOWLEDGMENTS
I thank the following individuals for their review and contributions to the content of this article: Cathy Brennan, MA, OTR/L, FAOTA; Sharmila Sandhu, Esq.; and Judy Thomas, MGA.

REFERENCES

RESOURCES
Publications
Medicare contractor: www.cms.hhs.gov/apps/contacts
CCI Edits Quarterly Updates
National Correct Coding Initiative Edits (Carrier = OTPP, PTPP, and physicians) www.cms.hhs.gov/physicians/cciedits/default.asp
National Correct Coding Initiative Edits Hospital Outpatient Prospective Payment System http://www.cms.hhs.gov/providers/hopps/cciedits/default.asp

Physician Fee Schedules (CPT codes) http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage

Orthotics/Durable Medical Equipment Regional Carriers Fee Schedule http://www.cms.hhs.gov/center/dme.asp

NEW ELECTRONIC EXAM: Immediate Results and Certificate

How To Apply for Continuing Education Credit:
1. After reading the article Medicare 101: Understanding the Basics, answer the questions to the final exam found on p. CE-8 by registering to take them online and receive your certificate immediately upon successful completion of the exam. You can still complete the exam by darkening the appropriate boxes in Section B of the Registration and Answer Card, which is bound into this issue of OT Practice following the test page. In either case, each question has only one answer.
2. To register click on www.aota.org/cea or call toll-free 877-404-2082. Once you are registered, you can log on to www.aota-learning.org to take the exam online. If you are using the Registration and Answer Card, complete Sections A through D and return the card with the appropriate payment to the address indicated.
3. There is a nonrefundable processing fee to score the exam, and continuing education credit will be issued only for a passing score of at least 75%. Use the electronic exam and you can print your official certificate immediately if you achieve a passing score. If you are submitting a Registration and Answer Card, you will receive a certificate within 30 days of receipt of the processed card.
4. The electronic exam must be completed by February 28, 2009. The Registration and Answer Card must be received by February 28, 2009, in order to receive credit for Medicare 101: Understanding the Basics.
Final Exam

MEDICARE 101: UNDERSTANDING THE BASICS
February 19, 2007

Learning Level: Intermediate
Target Audience: Occupational Therapist and Occupational Therapy Assistants
Content Focus: Category 3: Professional Issues, Legal, Legislative, & Regulatory Issues

Register for the electronic exam and certificate online at www.aota.org/cea, call toll-free 877-404-2682, or use the Registration and Answer Card bound into this issue of OT Practice following the test page.

1. Medicare is the largest health care payer in the United States.
   A. True
   B. False

2. Congress established Medicare in Title XVIII of the Social Security Act of ___?
   A. 1941
   B. 1950
   C. 1965
   D. 1970

3. Which of the following does not follow the Medicare Part A program?
   A. Inpatient hospitals
   B. Occupational therapist private practitioners (OTPPs)
   C. Home health
   D. Inpatient rehabilitation facilities

4. OTPPs follow Medicare program
   A. Part A
   B. Part B
   C. Part D
   D. None of the above

5. The first Medicare PPS was:
   A. Inpatient (acute) hospitals (DRG)
   B. Inpatient rehabilitation facilities (IRF-PAI)
   C. Home health care (OASIS)
   D. CPT coding

6. Medicare Part B is an optional program.
   A. True
   B. False

7. Medicare Advantage Plan includes coverage for
   A. Medicare Part A
   B. Medicare Part B
   C. Medicare Parts A & B
   D. Medicare Prescription Drug Plan only

8. When billing Medicare Part B outpatient occupational therapy services, use the following to record and bill your service:
   A. CPT codes
   B. PPS categories
   C. ICD-9 codes
   D. None of the above

9. The following policy is used to prevent unbundling of CPT codes:
   A. KX modifier
   B. CCI edits
   C. ICD-9 codes
   D. None of the above

10. Which of the following describes elements of occupational therapy documentation?
    A. An evaluation/plan of care
    B. Physician involvement
    C. Encounter notes
    D. All of the above

11. Medicare contractors develop guidelines for paying services; these guidelines are:
    A. National coverage determinations
    B. Local coverage determinations
    C. Regulations
    D. None of the above

    A. True
    B. False
III. Context for Medicare Payment Policy
Context for Medicare payment policy

Chapter summary

Medicare and other purchasers of health care in our nation face enormous challenges for the future. As growing health care costs challenge individuals and private and public payers, quality frequently falls short of patients’ needs. The Commission has recommended a number of measures to increase the value of care, such as pay for performance, measuring resource use, and comparative effectiveness. The increasing spending and variation in use and quality of care in the current system suggest that opportunities exist for reducing waste and improving quality for beneficiaries, but realizing them requires addressing the myriad factors that drive the current health care system.

Another difficult challenge relates to financing. As is true for other purchasers of health care, Medicare’s spending has been growing much faster than the economy. Our substantial national income, the availability of newer medical technologies, and health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending higher. Medicare will have the additional challenge of higher enrollment associated with retiring
baby boomers, which will affect program spending as well as the demand for federal resources for other programs that benefit the elderly, such as Social Security and Medicaid.

Because of these forces, the Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing. Projected levels of spending could also impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing.

The program’s shaky financial outlook is a strong impetus for change. As is true for other purchasers of health care services in the United States, Medicare’s spending is growing much faster than the U.S. economy. In addition, CMS began Medicare’s new outpatient prescription drug program, Part D, in 2006. This program added an important benefit to Medicare but greatly expanded the program’s need for resources. Finally, the leading edge of the baby boomers will become Medicare beneficiaries after 2010, which will also accelerate Medicare spending. These factors will lead Medicare to require an unprecedented share of our gross domestic product.

Moreover, because of the retirement of the baby boom generation, other federal programs such as Social Security and long-term care services financed through Medicaid will require greater resources at the same time that Medicare spending expands. Some analysts point out that growth in our nation’s economy has historically been large enough to finance expansion of both health and nonhealth spending (Chernew et al. 2003). Other analysts disagree, saying long-term economic growth alone will not be sufficient to bring the country’s fiscal position into balance (Bernanke 2007). According to this point of view, fiscal stability will likely require a sizable slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation’s economy (CBO 2005).
Addressing a challenge of this magnitude will require an extended effort, and analysts have urged policymakers to take immediate action to address Medicare’s finances. They argue that major changes to these programs should be phased in to allow beneficiaries, providers, and taxpayers time to adapt to major alterations. However, Medicare’s financial challenge is already growing more acute. For example, in 2004, expenditures for the Hospital Insurance trust fund, which funds inpatient stays and other post-acute care, began to exceed its annual income from taxes. Since 2004, Part A has remained solvent due to existing trust fund balances and interest income. As cost inflation continues to outstrip revenue and the retirement of the baby boom generation begins, the time for phasing in major changes is growing shorter.

Examining Medicare in a broader context is useful for understanding the choices facing policymakers. This chapter begins with a review of Medicare eligibility and financing and then discusses the factors that are increasing spending for Medicare and the health care system.
Introduction

Medicare fills a critical role in our society—ensuring that the elderly and disabled have access to medically necessary care. Along with other payers in our health care system, the program has helped to finance important strides in medical technology. For the sake of its beneficiaries, we must preserve those aspects of the Medicare program. However, Medicare is not unique in struggling to control costs and improve quality. While Medicare is unique in its financing and eligibility relative to other health care programs, many of the factors that increase spending for other health care payers also increase Medicare spending (Aaron 2007).

Eligibility and financing for Medicare

Medicare shifted much of the financial liability for health care spending from the elderly to taxpayers through a hybrid system with three major parts—A, B, and D—that had different eligibility requirements and different financing mechanisms.1

Part A, the Hospital Insurance (HI) program, covers stays in hospitals and skilled nursing facilities, hospice care, and some home health care. The Congress designed Part A as a compulsory social insurance program tied to employment in work covered by Social Security, currently financed through a dedicated 2.9 percent payroll tax. Part A essentially finances health care expenses through payroll taxes on current workers, with the promise of future benefits to those workers.

The Congress also established Part B, Supplementary Medical Insurance (SMI), covering services such as physician visits and outpatient hospital care. Part B is voluntary and available to anyone aged 65 or older. Beneficiary premiums finance about 25 percent of Part B program spending, and general revenues finance the remainder, which currently requires about 10 percent of all personal and corporate income tax revenue. Beneficiaries also pay cost-sharing requirements for a portion of their services, described in the following section.

In 2006, the Medicare prescription drug benefit, known as Part D, began operation. Like Part B, the drug benefit is voluntary and funded through a mixture of beneficiary premiums and a general fund contribution. Premiums cover about 11 percent of Part D costs, and the general fund pays for about 78 percent of spending. States make payments to offset some of the costs of their Medicaid-eligible beneficiaries who receive Part D benefits.

Beneficiaries may opt to receive their benefits through private plans that have contracted with Medicare under Part C, also known as Medicare Advantage. Payments to these plans are funded through the HI and SMI trust funds. Beneficiaries must be eligible for both Part A and Part B to enroll in Medicare Advantage.

Most beneficiaries become eligible for Medicare when they turn 65, but there are two major exceptions. Individuals who qualify for disability payments from the Social Security disability program are eligible for Medicare after they complete a 24-month waiting period. Individuals with end-stage renal disease are eligible regardless of age.

Benefit design and cost sharing

Medicare places some financial responsibility for health spending on beneficiaries through cost-sharing requirements at the point where they receive medical services. Medicare’s original benefit package left certain services uncovered; for example, until 2006 Medicare did not cover outpatient prescription drugs. These factors have led most Medicare beneficiaries to obtain supplemental coverage, primarily through individual medigap policies or employer-based retiree coverage. Medicaid provides supplemental coverage for lower income Medicare beneficiaries.

The proportion of spending for Medicare-covered services paid through cost sharing has remained fairly stable. Part A cost-sharing requirements generally increased at the same rate as payment updates for Part A services. Cost sharing for many Part B services is proportional to allowed charges (typically 20 percent coinsurance).2 Before 2005, lawmakers rarely increased Part B’s annual deductible. However, in 2005 they raised it to $110, and it now increases at the same rate as growth in Part B spending per person (in 2008, the deductible is $135).

Most Medicare beneficiaries have supplemental coverage to fill in some or all of Medicare’s gaps in cost sharing and coverage. In 2004, about 91 percent of Medicare beneficiaries obtained supplemental coverage through former employers (33 percent), medigap policies (26 percent), Medicare Advantage plans (13 percent),
Medicaid (17 percent), or other programs (2 percent) (MedPAC 2007). Supplemental coverage often allows enrollees better predictability of their out-of-pocket spending. In return for paying an annual premium, beneficiaries receive supplemental coverage, such as medigap policies, that reduces their cost sharing to zero or nearly zero from the time they begin using health services each year.

