SECTION 1123 OUTPATIENT REHABILITATION SERVICES

(a) Coverage - The outpatient rehabilitation services described in this section are:

(1) outpatient occupational therapy;

(2) outpatient physical therapy;

(3) outpatient speech-language pathology and audiology services; and

(4) outpatient vision-related rehabilitation services.

(b) Limitations. Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS. - The services described in paragraphs (1), (2), and (3) of subsection (a) include only items or services used to maintain, restore, or prevent deterioration of functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

(2) RESTORATION OR PREVENTION OF DETERIORATION IN FUNCTIONING. -- The services described in subsection (a)(4) include only items or services used to restore, or prevent deterioration in, independent functioning.

(3) MAINTENANCE OR PREVENTION PROGRAM. - To the extent that the services described in paragraph (1), (2), or (3) of the subsection (a) are provided to an individual for the purposes of maintaining, or preventing **or minimizing** deterioration of, functional capacity, such services shall be limited to the following:

(A) The initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional.

(B) The designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate to the capacity and tolerance of the patient and the treatment objectives.

(C) The instruction of the patient, family members, and **any personnel providing rehabilitation-related assistance to the individual**, in carrying out the program **described in subparagraph (B)**.

(D) Reevaluations **of a program described in subparagraph (B)**.

(3) REEVALUATION --

(a) At the end of each 60-day period of outpatient rehabilitation services **(other than services described in paragraph (3))**, the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that **the requirement in paragraph (1) is satisfied.**

(b) Periodically, outpatient rehabilitation services described in paragraph (3) shall be reevaluated by a qualified rehabilitation health professional.

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AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Page 66, line 17, strike "and".

Page 66, strike lines 18 through 19 and insert the following:

(3) outpatient speech-language pathology and audiology services; and

Attachment B

STAFF DISCUSSION DRAFT
AMENDMENT TO OUTPATIENT REHABILITATION SERVICES PROVISION
OF THE HEALTH SECURITY ACT

SEC. 1123. OUTPATIENT REHABILITATION SERVICES

(a) COVERAGE-The outpatient rehabilitation services described in this section are:

(1) outpatient occupational therapy;

(2) outpatient physical therapy;

(3) outpatient respiratory therapy; and

(4) outpatient speech-language pathology services and audiology services.

(b) LIMITATIONS.-Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.- Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

(2) MAINTENANCE OR PREVENTION PROGRAM. ~~Services described in paragraph (1) include the following outpatient rehabilitation services designed to maintain functioning or prevent or minimize deterioration:~~

(A) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional,

(B) the designing by the qualified rehabilitation health professional of a maintenance or prevention program which is appropriate to the capacity and tolerance of the patient and the treatment objectives,

(C) the instruction of the patient, family members, or support personnel in carrying out the program, and

(D) reevaluations.

(3) REEVALUATION.- (A) At the end of each 60 day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(B) Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

EXPLANATION OF CHANGES

1. ILLNESS OR INJURY.

The bill limits coverage of outpatient rehabilitation therapies to those therapies used to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury."

This policy is tantamount to perpetuating a pre-existing condition clause for persons with congenital conditions. It results in arbitrary distinctions between two infants with the same pattern of disability and the same need for identical services. For example, there is no difference between the need for outpatient rehabilitation therapy services by a child born with cerebral palsy and a child who one hour after birth develops an infection in the brain (meningitis) and then develops cerebral palsy.

Solution: Insert "**illness, injury, disorder or other health condition**" in lieu of "illness or injury." The phrase in bold is consistent with language used elsewhere in the Health Security Act (at page 846 of S. 1757) with respect to development of practice guidelines.

This solution is consistent with policies included in many private insurance policies (e.g., Blue-Cross/Blue Shield; Government Employees Hospital Association). According to discussions between the March of Dimes and the Health Insurance Association of America, even those policies that include "illness or injury" language in fact cover therapies required to address a congenital condition. However, negotiations between the insurer, family and health professionals often are required.

2. RESPIRATORY THERAPY.

Outpatient respiratory therapy is an accepted, cost-effective modality for the treatment of individuals with compromised cardiopulmonary systems.

It is our understanding that respiratory therapy is intended to be included under the Health Security Act. The proposal simply clarifies this understanding. This language is consistent with existing Medicare and private insurance coverage.

3. SPEECH PATHOLOGY

The bill limits coverage to "outpatient speech pathology services for the purpose of attaining or restoring speech." This description is not reflective of the breadth of need. "Speech-language pathology" is the accepted term rather than "speech pathology" because the speech-language pathologist assesses and treats individuals who have speech, language, and related disorders.

