Q&A
Medicare Access to Physical Medicine and Rehabilitation Services Improvement Act, H.R. 1846

Q1. What is the name of the bill?
A1. Medicare Access to Physical Medicine and Rehabilitation Services Improvement Act, H.R. 1846

Q2. What are the provisions of this bill?
A2. This bill has two parts:

1) **The bill would restore the long-standing Medicare policy that gave the physician broad latitude to determine who best to employ to provide physical medicine and rehabilitation services.** This is what is generally referred to as the "incident to" policy. Incident to allows the physician to be reimbursed for services provided by another health care provider working under the physician's direct supervision. For example, prior to being recognized as "named" providers under Medicare, this is how physician assistant and nurse practitioner services were covered by Medicare for many years. Under incident to, the physician is always present in the office suite when the services are provided by the other health care professional. The health professional must be an employee of the physician's practice.
2) **Second, the bill would recognize services provided by athletic trainers (ATs) and lymphedema therapists (LTs) as "covered" under the Medicare program.** Services would have to be of the type already covered by Medicare if provided by a physician. **This DOES NOT expand the scope of the Medicare benefits,** merely says that if ATs or LTs can legally provide a service—as provided by the state scope of practice—that is already covered by Medicare, and the AT or LT is working with physician supervision, then the service will still be covered if provided by an AT or LT. This allows athletic trainers and lymphedema therapists to provide services in an outpatient clinic, physician office or hospital under the supervision of a physician. Supervision is defined by state law or other state regulatory mechanism. Unlike incident to, in this case, the physician may not necessarily be in the office suite. This facilitates the delivery of services in locations that may be more appropriate or convenient for the patient. This is especially important in rural settings where the AT or LT can go to a patient's home to provide the necessary service, if necessary.

Q3. Why is Federal legislation necessary to reverse the incident to rule?
A3. CMS implemented a rule in 2005 that **prohibited all other therapy providers** except physical therapists, occupational therapists and speech language pathologists from providing physical medicine and rehabilitation services "incident to" a physician. CMS maintains that adoption of the rule was required by an obscure change in the Medicare law enacted in the mid-1990s. Although CMS (and before that HCFA) had for seven years consistently interpreted the law differently, this new interpretation has prevented thousands of therapy providers from

delivering services to Medicare beneficiaries that state law and state regulatory mechanisms say they are qualified to provide.

Q4. What will this legislation accomplish?
A4. It will accomplish three things:
1) It will improve Medicare beneficiaries' access to quality health care.
2) It will restore the rights of physicians to choose how and to whom they delegate the delivery of therapy services.
3) It will save Medicare money by allowing all state licensed or certified health care providers to provide therapy services incident to physicians' services.

A 2005 Medicare Payment Advisory Commission (MedPAC) report noted that, based upon 2002 payment data, the most cost-effective place for Medicare beneficiaries to obtain physical therapy was in the physician's office, which supports the long-standing practice of providing "therapy-incident to."

Average Per Beneficiary Costs for Therapy Services by Setting

Physician Office $405.00 ⇨ 30% less than the average cost of care
Hospital OPD $429.00
Average $581.00
PT in Private Practice $653.00⇨ 39% more than the cost of care delivered in physician offices
OT in Private Practice $594.00
Skilled Nursing Facility $868.00

Q5. Who receives the payment for services?
A5. The physician office, clinic or hospital receives the reimbursement payment.

Q6. Why are only athletic trainers and lymphedema therapists named providers?
A6. There are various identifiable groups of health professionals adversely affected by the CMS policy. These are those who, by state law or certification are qualified to perform physical medicine services. At this time vision and chiropractic communities are pursuing other legislative avenues for addressing this problem.

The bill has two substantive parts:
Section 2: would modify that section of the Medicare law (1862(a)(20)) that CMS has pointed to, to justify the rules that we are seeking to void. This would remove the authority CMS says it has to restrict "therapy incident-to" services to only physical therapists and allow physicians to employ other qualified providers to deliver these services.
Section 3: would provide statutory recognition of both athletic trainers (ATs) and lymphedema therapists (LTs) for the Physical Medicine and Rehabilitation services they are legally authorized to provide that are otherwise covered by Medicare.

Also, Section 3 is what will allow us to produce identifiable savings by enactment of this legislation. It should be noted that historically, CBO has not identified "scorable" savings in the incident to area of the Medicare program because of the nature of the way claims are submitted. When a claim is submitted to Medicare, it does not identify the health care professional who actually delivers a service "incident to" but rather uses the physicians billing number and appears

as if the physician provided the service personally. CBO will not score these "incident to" savings because they cannot distinguish between claims submitted for services done personally by the physician and those delegated to someone else. This, even though we know intuitively and as a practical matter that these services are rarely performed by the physician personally. Therefore, the only way we can achieve scorable savings is by having the AT and LT service specifically identified.

Q7. Will the bill's language be added to the outpatient therapy section of Medicare law?
A7. No.

Q8. Why not?
A8. The language will not be part of the Medicare outpatient therapy law. The language more closely reflects the way in which physician assistants are reimbursed by Medicare. Furthermore, unlike physical therapists, the therapy providers included in this bill work directly with physicians and welcome the involvement of physicians in the care they provide to their patients. Technically, **these services are "physical medicine and rehabilitation"** and not "physical therapy" and therefore do not appropriately belong in the PT section of the Medicare statute.

We view this as a team approach to health care rather than an "us or them" approach to healthcare. We find this team approach improves the quality of health care for patients.

Q9. Are these services subject to the therapy cap?
A9. Yes. All services whether provided in a physician's office or clinic would be subject to the current therapy cap.

Q10. How does this affect a provider's state scope of practice?
A10. It won't. This federal legislation will not affect existing states' scopes of practice. This federal legislation only deals with how physician practices that employ health professionals deliver these services and how they will be reimbursed for physical medicine and rehabilitation services provided to Medicare beneficiaries, which the provider is legally authorized to provide.

Q11. If this legislation is passed, will this automatically resolve any problems with private, third-party insurance company reimbursement for these services?
A11. No, but the chances for private-plan reimbursement will be greatly improved. Medicare reimbursement is considered the gold standard for third-party payers.

Q12: Who do I contact for more information?
A12: You can contact the Coalition to Preserve Patient Access to Physical Medicine and Rehabilitation Services at www.coalitiontopreservepatientaccess.org. Or reach the Coalition organizer, Cate Brennan Lisak at 972.532.8848 or catel@nata.org .

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