Some protection against high out-of-pocket spending is desirable, but such coverage may reduce beneficiaries' sensitivity to costs. Individuals with supplemental coverage tend to use services more than those with similar health status and no supplemental coverage. One estimate based on data from the mid-1990s suggests that Medicare spending ranges from 17 percent higher for those with employer coverage to 28 percent higher for those with medigap policies (Christensen and Shinogle 1997). Other analysts believe that when supplemental coverage encourages beneficiaries to adhere to medical therapies that prevent hospitalizations or the use of other services, higher levels of Medicare spending may be more modest than this (Chandra et al. 2007). However, while many supplemental plans cover all or nearly all of Medicare’s cost-sharing requirements, they do not cover medical services that have better evidence of preventing hospitalizations any more selectively than they cover services that tend to be used inappropriately. Another line of research suggests that the responsiveness of beneficiaries to cost sharing is varied, and the effects of supplemental coverage are more modest for individuals in poorer health (Remler and Atherly 2003).

Policymakers created the Medicaid program at the same time as Medicare to address the health care needs of low-income individuals. The federal government, along with the states, assumes nearly all the cost of health care for beneficiaries who meet means and asset tests, and the federal share is financed with general revenues (like Part B). The presence of Medicare and Medicaid creates certain challenges for serving individuals eligible for both programs (called dual eligibles). Federal and state policy goals for the programs sometimes conflict, and current policies toward dual eligibles create incentives to shift costs between payers, often hinder efforts to improve quality and coordinate care, and may reduce access to care (MedPAC 2004a). Medicaid has become the primary public payer for long-term care, with many beneficiaries gaining eligibility and qualifying for benefits through medical indigence (Moore and Smith 2005). The intersection of the two programs’ payment policies has created particular problems related to shifting costs among payers for beneficiaries’ post-acute and long-term care needs.

There are myriad federal programs, some funded through Medicaid, to help low-income beneficiaries with their Medicare costs, such as the low-income drug subsidy (LIS) and the Medicare Savings Programs. These programs help beneficiaries pay their premiums and, in some cases, their copays and deductibles. Eligibility for these programs is based on income and assets. Despite the protection these programs offer, only a fraction of eligible beneficiaries enroll in them. For example, despite considerable publicity, participation for LIS remains limited. As of January 2007, about 9.5 million beneficiaries were receiving the drug subsidy. Of these, about 7 million were deemed automatically eligible because they were dual eligibles (Kaiser Family Foundation 2007). Another 2.3 million, or 17 percent of the eligible population, applied for LIS and were found eligible by the Social Security Administration. Of those beneficiaries not automatically enrolled in LIS, the National Council on Aging estimates that between 35 percent and 42 percent of those eligible have enrolled. A number of concerns, including complex program requirements, lack of awareness of the program, and the challenges of communicating with hard-to-reach populations, have been faulted as hindering enrollment (see Chapter 5 for discussion of Medicare programs for low-income enrollees).

**Today’s concerns about Medicare**

As is true for other purchasers of health care, Medicare’s spending is growing much faster than the economy (Figure 1-1). Projections of continued rapid growth in spending in the health care system combined with the retirement of the baby boom population foreshadow accelerated growth in Medicare outlays in 2010 and beyond. At the same time, the Medicare program spends widely different amounts per beneficiary across geographic regions, much of which can be attributed to differences in practice patterns rather than to differences in underlying health status. There are also wide geographic disparities in the quality of care beneficiaries receive, with no relationship or a negative relationship between quality of care and spending (Fisher et al. 2003).
Projections of Medicare’s long-term financing needs

In their most recent report, the Medicare trustees project that the assets of the HI trust fund will be exhausted in 2019. Income from payroll taxes collected in that year would cover 79 percent of projected benefit expenditures. In the future, the share of benefit expenditures covered by payroll tax collections would fall as health care cost inflation exceeds growth in payroll; by 2080, payroll tax collections at current levels would cover only 29 percent of projected Part A expenditures. Medicare will have no authority to pay the remainder of Part A benefits due. The SMI trust fund is financed automatically with general revenues and beneficiary premiums, but the trustees point out that SMI financing would have to increase sharply to match the expected growth in spending. Such rapid growth would have repercussions on beneficiaries as well as on the availability of funds for other federal priorities.

The status of Medicare trust funds does not give a complete picture. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D (see text box, pp. 10–11). The trustees project that dedicated payroll taxes will make up a smaller share of Medicare’s total revenue and that a large deficit between spending for Part A (HI) and revenue from dedicated payroll taxes will develop (Figure 1-2, p. 12).

To finance the projected deficit through 2080, the trustees estimate that Medicare’s payroll tax would need to increase immediately from 2.9 percent to 6.44 percent of GDP (gross domestic product). These projections are based on the trustees’ intermediate set of assumptions.
In making long-term projections of Medicare’s costs, a critical assumption is the growth rate in program spending per person, exclusive of impacts due to the changing age and gender mix of the population. Growth rates vary depending on the time period for which one calculates them. Nevertheless, on average, real rates of increase in our nation’s health expenditures have risen faster than real growth in the economy over the past six decades (2004 Technical Review Panel on the Medicare Trustees Report).

Before their 2001 report, the Medicare trustees assumed that long-range spending would grow at about the same rate as gross domestic product (GDP) per person, in recognition of the practical inability of growth in health spending to exceed economic growth indefinitely. This assumption was adopted in the mid-1980s (when 75-year projections were first included in the annual trustees report) as a way to highlight the long-term impact of demographic changes on Medicare costs, and the assumption was found to be “not unreasonable” by the independent 1992 Medicare Technical Review Panel. In recognition of the continuing significant growth differential, however, the Medicare trustees asked the 2000 Medicare Technical Review Panel to consider this assumption. The 2000 panel recommended that the trustees assume that long-range Medicare program spending per person would grow at a rate of GDP plus 1 percentage point, excluding effects resulting from the population’s age and gender mix (which they model separately). The panel arrived at this unanimous recommendation after consideration of several different approaches and based the assumption principally on the expected ongoing effects of new medical technology. Their recommendation was adopted by the Medicare Boards of Trustees in 2000 and again in 2001 and was first implemented with the 2001 annual report. The 2004 Medicare Technical Review Panel concurred with its continued use. Both expert panels also recommended further research into the relationship between the health sector and the overall economy and how this relationship would change in the future.

For their 2006 report, the Medicare trustees refined their assumptions based on an economic model developed by the Office of the Actuary at the Centers for Medicare & Medicaid Services. This model incorporates the expected future societal trade-off between health care and nonhealth consumption, as the cost of health care continues to require a growing share of national income. It also reflects the potential for new medical technology to reduce costs versus continuing (on average) to increase costs. The new approach was reviewed and approved by an independent panel of health economists and actuaries and was adopted as a minor refinement of the “GDP + 1 percent” assumption. (Because the model parameters could not be uniquely estimated based on past data, they were selected to be consistent with calculations of 75-year Hospital Insurance actuarial balances under an assumption of growth rates of GDP plus 1 percentage point.)

The key impact of the new forecasting model is a more gradual transition from current rates of growth to an assumption that Medicare growth rates ultimately will equal GDP growth. For example, the model projects that per capita growth rates in Medicare spending for 2030 will be 1.4 percentage points above GDP growth, declining gradually to GDP plus 0.8 percent in 2050 and to about GDP plus 0.2 percent in 2080 (Boards of Trustees 2007). The Medicare Trustees anticipate that cost growth will be slowed, even in the absence of legislative changes, by factors such as private and public health plans’ limits on payment for new technology, individuals’ ability to afford health care

earned income, or HI spending would need to decrease immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts in spending. The premiums and general revenues required to finance projected spending for SMI services could impose a significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at the historical average share of the economy, the Medicare trustees estimate that the SMI program’s share of personal and corporate income tax revenue would rise from 11.4 percent today to 25 percent by 2030. For beneficiaries,
insurance premiums or cost-sharing payments, and a greater focus by payers, physicians, and other providers on more efficient, outcome-oriented practice standards.

The Congressional Budget Office (CBO) has developed an alternative projection of long-term spending that has a higher assumption about the long-term rate of excess growth (CBO 2007). CBO’s projection includes all health care spending, both public and private sector, and it uses the same approach for modeling excess growth in these sectors. Between 2008 and 2017, the projection follows the spending for Medicare and Medicaid that CBO uses for its budget baseline. After 2018, CBO’s projection assumes the rate of excess growth will gradually slow to prevent a decline in real per capita spending for non-health care goods and services. In effect, the projection assumes that consumers will allow excess growth to continue at the historical rate as long as it does not reduce income by so much that they have to reduce the consumption of non-health care goods in real terms.

CBO’s projections assume that the private sector will begin to act to curb excess growth as it threatens to shrink per capita non-health care spending. The projection does not assume implementation of any particular set of reforms to slow growth, but the assumption is that payers, providers, and consumers will begin to behave in a more cost-sensitive manner in the face of higher costs. For example, plans may raise cost sharing or limit the services they cover. Some of these changes may spur health care providers to change their practice patterns. The net effect of these changes would be to slow health care spending so it does not reduce the inflation-adjusted level of spending for non-health care goods. Under this assumption, per capita excess growth for the private sector and federal programs besides Medicare and Medicaid would decline from 2 percent in 2018 to 0.1 percent in 2082.

The projection assumes that a “spillover effect” from the slowdown in private sector excess growth, increases in beneficiary cost sharing, and regulatory action by Medicare will curb costs in the future, but that excess growth will fall at a slower rate compared with that for private payers. Specifically, for Medicare the decreases in excess growth will be equal to a quarter of the size of the decrease for non-Medicare and non-Medicaid health care spending. CBO assumes a smaller decline for Medicare because the private sector should have more flexibility to implement major changes, and CBO did not assume that legislative changes that reduce Medicare spending would occur. Consequently, the rate of excess spending will not fall by the same amount as the rest of health care spending. Over the period from 2018 to 2082, CBO assumes excess growth will decline from 2.4 in 2018 to 1.1 in 2082. CBO’s projections, by assuming that consumers will not allow real non-health care spending to decline, reflect one estimate of a spending slowdown. However, even with this slower rate, CBO finds that Medicare spending as a percentage of GDP could grow from 3 percent in 2018 to almost 17 percent in 2082.

Compared with the trustees’ methodology, CBO’s methodology produces a higher rate of excess growth for Medicare in the long run, with an average of 1.7 percent for 2018 to 2082. The differences between the two projections materialize gradually, and the two projections have nearly identical spending projections through 2037. Over 75 years, however, the CBO projection is higher. In 2082, Medicare spending as a percentage of GDP equals about 11 percent under the trustees’ projection, while in CBO’s projection it will be about 17 percent.