Examples of language disorders include aphasia due to a stroke or head injury. The ability to speak may be intact but the ability to use the appropriate vocabulary or even find the appropriate word may be impaired. Additionally, speech-language pathologists can provide swallowing assessment and rehabilitation services. For example, a infant with cerebral palsy may require speech-language pathology services to learn how to swallow. Without the therapy, the child might choke on food or not be able to eat at all. Further, audiology services are important for individuals with hearing impairments. Audiologists provide diagnostic and aural rehabilitation services to individuals with hearing loss.

Solution: Insert "**Speech-language pathology services and audiology services**" in lieu of "speech pathology services for the purpose of attaining or restoring speech."

This solution is consistent with policy under Medicare and most private insurance policies. Although audiology is not mentioned in the Medicare statute, it is a covered service as defined in section 2070.3 of the Medicare Carriers Manual.

4. MAINTENANCE OR PREVENTION PROGRAM

The bill specifies that therapies are provided to "minimize limitations on physical and cognitive functions." While payment for services designed to maintain functioning or prevent or minimize deterioration are recognized under existing private and public policy, questions have been raised whether the language of the bill is sufficiently clear to reflect this policy.

Under Medicare policy, "maintenance programs" are covered. The premise of the policy under Medicare is that repetitive services required to maintain functioning or prevent or minimize deterioration do not necessarily involve complex and sophisticated therapy procedures and consequently provision by a qualified rehabilitation health professional are not always required for safety and effectiveness. However, Medicare also recognizes that the specialized knowledge and judgment of a qualified rehabilitation health professional may be required to establish, monitor, and oversee a maintenance program.

The proposal clarifies the language in the Health Security Act to ensure that outpatient rehabilitation services includes maintenance and prevention programs, whenever medically necessary or appropriate.

The language is based on language in Medicare policies. The language is also consistent with statements by the Administration that the bill language is intended to include training individuals, their families, and others to continue working to maintain functioning and prevent deterioration.

The proposal includes the term "rehabilitation health professional" in lieu of "therapist." The recommended terminology is consistent with the definition of "health professional" set out in section 1582 of the Health Security Act.

5. REEVALUATION

Under the bill, additional periods of services are covered only if such person determines that "function is improving." This language is ambiguous in light of the scope of services provided under section 1123(b)(1) (i.e., restore functional capacity or minimize limitations on physical and cognitive functions).

The proposal strikes "Additional periods of services are covered only if such person determines that functioning is improving" and inserts in lieu thereof "Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied."

This clarification is consistent with the clarification made by the Administration with respect to home health care (See section 1118 of the Health Security Act as compared to the September 7 "Working Group draft" at page 24).

The reevaluation section also reflects the different requirements for reevaluation for a "maintenance or prevention program."

Memorandum

To: Ken Thorpe, Ph.D.

From: Gordon R. Trapnell

Date: February 8, 1994

Re: The Cost of Expanded Coverage of Outpatient Rehabilitation Services

A. Objective

The purpose of this note is to provide an estimate of the impact on the premium rates charged in the public alliances of reducing or eliminating the restrictions imposed by H.R. 3600 on outpatient rehabilitation services to treat persons born with birth defects.

B. Coverage in H.R. 3600

H.R. 3600 has three sets of restrictions on outpatient rehabilitative care.

Section 1141, "Exclusions", excludes "an item or service that is not medically necessary or appropriate". It goes on to exclude "cosmetic surgery" services except those required incident to surgery to correct a congenital anomaly.

Section 1123, which provides for coverage of outpatient rehabilitation services, limits such coverage to "items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury."

There is also a requirement for a reevaluation at the end of each 60-day period, and further services are covered only if the patient's functioning is improving. The reevaluation, however, is "by the person who is primarily responsible" for providing the services.

C. Present Health Insurance Coverage and Practices

1. Private Health Insurance

The general intention of the bill drafters was to model an acute care benefit. The language limiting services to those that are medically necessary or appropriate was used in an attempt to replicate the traditional restrictions in private health insurance policies that limit covered services to those required to diagnose or treat an "accident and illness", with the understanding that

this would denote acute care. The specific issue of how this language would apply to outpatient rehabilitation services for persons with birth defects was not explicitly addressed, other than in the limitations incorporated into the benefits for outpatient physical, occupational and speech therapy.

Given the general intention to follow the present practices in private health insurance, I investigated how some specific insurers applied their criteria for necessary medical care to outpatient rehabilitation services. There is a wide range of outpatient rehabilitation coverages in private health insurance policies and self insured programs. These range from very restricted to extended comprehensive coverage of outpatient rehabilitation services in terms of limits on the types of providers whose services will be reimbursed, limits on the number of services in an episode of care or calendar year and the types of conditions treated. Some examples of the coverage found in specific policies are described below.

a. A For-Profit Insurance Company

Coverage for outpatient rehabilitation for children solely related to congenital anomalies is excluded as not related to the care of an accident or illness. Even without this exclusion, coverage would be limited by not recognizing providers other than physicians specializing in physical medicine (and clinics that they head), licensed physical therapists, the outpatient departments of hospitals, and community health centers.