The 45 percent trigger

Medicare’s problems with long-term financing will become more visible to policymakers over the next few years because of a warning system established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) known as the 45 percent trigger. Lawmakers included this provision to

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even though Part D now covers a portion of their spending on prescription drugs, growth in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some; in 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level (MedPAC 2007).³
spark debate on balancing national priorities between Medicare and other uses for general revenue financing.

Each year, the Medicare trustees are required to project the share of Medicare outlays that are financed with general revenues in the current and six succeeding fiscal years. Under the warning system, if two consecutive annual reports project that general revenue will fund 45 percent or more of Medicare outlays in any year of the seven-year projection window, then the President must propose and the Congress must consider legislation to bring Medicare’s spending below this threshold. However, the provision does not require the Congress to pass legislation. In their 2006 report, the Medicare trustees projected that the program would hit this 45 percent trigger in 2012, the last year of the seven-year window (Boards of Trustees 2006). The trustees released a similar finding for their 2007 report, so policymakers will need to consider changes to Medicare’s benefits, payments, and financing by the spring of 2008.

The trigger has been criticized as an arbitrary mechanism that limits options for responding to Medicare’s financial problems (Moon 2005). For example, it is not clear why limiting Medicare’s general fund contribution to 45 percent is appropriate. However, the trigger raises an issue that policymakers must confront: How much of the federal government’s general fund should be devoted to Medicare? General fund financing has always been a part of Medicare, but the level required in future years will

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**FIGURE 1–2**

Medicare faces serious challenges with long-term financing

![Graph showing Medicare's long-term financing challenges](graph.png)

**Note:** GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees’ intermediate set of assumptions. Tax on benefits refers to a portion of income taxes designated for Medicare that higher income individuals pay on their Social Security benefits. State transfers (often called the Part D “clawback”) were called for in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 annual report of the Boards of Trustees of the Medicare trust funds.
grow substantially. In addition to balancing Medicare’s funding needs with other federal priorities, policymakers will need to assess the burden of Medicare’s funding on taxpayers and beneficiaries. Measures of solvency should not dictate the choices of policymakers, but the underlying questions they raise about Medicare’s sustainability cannot be avoided.

**Increasing financial liability for beneficiaries**

Rapid growth in Medicare spending has implications for beneficiaries as well as taxpayers, since both groups finance the program. Although the premiums Medicare beneficiaries pay (primarily for Part B and Part D) are projected to make up a steady 12 percent to 13 percent of total program revenue, the dollar amounts of those premiums will require growing shares of beneficiaries’ incomes. Part B premiums for 2008 are $96.40 per month (or almost $1,157 for the year), a $2.90 per month increase (3.1 percent) over the 2007 amount. This is a much smaller increase than expected—the lowest since 2000. The small increase is attributable to the discovery of an accounting error that misallocated Part A benefits to Part B and to lower-than-anticipated growth in Part B spending. In addition to projected increases in Part B spending, the need to ensure an adequate financial reserve to cover unanticipated increases in expenditures accounted for a portion of the increase. The additional financial reserve should serve as a cushion if policymakers act to override the planned decrease in physician payments; similar decreases have been reversed in each of the last five years. The MMA also created a Part B income-related premium; CMS estimates that about 5 percent of Part B enrollees will pay higher premiums based on income (CMS 2006). The highest income beneficiaries will pay premiums of about $238 in 2007, more than double the standard premium.

Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 11 percent. Meanwhile, monthly Social Security benefits, which averaged around $900 per month in 2005, grew by about 3 percent annually over the same period. Under hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in an individual’s Social Security benefit. The dollar amount of recent increases in Part B premiums has absorbed 20 percent to 40 percent of the dollar increase in the average Social Security benefit. Part D premium increases are not subject to a hold-harmless provision.

Medicare has provided important financial protection to beneficiaries, but they still need to cover some of the costs through cost sharing. In 2002, about half of beneficiaries had incomes of about $20,000 or less (MedPAC 2007). Eighteen percent had incomes less than the poverty level (defined then as $9,060 for people living alone and $11,430 for married couples), and 49 percent had incomes at 200 percent of the poverty level or below (MedPAC 2007). In 2005, Social Security payments were 50 percent or more of annual income for about 65 percent of elderly recipients (SSA 2007).

Early analysis of Part D suggests that more beneficiaries have prescription drug coverage but that drug costs remain a problem for some enrollees. The number of seniors without prescription drug coverage has dropped from 33 percent to 10 percent (Neumann et al. 2007). However, enrollees in stand-alone Part D plans may face higher costs than those in employer-sponsored plans or seniors with access to the drug benefit available from the Department of Veterans Affairs. Only 8.1 percent of enrollees in employer drug benefits reported not filling a prescription because of cost, while 15.6 percent of enrollees in Part D plans reported not filling a prescription for the same reason. The differences, however, may not be surprising because the standard Part D benefit includes a coverage gap that significantly increases beneficiary liability. This coverage gap was included to lower the cost of the Part D benefit for the federal government, and consequently the design of the Part D benefit is less generous than a typical employer-sponsored plan (Moon 2006). Beneficiaries enrolled in the Part D LIS are not subject to the coverage gap and report lower rates of skipping prescriptions and lower out-of-pocket spending (see Chapter 4 for a discussion of the Medicare prescription drug benefit).

Even with the expansion of Medicare’s benefits to include prescription drugs, growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. With the introduction of Part D, the average cost of SMI premiums and cost sharing for Part B and Part D absorbs about 30 percent of Social Security benefits. However, this amount is likely to be less than what beneficiaries spent on premiums and cost sharing for Part B and prescription drugs before 2006. On balance, even though most beneficiaries get relief from out-of-pocket spending because of Part D, growth in health care spending eventually will outpace growth in Social Security benefits (Figure 1-3, p. 14). At the same time, Medicare’s lack of a catastrophic cap on cost sharing...
under Part A and Part B means that some beneficiaries could face extremely high out-of-pocket expenses.

Projections such as these highlight the importance of finding ways to slow growth in Medicare spending (Figure 1-4). If policymakers do not act quickly, Medicare’s need for financing will place an increasing liability on beneficiaries through their premiums and cost sharing, crowd out resources for other federal priorities, and potentially affect the federal budget deficit, the level of federal taxation and debt, and economic growth.

The broader U.S. health care system

Medicare is a very large program with projected expenditures of $431 billion in 2007 (HHS 2007). Even so, it is just one part of an expansive and growing U.S. health care system. That system includes a broad array of private and public purchasers, insurers, providers, manufacturers, and suppliers. Combined expenditures on health care services in the United States totaled nearly $2.1 trillion in 2005, or 16 percent of our economy (Catlin et al. 2007) (Figure 1-5, p. 16).

Private versus public financing in the U.S. health care system

Currently, public financing—federal, state, and local programs—makes up about 45 percent of all U.S. health care spending, with private sources providing the rest. The public share will rise by a few percentage points to nearly 50 percent by 2016 (Poisal et al. 2007). In 2004, employers were the largest source of health insurance,
covering about 60 percent of individuals residing in the United States (Fronstin and Collins 2005).

The United States uses private health insurance extensively because of the country’s tax policies and economic history. During the World War II era, larger U.S. companies began offering health insurance to provide higher compensation to a relatively scarce labor force while avoiding wage and price controls. The federal government did not consider such fringe benefits subject to wage controls, and health insurance contributions paid by employers were not considered taxable income (Helms 2005). At the time, the health insurance industry was in its infancy. Since then, the use of employer-sponsored health insurance and the broader market for private insurance have grown substantially. For 2004, the exemption of employer-paid health insurance from payroll and individual income taxes reduced federal revenues by about $160 billion—about 6.6 percent of federal revenues (OMB 2007).

Some analysts believe that, if one considered the value of tax subsidies for employer-paid health insurance, the public share of health care spending would be closer to 60 percent (Woolhandler and Himmelstein 2002). A counterargument is that a wide variety of tax policies affect decisions about the mix of goods and services the country produces and consumes, yet generally we do not include the value of those tax subsidies in any of our national accounts. The exemption of employer-paid health insurance from payroll and individual income taxes is one reason our nation uses private health insurance so extensively.
Higher spending in the United States

Health care spending in the United States is far higher than in other countries—about $6,400 per person in 2005, or more than twice the median of member countries of the Organisation for Economic Co-operation and Development (OECD) (OECD 2007). Though all industrialized nations have seen cost growth in excess of gross domestic product (GDP), there is some evidence that health care spending has grown faster in the United States than in other countries. One recent analysis suggests that this higher growth rate remains even after adjusting for changes in demographics and differences in the rate of growth in the economies of industrialized nations (White 2007). The increase in health care costs exceeded the annual growth in GDP by 2 percent for the United States in the period from 1970 to 2002, while excess growth was only 1.1 percent for the other OECD nations. Several factors, such as differences in the availability of insurance and the structure of health financing, may account for these differences. However, the finding of excess growth may be sensitive to the way it is measured. As many countries continue to experience significant growth, it is not clear that this differential in growth rates will continue.

Another study found that the United States has higher spending even after adjusting for differences in wealth and disease prevalence (McKinsey Global Institute 2007). The analysis estimated how much the United States would have spent based on per capita income. It found that the United States spent $477 billion more, or $1,645 per capita, even after accounting for the United States’ higher per capita income. The increased incidence in disease accounted for only $25 billion of the difference.
The remainder was attributable to higher utilization, higher input costs for labor and capital, and administrative and operational costs. The analysis suggests that the inefficiencies that increase costs are spread throughout the system, and any reform will require multiple strategies.

Other estimates have suggested that the rates of diagnosis and treatment (“rate of treated disease”) are much higher for many common conditions in the United States (Thorpe et al. 2007). For example, the rate of chronic lung disease among individuals age 50 or older in the United States is almost double that among the same age group in certain European countries. Among those with this diagnosis, almost twice as many individuals in the United States reported receiving medication associated with this condition compared with people in Europe. Thorpe concluded that if the United States had the same rate of treated disease for the studied conditions as the selected European countries, aggregate expenditures on health care in the United States would have been 13 percent to 19 percent lower in 2003. Thorpe did not examine how health outcomes varied for the selected conditions, but other analysts have found that the quality of care in the U.S. health care system often lags behind Europe (Davis and Schoen 2007).

Because the organizational structure of financing health care is more fragmented in the United States, providers may use their market power to negotiate more favorable payments and higher incomes than providers in other countries (Bodenheimer 2005). By being more monopsonistic or exerting regulatory power to a greater degree, other governments may lower or restrain growth in payment rates for providers and prices for other services. The tactics of those governments include using a single-purchaser approach, allowing multiple purchasers to bargain collectively, and using global budgets (Reinhardt et al. 2004).

The health care systems of other countries may not be clearly preferable to ours. A recent survey of patients in the United States and six other countries found that patient satisfaction and access to care varied, and no country clearly outperformed the others (Schoen et al. 2007). For example, the wait time for elective surgery was shortest in Germany and longest in the United Kingdom. However, more patients in Germany reported going forgo doctor visits for financial reasons. The United States ranked second after Germany in short wait times, but the share of patients opting to forgo care was nearly double that in Germany. Each health care system reflects the social, economic, and political circumstances of its country, and as a result each system has a mixture of strengths and weaknesses. Comparison with other countries may provide useful information for benchmarking performance, but it is not clear that any one country’s system is preferable.

Some analysts believe the high levels of spending in U.S. health care are largely attributable to paying higher prices for the same services than other countries do, including higher administrative costs. Data from the mid-1990s suggest that U.S. physicians had considerably higher incomes than physicians in other OECD countries (Reinhardt et al. 2002). However, the United States has a wider distribution of compensation for all workers. For skilled health professionals, labor costs are higher because they would otherwise enter other fields that offer high compensation. The organizational structure of providers and the regulation of health services in other countries also affect salaries. Countries with public systems that provide care directly often contract with general practitioners at salaries negotiated centrally with physicians’ associations. Other countries make risk-adjusted, capitated payments to general practitioners for each patient they add to their list, thereby putting insurance risk on those physicians for the volume of care they provide. A few countries mix salary with capitated payments (Docteur and Oxley 2003).

Is higher spending worth it?

Advances in medical technology have led, on average, to improvements in our health and gains in life expectancy. Recently, Cutler and colleagues concluded that, on average across all ages, increases in medical spending between 1960 and 2000 (attributed largely to advances in medical care) provided reasonably good value, with an average cost per life-year gained of $19,900 (Cutler et al. 2006).

However, when focused on real spending adjusted for inflation and life expectancy for individuals age 65 or older, the same research found that the incremental cost of an additional year of life rose from $46,800 in the 1970s to $145,000 in the 1990s. These estimates suggest that the value of health care spending for the elderly has been decreasing, and the authors suggest that their estimates for the 1990s would fail many cost-benefit criteria.

More recent research suggests that survival gains have stagnated since 1996 for patients with acute myocardial infarction (AMI) (Skinner et al. 2006). Skinner and colleagues found that the survival rate for AMI has not improved since 1996, even though spending for patients with this condition has increased. These trends suggest that higher spending is not yielding better outcomes. These
authors also compared regional differences in spending for AMI and found that areas with higher spending did not have better health outcomes.

Research on the wide geographic variation in health care spending suggests that we waste resources (Fuchs 2005). Some payment systems contribute to the problem of wasteful spending by rewarding inefficient or low-quality care as much as—if not more than—high-quality care delivered by efficient providers. Given questions about Medicare’s sustainability, the Commission has called for distinguishing between high-quality care and care of more questionable value (MedPAC 2004b).

Despite spending more than other countries, the U.S. health care system does not consistently deliver higher quality care (Schoen et al. 2006). For example, the United States has a higher death rate for diseases that are amenable to medical care than the three leading industrialized nations. The United States also had a higher rate of medical errors than other industrialized countries. This disparity between spending and quality raises questions about the value for patients and health care payers of the higher level of spending in the United States.

Rapid growth in health care spending among all payers

For each of the past several decades, the United States has spent an expanding share of its resources on health care. In 1960, for example, national health expenditures made up about 5 percent of the GDP by 2005. That share grew to 16 percent, and CMS projects that it will make up 19.6 percent by 2016 (Figure 1-5, p. 16) (Poisel et al. 2007). All payers in the U.S. health care system—public (including Medicare and Medicaid) and private—are facing similar upward pressures on spending.

Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar (Pauly 2003). When comparing spending for benefits that private insurance and Medicare have in common—notably excluding prescription drugs—Medicare’s per enrollee spending grew at a rate about 1 percentage point lower than that for private insurance from 1970 to 2002. However, the comparison is sensitive to the endpoints of time one uses for calculating average growth rates (Figure 1-6). Differences have been more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services (Levit et al. 2004). Some analysts believe that, since the mid-1980s, Medicare—with its larger purchasing power—has had greater success than private payers at containing cost growth (Boccuti and Moon 2003). Others maintain that benefits offered by private insurers have expanded as cost-sharing requirements declined over the entire period and enrollment in managed care plans grew during the 1990s. The comparison is thus problematic, since Medicare’s benefits changed little over the same period (Antos and King 2003).

Although often disputed by economists, many analysts contend that certain health care sectors are able to shift costs by charging some payers higher prices to compensate for changes in the administered prices of other payers. Many hospital and other health industry executives are convinced that limits on Medicare and Medicaid payment rates lead to higher prices for private payers (Ginsburg 2003). Cost shifting could occur only when providers have sufficient market power to raise their prices. If such a phenomenon occurs, it underscores the need for public and private payers to collaborate with one another on payment policy, since both sets of payers face similar upward pressures on spending in the long term.

Drivers of growth in health spending

One main driver of growth in spending is growth in income. Some analysts believe that, as our country’s standard of living grows, we should expect to spend more on health care (Hall and Jones 2007). As individuals become better off and their consumption increases, the incremental value of buying more commodities (e.g., another television or more clothing) falls. By contrast, the marginal value to them of an extended life span does not diminish as quickly. Similarly, the marginal value of procedures that are not life saving but that may improve the quality of life (e.g., joint replacements or cosmetic surgery) may increase relative to other goods. Hall and Jones suggested that, because of our underlying preferences, it is reasonable to expect health care spending to reach 30 percent of GDP by the middle of this century.

Many analysts point to the rates of development and diffusion of new technologies as another major driver of growth in health care spending (Fuchs 2005, Newhouse 1992). Many technologies reduce the invasiveness, serious side effects, discomfort, or recovery time associated with the therapies they replace, thereby lowering nonmonetary obstacles to beneficiaries as they decide whether to seek treatment. When procedures, drugs, or devices become available, a base of evidence may not exist to help providers decide how newer therapies compare with older
ones. When providers recommend newer therapies that are covered by Medicare or other insurance, patients do not face the full cost of their care and may not be concerned about the comparative value of those therapies. Although some medical technologies lead to savings by reducing lengths of hospital stays or avoiding hospitalizations, most technologies tend to expand the demand for health care and increase spending. In some cases, providers may use new technologies inappropriately or more broadly than intended.

This uncertainty about the efficacy of new technology is compounded under fee-for-service payment systems. Because these payment systems tie reimbursement to the volume of services provided, new technologies can create opportunities for providers to increase their volume and revenues. Many of the additional services may be beneficial, but fee-for-service payment encourages providers to pursue the technologies that result in higher volume and payment regardless of value. This can bolster the “arms race” mentality that providers must pursue the latest technologies to remain financially successful relative to their peers (Berenson et al. 2006). Under alternative systems, such as capitation or value-based approaches that tie payments to a measure of a procedure’s clinical efficacy, the rewards for additional volume are diminished. Providers under these systems would have less financial incentive to pursue the volume opportunities associated with new technology.

Research highlights the important role of health insurance in fueling growth in spending. Finkelstein found that Medicare had a much more pronounced effect on hospital spending than estimates of insurance effects on an individual’s behavior would suggest (Finkelstein 2007). According to Finkelstein, the broad increase in

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**FIGURE 1-6**

Changes in spending per enrollee for Medicare and private health insurance

<table>
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<tr>
<th>Average annual percent change by period:</th>
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Note: PHI (private health insurance). This figure compares services covered by Medicare and PHI, including hospital services, physician and clinical services, and durable medical products.


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Changes in spending per enrollee for Medicare and private health insurance

![Graph showing changes in spending per enrollee for Medicare and private health insurance from 1970 to 2005.](image)

Per enrollee change (in percent)

demand for hospital services that occurred after the start of Medicare led to greater incentives for hospitals to enter markets, purchase new equipment and facilities, and adopt new practice styles. Extrapolating from her Medicare findings, she suggested that about half of the increase in per capita health spending between 1950 and 1990 could be attributable to the spread of health insurance. Other analysts have noted that small changes in assumptions behind Finkelstein’s extrapolation to all health care spending would lead to much smaller effects (Ellis 2006).

Our nation’s underlying health status and changes in clinical treatment thresholds also affect spending. Recent work by Thorpe and Howard suggests that, between 1987 and 2002, nearly all the growth in health care spending for Medicare beneficiaries can be attributed to patients being treated for five or more conditions (Thorpe and Howard 2006). In 2002, about 50 percent of all Medicare beneficiaries were being treated for five or more conditions, compared with about 31 percent of beneficiaries in 1987. At the same time, a larger proportion of patients being treated for five or more conditions reported that they were in excellent or good health—60 percent in 2002 compared with 33 percent in 1987. The authors concluded that medical professionals are treating healthier patients, treatments are improving health outcomes, or both are occurring.

Thorpe and Howard also suggest that the rising prevalence of obesity plays a part in the increased number of beneficiaries with multiple comorbidities. Obesity in the elderly is associated with increased risk of diabetes mellitus, cardiovascular disease, hypertension, stroke, lipid abnormalities, osteoarthritis, and some cancers.

The prevalence of obesity doubled among Medicare beneficiaries between 1987 and 2002 (reaching 23 percent), and obese individuals accounted for 25 percent of spending in 2002. While the share of spending for the obese is approximately proportional to their share of the population, 90 percent of the spending for the obese in 2002 was attributable to the 14 percent of beneficiaries with five or more comorbidities. To the extent that obesity has contributed to an increase in the number of beneficiaries with multiple comorbidities, the rise in obesity has increased Medicare spending. Higher weight, however, does not necessarily result in higher Medicare costs. Medicare beneficiaries who are classified as overweight but not obese have lower spending than obese individuals and have longer life expectancy relative to those in other weight classifications.

Medicare spending is concentrated among relatively few beneficiaries, but some evidence suggests that the concentration has fallen. For example, the most costly 1 percent of beneficiaries accounted for 15.5 percent of Medicare expenditures in 2004. However, recent analysis of long-term per beneficiary spending trends has found that the concentration of spending for Medicare beneficiaries has fallen (Riley 2007). In 1975, the top 5 percent of beneficiaries accounted for 54 percent of spending, while in 2002 they accounted for 43 percent of spending. The trend suggests higher treatment intensities for a broader range of patients. The balance of spending among services has also changed over time for all beneficiaries, not just the most costly. For example, in 1975 hospital services accounted for about 69 percent of the annual expenditures for a beneficiary. In 2004, hospital expenditures fell to 43 percent of annual spending, while the share for physician and outpatient services increased. Despite these changes, significant concentration does remain, and hospital services are still the largest single category of expenditures. However, the rise in spending for less costly beneficiaries and the growth in nonhospital spending suggest that improving the efficiency of health care delivery will require interventions that consider multiple categories of services and consider the changing concentration of beneficiary spending.