Apparently the courts have upheld the position that birth defects are not accidents or illnesses in most states. In some jurisdictions, however, there have been decisions finding specific birth defects to be the results of accidents. For example, cerebral palsy has been found to be caused by injuries that occur during labor and delivery. For the most part, however, insurers appear to have been able to deny coverage on the grounds that a congenital anomaly is not an accident or illness.

b. A Blue Cross and Blue Shield Plan

The standard contract of one large Blue Cross and Blue Shield plan with a dominant market share provides that payment for a service requires that three conditions are met:

- It is performed by an eligible provider
- It is within the durational limits
- The condition of the patient is such that the service is required to correct a congenital disease or anomaly that has resulted in a functional defect and there is a reasonable medical expectation that there will be a

substantial improvement in the condition of the patient to achieve a defined medical goal within the next 60 days.

Specific congenital conditions recognized by this plan and the services assessed to be appropriate for treatment are shown in Exhibit 1 attached.

Coverage is different in the company's fee for service and managed care products. The fee for service policies will pay only for the services of registered physical therapists, the outpatient department of a hospital or those of a community health center. In addition, most policies have limits on the number of services that will be covered during an episode of illness.

The managed care product covers short-term rehabilitative therapy for up to 60 consecutive days (from the first visit in an episode of care) when recommended in advance by the primary care physician and approved by the insurer. Payment may be made for the services of additional providers, including speech/language therapy, occupational therapy, and respiratory therapy.

Due to several state mandates, services by home health agencies and for certain "early intervention" services are less restricted. The latter include physical and occupational therapy, speech/language pathology, nursing care and psychological counseling. Total benefits are limited to $2,400 per year until age 3.

I understand from Sharman that Blue Cross and Blue Shield of Alabama will pay for physical therapy over extended periods of time, based on a phone call from the mother of a child who has weekly visits to a physical therapist for a number of years (and receives additional therapy at school).

c. Blue Cross and Blue Shield Standard Plan in the FEHBP

The 1994 Blue Cross and Blue Shield Standard Option plan in the Federal Employees Health Benefits Program (FEHBP) covers outpatient rehabilitation for physical therapy for 50 visits in a calendar year, and occupational or speech therapy for up to 25 visits in a calendar year - when billed by a hospital or other outpatient facility, physician or a licensed therapist.

Persons with congenital anomalies appear to be eligible by including the word "condition" in the standard definition of medical necessity, i.e. coverage is limited to services that the Carrier determines to be "appropriate to diagnose or treat the patient's condition, illness or injury".

There is a targeted exclusion for "maintenance or palliative physical, occupational or speech therapist, except during acute exacerbations of the disease or condition." There is also another, more general, exclusion that appears directed at least in part to outpatient rehabilitation or "recreational, or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay or through an approved Home health care program."

d. Self Insured Plans

There are no legal restrictions on the capacity of self insured plans to offer or restrict outpatient rehabilitative care for children with birth defects. The coverage actually offered tends to reflect the pressures brought on the employee benefits office by employees with problems and the perceptions of the executives. If the company is not under severe financial pressure with respect to the cost of the health plan, coverage may be relatively extensive, especially if an executive's child or other visible employee is involved.

2. Medicare

The Social Security Act is silent concerning the level of care required for payment for outpatient rehabilitation services, except when provided through a home health agency and there are no explicit regulations on the subject. There are very explicit directions, however, in the coverage manual (and summarized succinctly in "Medicare Explained" published by Commerce Clearing House, Inc.).

According to the coverage manual, Medicare uses three sets of separate criteria for a covered service, relating to the provider, the service and the patient's condition.

- The provider must be a physical, speech or occupational therapist as defined in the law.

- The service rendered must meet four conditions: (i) it is a specific and effective treatment for the patient's condition under standards of medical practice; (ii) it is of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or under a therapist's supervision; (iii) there must be a reasonable expectation that the patient will improve significantly in a reasonable and generally predictable, period of time or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and (iv) the amount, frequency and duration must be reasonable.

- Two basic levels of care are specified.

  - Restorative therapy: there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.

  - Maintenance therapy: repetitive services required to maintain function, which do not involve the use of complex and sophisticated therapy procedures and the judgment and skill of a qualified therapist for safe and effective rendition.

    Medicare pays only for restorative therapy and the establishment of a maintenance program.