Recent years have also seen the consolidation of health care providers and health plans. These consolidations may result in new efficiencies that lower costs, but they can also lead to lower quality and higher prices (Vogt and Town 2006). The concern is that the primary motivation for much of this consolidation is to capture more market share and to leverage this market share for more favorable payments. Similarly, insurers seek market share to push providers for lower rates. This consolidation has resulted in some markets being served by a few dominant plans and providers, and depending on the characteristics of the local market it can sometimes result in cooperation to achieve system improvements (Ginsburg and Lesser 2006). In markets where collaboration takes place, consolidation may unify local delivery systems around common goals such as improving quality. However, markets with few plans and providers may lack sufficient competition to spur needed improvements in efficiency and innovation. Some analysts have found that providers do not compete on price and efficiency in many markets; instead, they compete to increase their market share of the most profitable business lines (Berenson et al. 2006). This can lead to an increase in the supply and volume of medical...
services, but this type of competition does not necessarily address quality or efficiency concerns.

**Consequences of rapid growth in health spending**

Rapid growth in health spending has wide-ranging effects. The U.S. health care sector has produced many medical innovations that lengthen or improve the quality of life. At the same time, some employers argue that the rising cost of health care premiums affects their ability to compete in the world marketplace. However, most economists contend that growth in health premiums paid by employers has no long-term effect on the competitive position of firms (Fuchs 2005). Instead, a firm’s costs for health premiums substitute for cash compensation that it would otherwise pay to workers, in the same way that retirement and other benefits substitute for higher wages. Long-term contracts with workers may prevent some firms from keeping their full compensation package in line with their productivity. As would be the case with any other cost, rapid growth in health premiums can make apparent firms’ need for greater productivity. To achieve productivity gains quickly, firms sometimes take disruptive steps and redistribute income and health coverage for workers and retirees.

Other distributional issues arise from rapid growth in spending on health care. In response to rapid increases in premiums, many employers have raised cost-sharing requirements for their employees, asked them to pay a larger share of premiums, or—particularly for smaller firms—reduced the availability of coverage. The percentage of nonelderly individuals with employer-based health insurance fell from 67 percent in 2000 to 62 percent in 2005, which analysts attribute to the rising cost of providing health benefits (Fronstin 2006). Since required premium contributions by enrollees have risen faster than income, some workers choose to forgo coverage (Ginsburg 2004). During 2006, nearly 47 million people, or 15.8 percent of the U.S. population, were uninsured at some point in time (DeNavas-Walt et al. 2007).

Increases in the numbers of people without private health insurance raise demand for public coverage. In addition, those who cannot secure coverage may receive uncompensated care, and providers may seek higher payments for insured patients to cover losses. The costs of caring for the uninsured do not fall equally on all providers, since the uninsured often postpone care until their condition becomes more serious. In turn, providers that bear more of those costs sometimes seek public subsidies or limits on the competition they face. Rising costs put upward pressure on the financing needs of public and private health care programs for the beneficiaries who already have coverage. Some analysts believe that higher health care costs may also lead to greater fragmentation of risk pools in the health care market, as healthier people search for insurance alternatives that are less costly (Glied 2003).

New insurance products have emerged in response to rapid growth in spending on health care. Employers are beginning to offer health plans that combine a health reimbursement or savings account with a high-deductible insurance policy. Although more employers are beginning to offer these products to their workers, thus far enrollment is low. Enrollees in these newer products generally accept higher cost sharing at the point of service. The intent is to make them more cost conscious when they seek care. In return, they pay lower premiums (Tollen et al. 2004). The law allows employers to make nontaxable contributions to certain health savings accounts (HSAs), and contributions by individual account holders are tax deductible. Current Medicare beneficiaries cannot establish HSAs, but as individuals enroll in Medicare, they may use tax-free distributions from existing HSAs to pay for Medicare premiums or the retiree share of premiums for employment-based retiree health insurance. Medicare beneficiaries may use a similar type of product if they choose: medical savings accounts, a type of high-deductible plan that is combined with a savings account offered by several private organizations within Medicare Advantage.

A recent review of the literature on high-deductible plans suggested that the current evidence on the effectiveness of such plans is mixed (Beeuwkes Buntin et al. 2006). Individuals who selected such plans were often more wealthy and healthier than beneficiaries who opted for other products in the selected studies (GAO 2006, Fronstin and Collins 2005). Enrollees generally had lower costs and lower cost growth, but Beeuwkes Buntin cautioned that further study of this issue with more robust methods is necessary. The results for the effect of such plans on quality of care were mixed. Some studies have found that beneficiaries receive more of certain preventive procedures and are better about following medication regimes (Downey 2004, Humana 2005). Other studies have found that the cost consciousness that plans emphasize led enrollees to forgo care for less serious conditions and skip some medical visits (Agrawal et al. 2005, Davis et al. 2005). It may be too early...
to draw conclusions about the prospects for these plans. Beeuwkes Buntin and colleagues noted that the current literature reflects that the experience of “early adopters” is limited to a few case studies and needs more rigorous analysis of the population differences.

Addressing the quality and efficiency challenges will require a robust long-term effort, and reaching agreement on reform will likely prove challenging. Adding to the challenge, social, economic, and technological changes will continue to alter the health care system. Long-term success will require continuous intervention that adapts to future changes in the financing and delivery of care. However, even small improvements in productivity could yield significant gains for payers.
1 As Robert Myers, the Social Security Administration’s Chief Actuary in 1965, put it, designing a two-part program resulted from a “legislative process [that] was a matter of political compromise and was not by any means dictated by actuarial principles” (Myers 2000).

2 Aside from the direct method of increasing the payroll tax rate, a number of changes over the years have increased revenue to the HI trust fund. Certain employment groups were not included in the Social Security system and were added, expanding the payroll tax base. For example, self-employed physicians were not covered under Social Security until 1965. State and local government employees and federal civil servants were also excluded from the set of workers covered under Social Security (and therefore were not paying HI payroll taxes) until the 1980s. While the Social Security portion of the payroll tax has an upper limit of yearly earnings that are taxable ($97,500 for 2007, having gradually increased from the 1966 level of $6,600), the upper limit on HI contributions was removed in 1994 so that all earnings are subject to the HI tax. The age of Medicare entitlement for the nondisabled remains 65, but raising the “normal retirement” age for Social Security—the age at which beneficiaries can receive unreduced retirement benefits—also increases the pool of workers contributing to the HI trust fund to the extent that individuals 62 or older continue to work. Provisions that make Medicare the secondary payer in relation to other insurers have also reduced expenditures for Medicare. An additional source of funds for Medicare is the income tax on Social Security benefits that is designated for the HI trust fund.

3 In 2004, 200 percent of the federal poverty level equals about $18,000 for individuals and $22,000 for married couples.

4 One exception is funding for the HI trust fund. CBO assumed that Medicare would continue to pay all benefits due for Part A, even after the trust fund becomes insolvent in 2019.

5 Individuals with modified adjusted gross incomes (MAGIs) of $82,000 or more and married couples with MAGIs of $164,000 or more will receive less than the 75 percent subsidy that all other Part B enrollees receive. CMS is phasing in higher premiums over a three-year period. By the end of that time, higher income individuals will pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare’s average Part B costs for aged beneficiaries, depending on their income. All other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. Whether higher premiums will affect beneficiaries’ willingness to remain enrolled in Part B remains to be seen.

6 Social Security recipients received a 3.3 percent increase for 2007.

7 The standard Part D benefit for 2007 includes a $265 deductible and 25 percent coinsurance up to $2,400 in total drug costs, followed by the coverage gap where enrollees pay 100 percent of drug costs until they have $5,451 in total drug costs ($3,850 from their own pocket). Beyond this level, Medicare pays 95 percent of drug costs and the enrollee pays 5 percent. Many Part D plans offer benefits that vary from the standard benefit, but all Part D plans must be actuarially equivalent to the standard benefit, and most plans include a coverage gap (Kaiser Family Foundation 2007).

8 Medical insurance premiums and cost sharing will make up a lower percentage—just under 20 percent—for those beneficiaries who do not enroll in Part D.

9 For example, when calculating how much we spend on children, we would not include the value of personal exemptions from individual income tax for dependent minors.

10 Dollar amounts are adjusted for purchasing power parity—differences in the cost of living across countries—by comparing prices for a fixed basket of goods. OECD’s adjustment is a broad-based basket, not one specific to health costs.

11 The model uses data from OECD countries to estimate the predicted relationship between per capita income and per capita health care consumption. The authors then compare the estimated health care spending for the United States based on the model with actual health care spending and arrive at a variance of $477 billion between actual and predicted spending.

12 In 2005, about 10 percent of privately insured, nonelderly adults were enrolled in high-deductible health plans (Fronstin and Collins 2005). Nevertheless, such plans have attracted considerable attention. Supporters believe that higher cost sharing will lead members to lower their use of unnecessary services, thereby slowing growth in health spending. Other analysts expect that this new type of product will encourage risk segmentation, since healthier enrollees might find lower premiums attractive while sicker individuals would likely stay with more comprehensive coverage. A recent review of the literature on these products suggests that, at this early stage, the evidence is not sufficient to draw firm conclusions. Nevertheless, early studies show modest favorable selection into consumer-directed health plans, some evidence that such plans may help lower costs and cost increases, and mixed effects on quality with evidence of both appropriate and inappropriate changes in use of services (Beeuwkes Buntin et al. 2006).
References


IV. Reimbursement and Regulatory Policy Group
# REIMBURSEMENT AND REGULATORY POLICY GROUP

**Hot Payment Issues in FY 2007 - 2008**

AOTA’s Reimbursement and Regulatory Policy (RRP) staff is working for you to assure the voice of occupational therapy is heard by payers and policy makers.

<table>
<thead>
<tr>
<th>Area of Interest</th>
<th>AOTA Action</th>
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| Therapy Cap and Exception Process                     | • Work with AOTA’s Federal Affairs on Congressional exception extensions and proposals for alternatives to the cap.  
• Informed members about changes to the outpatient occupational therapy cap exception process for 2008.  
• Continue to work closely with CMS regarding the cap exception process based on AOTA member input.                                                                                                                                                                             |
| Medicare Outpatient Therapy Alternative Payment System (OTAPS) | • Met with CMS regarding the pursuit of outpatient alternative payment initiatives  
• Commented on procedure and methodology for CMS alternative to cap therapy data collection project.                                                                                                                                                                                                                      |
| Implementation of Medicare Modernization Act (MMA) provisions | • Continue to monitor implementation of MMA legislation related to competitive bidding, supplier accreditation, and supplier quality standards.  
• Successfully advocated for OT’s to be exempt from the Proposed Rule on Competitive Acquisition for DMEPOS.  
• Engaged in close collaboration with the CMS approved organizations who will be accrediting occupational therapists who bill for orthotic devices. Educated these organizations about how occupational therapists meet the CMS supplier quality standards.  
• Submitted comments on CMS’ proposed rule on Surety Bond Requirements for durable medical equipment, prosthetics, and orthotics devices (DMEPOS).  
• Submitted comments on CMS’ proposed rule on DMEPOS Supplier Enrollment Safeguards.  
• Submitted comments on CMS’ revisions to the supplier quality standards.                                                                                     |
| Physician Quality Reporting Initiative (PQRI)         | • Successfully advocated to CMS and the American Medical Association (AMA) for the inclusion of occupational therapy quality measures in PQRI for 2007 and 2008 including, but not limited to: fall screenings, pain assessment, co-development of plan of care, screening for cognitive impairment, and documentation of current medications.  
• Worked closely with CMS contractor, Quality Insights of Pennsylvania, and OT expert workgroup to develop measures for 2008 and 2009 PQRI and provided supporting comments to endorsement bodies (NQF and AQA). |
| Changes to Medicare Policies on Power Mobility Device Coverage | • Successfully convinced CMS to permit occupational therapists to evaluate beneficiaries’ needs for power mobility devices, without additional certification.                                                                                                           |
| Medicare Therapy Outpatient Payment System (Physician Fee Schedule) | • Successfully convinced CMS to update the OT qualification regulations.  
• Educated members on the new, less onerous 90-day certification requirements.  
• Successfully convinced CMS to include OT quality measures in 2008 PQRI.                                                                                                                                                                                                 |
| Skilled Nursing Facility (SNF) PPS                    | • Submitted detailed comments on proposed rule regarding SNF payment.  
• Advocated to CMS and its contractor RTI concerning the development of a post acute patient assessment tool.  
• Monitored CMS staff time and resource intensity verification project (STRIVE).                                                                                                                                                                                                     |
<p>| Outcomes Measures                                     | • Staffed the AOTA Board ad hoc Committee on Outcomes. Support of this committee includes providing information and feedback regarding payment and regulatory trends to link payment to practice outcomes.                                                                                                                |</p>
<table>
<thead>
<tr>
<th>Area of Interest</th>
<th>AOTA Action</th>
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| American Medical Association (AMA) CPT Coding        | • Successfully advocated for new 2008 CPT code for Cognitive Testing (96125).  
• Successfully advocated for new 2008 CPT code for Team Conferences by non-physician practitioners (99366 and 99368).  
• Supported new and revised CPT codes needed to describe the scope of occupational therapy practice.  
• Assured that the work of occupational therapists is included in the relative values of codes used by the profession. Conducted surveys which provide input to CMS in computing payment amounts under the Medicare Part B Fee Schedule. |
| Local Coverage Determinations (LCDs)                 | • Created an LCD advocacy booklet to empower members and state affiliates, this booklet is now distributed online through environmentally conscious practices.  
• Continued collaboration with Palmetto to advance the use of (ICF) International Classification of Functioning terminology in local coverage guidance, including participation with Palmetto’s OT advisory committee refining OT case scenario.  
• Successfully advocated for less burdensome and more transparent power mobility device LCD qualification standards for OT specialized seating evaluations.  
• Submitted comments regarding Physical Medicine and Rehabilitation LCD to NGS.  
• Submitted comments regarding SNF LCD to NGS. |
| Additional Medicare Activities                        | • Provided comments about the proposed payment refinements under the home-health PPS.  
• Urged CMS to modify regulatory language to explicitly include OTPP in the definition of “supplier.”  
• Submitted comments advocating that OT’s have a mechanism to report quality data in hospital out-patient departments. |
| State Directed Payers and Private Insurers           | • Provided guidance on appeal letter to MI BCBS private insurance policy.  
• Challenged several BCBS private insurance policies that exclude coverage for 97535 (self-care ADLs) and 97537 (community re-integration).  
• Provided guidance on appeal letter to MI BCBS private insurance policy regarding orthotics billing denials.  
• Sent OT practice guidelines and additional information to several private payors to assist member advocacy on OT scope of practice. |
| Payment for Occupational Therapy for Workers’ Compensa-| • Provided significant input to CA Division of Workers’ Compensation on frequency and duration of post-surgical occupational therapy visits.  
• Worked with OT experts on comments to revisions to the low back chapter of the Occupational Medicine Practice Guidelines (ACOEM).  
• Continued work with Director of Evidence-based Practice, in developing treatment guidelines for occupational therapy services for clients with work-related injuries or illness. |
| tion Clients                                          | Education and training in public policy issues |
|                                                       | • Lectured to students at Shenandoah University and Howard University on reimbursement and regulatory policy advocacy.  
• Presented reimbursement and regulatory policy training for the National Student Conclave in Pittsburgh, PA.  
• Updated member resource materials on private practice and will distribute materials through environmentally conscious means. |
WHO WE ARE

AOTA’s Reimbursement and Regulatory Policy Staff

- Charles H. Willmarth, Director of Reimbursement and Regulatory Policy
- Sharmila Sandhu, Esq., Senior Regulatory Counsel
- Jennifer J. Bogenrief, Senior Regulatory Analyst
- Steven Fowler, Administrative Assistant

Other AOTA staff assisting members with payment issues:
- V. Judith Thomas, MGA, Senior Policy Manager, Public Affairs Division

HOW TO REACH US
Phone: 1-800-SAY-AOTA x2013
Email: rrpd@aota.org

WHAT RRPD DOES...

- Submits comments on Federal regulatory and policy proposals
- Advocates for the profession of occupational therapy in collaboration with
  - AMA advisory committees
  - Medicare (CMS Central Office, Regional Office and Medicare contractors; Research Contractors: e.g., Computer Sciences Corporation, Abt, Urban Institute)
  - Rehab Coalition/Trialliance organizations
  - ITEM Coalition
  - Home Care Coalition
  - Rehab Directors
  - State Associations

Protects the profession on a wide range of issues

- HCPCS/AMA CPT coding
- Medicaid coverage limitations
- Medicare Program Safeguard Initiatives
- Private insurance denials and coverage limitations
- Medicare Policy Changes

Educates and interacts with members
- Publishes updates on reimbursement and regulatory issues
- Publishes analyses of regulations and prepares comments to federal agencies on behalf of AOTA members
- Communicates with members via OT Practice column, AOTA website, letters, email, and telephone
- Develops educational materials for members
V. LCD Development Process
What is a Local Coverage Determination?
A Local Coverage Determination (LCD) is a formal determination by a Medicare contractor (i.e., fiscal intermediary or carrier) whether a particular item or service is reasonable and necessary and should be covered in the contractor's jurisdictions. Contractors were required to develop LCDs in a final rule that was effective as of December 8, 2003. The objective of an LCD is to assist providers in submitting correct claims for payment to ensure that they meet Medicare coverage and coding requirements.

LCDs Differ from NCDs, But Must be Consistent
LCDs should not be confused with National Coverage Determinations (NCDs), which represent CMS' determination of whether a particular item or service should be covered on a national basis. The NCD process is lengthy and complex, and results in a decision that all contractors must follow. In the LCD, contractors may provide beneficiaries and providers with more expansive guidance regarding the reasonable and necessary criteria for a service than is in the NCD. But LCDs must remain consistent with the Medicare law, regulations, manual instructions, and related CMS guidance. Where an LCD is inconsistent with any of these sources of national guidance, the LCD should be challenged and may be overturned.

LCDs Replace Policies Formerly Referred to as LMRPs
LCDs must also be distinguished from Local Medical Review Policies (LMRPs), which were required to be completely phased out and replaced by LCDs by December 2005. Both LCDs and LMRPs are developed by contractors and apply to all regions in that contractor's jurisdiction (unless specifically restricted). The main difference between LCDs and LMRPs is that, under the law, LCDs are comprised ONLY of medical necessity information, while LMRPs generally contained additional information, including: coding provisions; benefit category provisions; and statutory exclusion provisions.

Note that contractors can only include coding descriptions in an LCD if they are integral to the discussion of medical necessity. Only codes describing what is covered and what is not covered can be part of the LCD. This includes, for example, lists of Healthcare Common Procedure Coding System (HCPCS) codes that spell out which services the LCD applies to, lists of ICD-9 codes for which the service is covered, lists of ICD-9 codes for which the service is not considered reasonable and necessary, etc.

Development of LCDs:
Notice and Comment
LCDs are developed through a two step process, typically referred to as the “notice and comment” process. First, a contractor develops a draft LCD and circulates it to providers and the public for comment through its website and provider education emails/mailings. The development of the draft LCD (and in many cases, the development of the final LCD) may have involved the input and feedback of an Advisory Committee to the contractor Medical Directors. The Advisory Committee may review policy and provide clinical consultation to contractors.

Second, the contractor considers the comments of providers and other interested parties on the draft LCD. Please note that contractors are required to develop LCDs by considering the strongest evidence available, including medical literature, advice of national and state professional societies and medical consultants. Finally, the contractor makes revisions to the LCD as needed based upon the comments received, and gives notice of the final LCD issuance (both comment and notice periods must be a minimum of 45 calendar days).

CMS is not involved with the LCD development process, except to review the LCD for conflicts with national coverage policy. Draft and final LCDs are maintained directly on Medicare contractor Websites and on CMS' Medicare Coverage Database at http://www.cms.hhs.gov/mcd/search.asp
When Can an LCD be Developed?
Contractors have the option to develop an LCD when any of the following occur:

- Contractor determines there is a widespread problem with increased utilization for certain service(s);
- An LCD is needed to ensure beneficiary access to care;
- Contractor is seeking LCD uniformity across jurisdictions (e.g., one contractor assumes the LCD workload of another contractor or a multi-state contractor pursues uniformity);
- Frequent denials are issued or anticipated.

OT-Related LCDs
LCDs that impact local coverage for occupational therapy (OT) services may be categorized as follows:

- Occupational therapy services;
- Physical medicine and rehabilitation services;
- Physical therapy services (where there is overlap with OT services);
- Speech language pathology services (where there is overlap with OT services)

Read More About It
You can download the LCD final rule from the Federal Register site at:
http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/pdf/03-27742.pdf
VI. Documentation
Basics
Documentation Basics: Why is Documentation so important?

OVERVIEW

Documentation has become more than a task to jot down brief notes on a treatment session for a therapist’s own patient records. What once used to be personal treatment notes for the therapist or physician and never seen by payers, today serve as a legal, binding record to justify and explain medical necessity of occupational therapy services and appropriateness of payment for services. Reimbursement success often hinges on proper and complete documentation which includes: referring orders for therapy, evaluation, progress, and discharge notes, long and short term goals, and proper codes to explain the services.

Medical records documentation is like telling a story to the payer. It requires pertinent, concise and thorough facts about the patient’s health history, illness, condition(s), treatments and outcomes. Selecting the proper diagnostic (ICD-9-CM) and procedural (CPT) codes are crucial components as is describing occupational therapy services to the payer. Explaining clearly and fully what it is you have provided a patient, client, or consumer can sometimes mean all the difference in whether or not you get paid.

Occupational therapists and occupational therapy assistants under the supervision of the occupational therapist view occupation and activity of the person as a meaningful experience. Therapists’ are responsible for conveying their experiences using appropriate documentation of services within their scope of practice1. Documentation in the medical record is more than making notes for the therapist and the interdisciplinary team. Its main purpose is to serve as the cohesive link between professions and payers. Writing should be legible and understandable. As stated in the Guidelines for Documentation of Occupational Therapy, the purpose of documentation is to:

1. **Articulate the rationale** for provision of occupational therapy services and the relationship of this service to the client’s outcomes
2. Reflect the therapist’s **clinical reasoning** and professional judgment
3. **Communicate information** about the client from the occupational therapy perspective
4. **Create a chronological record** of client status, occupational therapy services provided to the client, and client outcomes.2

Along with using these four guiding principles when completing documentation, there are several fundamental elements of documentation that should also be included:

- Patient’s full name and case number on each page of documentation.
- Date and type of Occupational Therapy contact.

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1 Occupational Therapy Practice framework: Domain and Process (AOTA, 2002).
Identification of type of documentation, agency, and department name.

- O.T. or O.T.A. signature with minimum first initial and last name and credentials.
- Countersignature of O.T. on documentation written by students and O.T.A.’s when required by law, facility, or the payer.
- Avoid using professional jargon to the extent that only you or your colleagues can decipher and review the documentation record.
- Errors should be corrected by drawing a single line through the error and by initialing the correction.
- Compliance with confidentiality standards and observance of HIPAA (Health Insurance Portability and Accountability Act) for medical services or FERPA (Family Educational Rights and Privacy Act) for educational services as applicable.
- Compliance with agency or legal disposal and storage of records.  

**MEDICARE**

CMS (The Centers for Medicare and Medicaid Services) published documentation guidance in 2006 for outpatient Medicare Part B providers detailing their expectations and requirements for describing treatment and interventions provided to Medicare beneficiaries. This guidance, found in the Medicare manual, is for use when documenting the occupational therapy services of Medicare beneficiaries and is relevant for all occupational therapy providers that document their services in a variety of settings to various payers. (Refer to Medicare benefit policy guidelines 100-02, Chapter 15, §220.3 in this packet for complete information). Much of the AOTA requirements summarized above are reiterated and expanded upon in the Medicare requirements. These include:

- Clear indication of the referring provider request (a.k.a certification / re-certification) for occupational therapy services
- Date of initial meeting (consultation, evaluation, etc.) and/or recommendation for continued need of occupational therapy services.
- Evaluation / Re-Evaluation / Plan of Care - which includes service type, frequency, intensity, and duration as well as any relevant previous interventions for the patient.
- Progress reports and/or treatment notes that include objective data, and review of short term and long term goals to assess improvement and the continued need or discontinue of therapy services.
- CPT, HCPCS Level II and ICD-9-CM codes to describe and define services and procedures and ICD-9-CM codes to classify diseases, illnesses, and conditions.
- For therapy cap exceptions, records to justify any necessary services over the cap.

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Medicare has provided several definitions to clarify the expectations and roles of its rehabilitation professionals. AOTA suggests that occupational therapists that provide services to Medicare beneficiaries pay close attentions to these definitions in their practice. Some key definitions are:

**Active Participation** - the clinician personally furnishes in its entirety at least 1 billable service on at least one day of treatment.

**Clinician** - refers to only a physician, nonphysician practitioner or a therapist (but not an assistant, aide, or any other personnel providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise.

**Interval** - a period of treatment that consists of one month or 30 calendar days whichever is more.

**Qualified Professional** - an occupational therapist and occupational therapy assistant when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide and may not supervise others.

**Qualified Personnel** - refers to staff or auxiliary personnel who have been trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician, nonphysician practitioner or a therapist.

If you are a therapist providing services to a Medicare beneficiary, it is extremely important to stay up-to-date on documentation requirements. This can expedite payment for services rendered and provide a clear understanding for other providers about the services being provided and the overall health care needs of the patient. For the latest information about documentation requirements from CMS visit, [http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf](http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf)

CMS issued new Medicare outpatient policy directives regarding documenting patient evaluations through Transmittal 63/Change Request 5478. This transmittal was published on December 29, 2006, became effective on January 1, 2007, and was to be implemented on or before January 29, 2007. AOTA has analyzed this directive and provided a summary and supporting chart (in PDF format) to assist you in complying with the new CMS requirements. To download this information, go to [http://www.aota.org/members/area5/docs/factsheet_trans63.pdf](http://www.aota.org/members/area5/docs/factsheet_trans63.pdf) on the AOTA website under Reimbursement.

**References**
VII. Selected HCPCS/L and CPT Codes
# SELECTED 2008 HCPCS LEVEL II CODES

The following HCPCS codes are used by occupational therapists in various settings to report fabrication and fitting of specific orthoses or use of specialized equipment during an occupational therapy intervention. Not all codes are accepted by all payers, including Medicare. State regulations and/or payer policies may establish limitations on the use of one or more of these codes. Always review state rules, the official HCPCS book, and request information from specific insurers concerning codes and payment policy.

## ORTHOTIC DEVICES-UPPER LIMB

### Shoulder Orthosis (SO)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>L3650</td>
<td>SO, figure of eight design abduction re-strainer, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3651</td>
<td>SO, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, Lycra)</td>
</tr>
<tr>
<td>L3652</td>
<td>SO, double shoulder, elastic prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)</td>
</tr>
<tr>
<td>L3660</td>
<td>SO, figure of eight design abduction re-strainer, canvas and webbing, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3670</td>
<td>SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3671</td>
<td>SO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3672</td>
<td>SO, abduction positioning (airplane design) thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3673</td>
<td>Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint / turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3675</td>
<td>SO, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3677</td>
<td>SO, hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment</td>
</tr>
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</table>

### Elbow Orthosis (EO)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>L3700</td>
<td>EO, elastic with stays, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3701</td>
<td>EO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)</td>
</tr>
<tr>
<td>L3702</td>
<td>Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3720</td>
<td>EO, double upright with forearm/arm cuffs, free motion, custom fabricated</td>
</tr>
<tr>
<td>L3730</td>
<td>EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated</td>
</tr>
<tr>
<td>L3740</td>
<td>EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated</td>
</tr>
<tr>
<td>L3760</td>
<td>Elbow orthosis, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type</td>
</tr>
<tr>
<td>L3762</td>
<td>EO, rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3763</td>
<td>EWHO, rigid, without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3764</td>
<td>EWHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface material, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3765</td>
<td>EWHO, rigid, without joints, may soft interface, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3766</td>
<td>EWHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment</td>
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</table>

### Wrist-Hand-Finger Orthosis (WHFO)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>L3800</td>
<td>WHFO, short opponens, no attachments, custom fabricated (see code L3808)</td>
</tr>
<tr>
<td>L3805</td>
<td>WHFO, long opponens, no attachments, custom fabricated (see code L3808)</td>
</tr>
<tr>
<td>L3806</td>
<td>WHFO, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L3807</td>
<td>WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type</td>
</tr>
<tr>
<td>L3808</td>
<td>WHFO, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment</td>
</tr>
</tbody>
</table>
Additions

L3810 WHFO, addition to short and long opponens, thumb abduction (C) bar
L3815 WHFO, addition to short and long opponens, second M.P. abduction assist
L3820 WHFO, addition to short and long opponens, L.P. extension assist, with M.P. extension stop
L3825 WHFO, addition to short and long opponens, M.P. extension stop
L3830 WHFO, addition to short and long opponens, M.P. extension assist
L3835 WHFO, addition to short and long opponens, M.P. spring extension assist
L3840 WHFO, addition to short and long opponens, spring swivel thumb
L3845 WHFO, addition to short and long opponens, thumb L.P. extension assist, with M.P. stop
L3850 WHO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855 WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860 WHFO, addition to short and long opponens, adjustable M.P. flexion control and L.P.

✓L3890 Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each

Dynamic Flexor Hinge, Reciprocal Wrist Extension/Flexion, Finger Flexion/Extension

L3900 WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3901 WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated

External Power

L3904 WHFO, external powered, electric, custom fabricated

Other Wrist-Hand-Finger Orthoses - Custom Fitted

L3905 WHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3906 WHO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3907 WHFO, wrist gauntlet with thumb spica, molded to patient model, custom fabricated
L3908 WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment
L3909 WO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)
L3910 WHFO, Swanson design, prefabricated, includes fitting and adjustment

• New 2008 HCPCS Code + Special Coverage Instructions ✓ Quantity Alert ▲ Not Covered by Medicare ◆ Revised Code

□ CMS Low Vision Demonstration Project Code Use only
L3932 FO, safety pin, spring wire, prefabricated, includes fitting and adjustment
L3933 Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3934 FO, safety pin, modified, prefabricated, includes fitting and adjustment
L3935 Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3936 WHFO, Palmer, prefabricated, includes fitting and adjustment
L3938 WHFO, dorsal wrist, prefabricated, includes fitting and adjustment
L3940 WHFO, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment
L3942 HFO, reverse knuckle bender, prefabricated, includes fitting and adjustment
L3944 HFO, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment
L3946 HFO, composite elastic, prefabricated, includes fitting and adjustment
L3948 FO, finger knuckle bender, prefabricated, includes fitting and adjustment
L3950 WHFO, combination Oppenheimer, with knuckle bender and two attachments, prefabricated, includes fitting and adjustment
L3952 WHFO, combination Oppenheimer, with reverse knuckle and two attachments, prefabricated, includes fitting and adjustment
L3954 HFO, spreading hand, prefabricated, includes fitting and adjustment
\[L3956\] Addition of joint to upper extremity orthosis, any material; per joint

**SHOULDER-ELBOW-WRIST-HAND ORTHOSIS (SEWHO)**

**Abduction Positioning, Custom Fitted**
L3960 SEWHO, abduction positioning, airplane design, prefabricated, includes fitting and adjustment
L3961 SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3962 SEWHO, abduction positioning, Erbs palsy design, prefabricated, includes fitting and adjustment
L3964 SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment
L3965 SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment
L3966 SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment
L3967 SEWHO, abduction positioning (airplane design), Thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3968 SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment
L3969 SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment

**Additions to Mobile Arm Supports**
L3970 SEO, addition to mobile arm support, elevating proximal arm
L3971 SEWHO, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3972 SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
L3973 SEWHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3974 SEO, addition to mobile arm support, supinator
L3975 SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976 SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977 SEWHO, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978 SEWHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

**Fracture Orthoses**
L3980 Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment
L3982 Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment
L3984 Upper extremity fracture orthosis, wrist,
prefabricated, includes fitting and adjustment

L3985 Upper extremity fracture orthosis, forearm, hand with wrist hinge, custom fabricated

L3986 Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist (example: Colles' fracture), custom fabricated

✓ L3995 Addition to upper extremity orthosis, sock, fracture or equal, each

L3999 Upper limb orthosis, not otherwise specified

Specific Repair

L4002 Replacement strap, any orthosis, includes all components, any length, any type

Repairs

+✓ L4205 Repair of orthotics device, labor component, per 15 minutes

+L4210 Repair of orthotics device, repair or replace minor parts

Additions: Upper Limb

L6624 Upper extremity addition, flexion/extension and rotation upper wrist unit

PROCEDURES/PROFESSIONAL SERVICES (TEMPORARY)

Note: The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes. Once CPT codes for these services and procedures are assigned, the G codes are removed from this section. G codes fall under the jurisdiction of the payer.

G0129 Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day

✓ G0281 Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

G0283 Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

VISION SERVICES V0000-V2999

Note: These V codes include vision-related supplies including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.

V codes fall under the jurisdiction of the DME regional carrier, unless incident to other services or otherwise noted.

Vision Aids

V2600 Hand held low vision aids and other nonspectacle mounted aids

HEARING SERVICES V5000-V5999

Note: This range of codes describes hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative system.

Hearing services fall under the jurisdiction of the local carrier unless incidental or otherwise noted.

▲ V5269 Assistive listening device, alerting, any type

▲ V5270 Assistive listening device, television amplifier, any type

▲ V5271 Assistive listening device, television caption decoder

▲ V5272 Assistive listening device, TDD

Speech-Language Pathology Services

▲ V5336 Repair / modification of augmentative communicative system or device (excludes adaptive hearing aid)

▲ V5364 Dysphagia screening

Referring to the official Level II HCPCSs book for a list of all possible codes.

LOW VISION DEMONSTRATION CODES

Beginning April 3, 2006, occupational therapy providers in selected areas of the country (New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington) may participate in the Centers for Medicare and Medicaid Services (CMS) Low Vision Rehabilitation Demonstration Project. The project is scheduled to last for 5 years ending on March 31, 2011.

Payment for vision rehabilitation services under this demonstration may be made to either the qualified physician who is supervising the occupational therapist or certified vision rehabilitation professional; or an occupational therapist in private practice; or a qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the certified vision rehabilitation professional; and where the services are furnished under the individualized written plan of care.
Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, for occupational therapists in private practice who are participating in the low vision rehabilitation demonstration, claims submitted must contain the same information as on a physician’s claim form and must use the demonstration “G” code for occupational therapists (G9041).

Payment to practitioners and facilities will be made using the Medicare Physician Fee Schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPPS system. Payment for services under this demonstration is limited to low vision rehabilitation.

CMS has developed the following temporary demonstration, or “G”, codes to be used when reporting Low Vision Rehabilitation services under this demonstration project only. These codes should not be used for any other purpose. Each code corresponds to the low vision rehabilitation professional that provides the service.

The temporary “G” codes descriptions below are used solely for the 5-year Low Vision Demonstration project:

- **G9041** Low Vision rehabilitation services, qualified occupational therapist, direct face-to-face one-on-one, each 15-minutes
- **G9042** Low Vision rehabilitation services, certified orientation and mobility specialist, direct face-to-face one-on-one, each 15-minutes
- **G9043** Low Vision rehabilitation services, certified low vision rehabilitation therapist, direct face-to-face one-on-one, each 15-minutes
- **G9044** Low Vision rehabilitation services, certified vision rehabilitation teacher, direct face-to-face one-on-one, each 15-minutes

Providers participating in the Low Vision Demonstration project can view the official instruction issued to your carrier/intermediary for complete details regarding this change.


Search for 3816 and 4294 and click on the file for those Change Request numbers. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/) on the CMS web site.
The following CPT© codes are frequently used by occupational therapists to report services in various settings. Additional codes, such as Case Management, and Psychiatry codes, are sometimes accepted by private insurers for classifying and billing OT services. Not all codes are accepted by all payers, including Medicare. Limitations on use of one or more of these codes may be established by state regulation and/or payer policy. Always review state rules, the official CPT© book, and request information from specific insurers concerning codes, time frames, and payment policy. NOTE: Medicare requires the use of CPT© 2008 codes effective January 1, 2008.

PHYSICAL MEDICINE & REHABILITATION

97003 Occupational therapy evaluation
97004 Occupational therapy re-evaluation

MODALITIES
Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

Supervised
The application of a modality that does not require direct (one-on-one) patient contact by the provider.

97010 Application of a modality to one or more areas; hot or cold packs
97012 traction, mechanical
97014 electrical stimulation (unattended)
97016 vasopneumatic devices
97018 paraffin bath
97022 whirlpool
97024 diathermy (eg, microwave)
97026 infrared
97028 ultraviolet

Constant Attendance
The application of a modality that requires direct (one-on-one) patient contact by the provider.

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033 iontophoresis, each 15 minutes
97034 contrast baths, each 15 minutes
97035 ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)

THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Physician or therapist required to have direct (one-on-one) patient contact.

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112 neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113 aquatic therapy with therapeutic exercises
97116 gait training (includes stair climbing)
97124 massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (Note: For myofascial release, use 97140)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques (e.g., mobilization /manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150 Therapeutic procedure(s), group (2 or more individuals) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)
97150 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97152 Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97153 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97155 Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97157 Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97159 Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97165 Work hardening/conditioning; initial 2 hours
97166+ each additional hour

ACTIVE WOUND CARE MANAGEMENT
Active wound care procedures are performed to promote healing, and involve selective and non-selective debridement techniques. (Do not report 97597- 97602 in addition to 11040-11044)
97597 Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure water jet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or...
without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters

97598 total wound(s) surface area greater than 20 square centimeters

97602 Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

97605 Negative pressure wound therapy (e.g., Vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

97606 total wound(s) surface area greater than 50 square centimeters

TESTS AND MEASUREMENTS

Requires direct one-on-one patient contact

97750 Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes

97755 Assistive technology assessment (e.g. to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

ORTHOTIC MANAGEMENT AND PROSTHETIC MANAGEMENT

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes (Code 97760 should not be reported with 97116 for the same extremity)

97761 Prosthetic training, upper and/or lower extremity(s), each 15 minutes

97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

OTHER PROCEDURES

97799 Unlisted physical medicine/rehabilitation service or procedure

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

92526 Treatment of swallowing dysfunction and/or oral function for feeding

EVALUATIVE AND THERAPEUTIC SERVICES

92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device

92606 Therapeutic service(s) for the use of non-speech-generating device, including programming and modification

92610 Evaluation of oral and pharyngeal swallowing function

92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording

92612 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording

92614 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording

MUSCLE AND RANGE OF MOTION TESTING

95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk

95832 hand, with or without comparison with normal side

95833 total evaluation of body, excluding hands

95834 total evaluation of body, including hands

95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

95852 hand, with or without comparison with normal side

95999 Unlisted neurological or neuromuscular diagnostic procedure

CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (e.g., NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)

96110 Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

96111 extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

96125 Standardized cognitive performance testing (e.g. Ross Information Processing Assessment) per hour of a qualified health care professional’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION

96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 re-assessment

96152 Health and behavior intervention, each 15 minutes; face-to-face; individual

96153 group (2 or more patients)

96154 family (with the patient present)

96155 family (without the patient present)
VIII. National Provider Identifier: Do you know your medicare NPI?
National Provider Identifier (NPI)

Do you have your Medicare NPI?

Beginning May 23, 2007, Medicare requires all individuals and organizations identified as healthcare providers are required to obtain a National Provider Identifier (NPI) number as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This identifying number will be used by HIPAA covered entities: health plans, health care clearinghouses, and health care providers conducting electronic transactions. Previously, health care providers have applied for and been assigned different numbers that identify them to various health plans. This national approach is intended to provide better data collection capability.

The NPI is a 10-digit standard healthcare provider number that will be required by all health plans to identify you regardless of your state and practice specialty. All HIPAA-covered entities except small health plans must begin using the NPI on May 23, 2007; small health plans have until May 23, 2008. A small health plan is defined as one that has annual revenues of $5 million or less. Your NPI number will never change and will be a lifelong identifying number for you across public and private health care plans.

Your NPI will identify you as a healthcare provider but you still need to properly enroll with various 3rd party payers, including Medicare. The health plans with whom you do business will instruct you as to when you may begin using the NPI in standard transactions. Check with each individual payer to verify their enrollment process procedures. It is important that you apply for and obtain an NPI before making changes to existing payer contracts or enrolling in programs such as Medicare. For example, under the Medicare program, a provider still must contact the appropriate Medicare Contractor (Fiscal Intermediary, Carrier, etc) in order to obtain information and complete the Medicare enrollment process. Payers will discontinue using their specific numbers at different times. Until you are instructed to discontinue using payer specific identifiers, you should use both the NPI and any payer specific identifiers in standard transactions.

Under the Medicare program, occupational therapists are allowed to enroll as providers in the Medicare program. However, both occupational therapists and occupational therapy assistants are individuals who need to obtain an NPI number. Examples of organizations that may apply for a NPI include but are not limited to: hospitals, home health agencies, group practices, clinics, supplies of durable medical equipment, and nursing homes.

For information about the NPI visit: http://www.cms.hhs.gov/apps/npi/01_overview.asp. To apply online, visit: https://nppes.cms.hhs.gov/NPPES/Welcome.do, or call 1-800-465-3203 to request a paper application.

The Centers for Medicare and Medicaid Services (CMS) has written a letter to providers introducing the NPI. To read this letter, refer to: http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIdearprovider.pdf.

The final rule for the NPI was announced on January 23, 2004. To read the rule in its entirety visit http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf.
IX. Internet Resources
The Centers for Medicare and Medicaid Services (CMS) maintains a user-friendly website to support the mission and vision of the Agency. The Reimbursement and Regulatory Policy staff has compiled some of the most frequently accessed Internet sites for policy and regulation updates.

### CMS Internet Links

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### CMS Transmittals & Manuals

In October 2003, The Centers for Medicare and Medicaid Services (CMS) began a much anticipated transformation process to move from a paper-based manual system to an internet-only manual system. At the current time, not all manuals have been completely transitioned to an internet only format. Below are links to selective internet-only and paper-based manual sites.

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| CDC National Center for Health Statistics (NCHS) - International Classification of Functioning, Disability and Health (ICF) | [http://www.cdc.gov/nchs/about/otheract/icd9/icfhome.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icfhome.htm) |