3. Comparison of Coverage in H.R. 3600 with Private Insurance

a. General

There are several sets of patients that are primarily affected by the restrictions on outpatient rehabilitative therapy. For example, some victims of severe accidents, stroke victims, patients suffering from chronic degenerative illnesses and persons born with physical or speech birth defects. Among persons under age 65, most victims of accidents and strokes and patients who develop degenerative conditions would be expected to qualify under the criteria in H.R.3600.

b. Patients meeting the necessary medical care standard

For patients with accidents, stroke or chronic debilitative conditions, the coverage provided by H.R. 3600 is similar to that in most private insurance policies in that the apparent intention is to restrict coverage primarily to restorative therapy. But the scope is much more expansive with respect to the types of providers eligible (having virtually no restrictions) and the potential duration of services (restricted only by the requirement that the therapist involved expect there to be improved functioning). In contrast, nearly all fee for service insurance plans strictly limit both the types of eligible providers and the duration of services.

The scope of the proposed coverage in H.R. 3600 is broader in providing for a maintenance level of care, similar to that provided for in Medicare. The coverage specifies both rehabilitative therapy and that required to "minimize limitations on physical and cognitive functions".

The impact of the requirement that there be a reevaluation at the end of each 60-day period at which time further services would be covered only if the patient's functioning is improving - is

unclear. The problem is that the sole responsibility for the reevaluation is with the provider, who may well have a vested interest in continuing the services.

Further, the primary operative word that could be used in regulations to limit care to restorative therapy, "improving", is only used in the requirement for a reevaluation at the end of each 60-day period. It is far from clear that such a self evaluation would have any practical impact in a fee for service plan or on out of network services in a point of service plan. The keys to the practical meaning would be the scope permitted health plans for utilization review and management and review activities of the alliances with respect to providers. For example, the Health Care Board could promulgate regulations that (i) specified in detail the standards to be used in the reevaluation, (ii) required extensive documentation of the grounds and (iii) provided for independent evaluations of all such documentation by a provider. The latter could be grounds for disqualification as a provider in the program. On the other hand, such regulations could be overthrown in court.

c. Patients with Birth Defects

As pertains to coverage of outpatient rehabilitation services for conditions related to birth defects, it is not clear what the coverage would turn out to be under H.R. 3600. The uncertainty rests primarily in three general areas:

- How the Health Care Board interprets the restriction to accidents and illness in detailed regulations promulgating the coverage that health plans must provide.

- The degree of control over the determination of the medical "appropriateness" of services that the Board permits in fee for service health plans and for out of network services in point of service plans.

- The extent to which alliance are permitted by the Board to sanction providers that abuse the discretion to determine when services are appropriate, and the vigor with which the public alliances pursue such providers.

- How the courts will interpret the legislative language if the Board (i) does not interpret the coverage to include birth defects or severely restricts any aspect of coverage on the basis that congenital anomalies are not accidents or illness, (ii) permits broad powers through precertification requirements or other utilization review techniques and (iii) upholds any sanctions authorized by the Board.

The references to "cognitive condition" also raise questions concerning whether special education services would be included in the coverage, especially if the coverage is expanded to include the maintenance therapy level. It is assumed here that services that are primarily of an educational or training nature are not considered health services. Obviously, the cost to include such services would increase premium rates significantly.

The intention of the drafters would appear to have been to include services provided in connection with a flair up of a condition related to a birth defect and to pay for services that lead to stabilization of the condition, but not to pay for professional services intended to maintain a stable condition. "Early intervention" services would then by fully covered. But whether this would be the actual coverage under the language of the bill is uncertain.

H.R. 3600 appears to cover virtually all surgery with respect to a birth defect, since a case can be made that such surgery will improve a patient's emotional outlook.

D. Expanded Coverage

It would not appear to be the intention in drafting H.R. 3600 to incorporate a blanket exclusion for outpatient rehabilitation for conditions related to birth defects. In particular, it was intended to include treatment related to flare ups of conditions as opposed to attempts to improve or maintain the functioning of patients in stable condition. Further, a distinction appears to have been intended between the intervention of highly skilled therapists introducing complex programs of treatment and programs of repetitive exercises to continue such an intervention over long periods of time.

The cost of expanded coverage of outpatient rehabilitative services depends importantly on the specific language under which they are authorized and how the language is interpreted by the Board and by the courts. There are several major changes that could be considered.

- Explicitly recognize some classes or all birth defects as covered conditions, e.g. by recognizing them as accidents

- Provide for an extended maintenance level of therapy.

The first would unambiguously provide for the restorative therapy level of care and setting up a maintenance program for conditions related to birth defects. Coverage could be for all patients with birth defects or just those meeting some criteria of "flaring up", i.e. a significant change in condition that can be corrected through appropriate treatment. The second measure would expand care for both those with birth defects and other patients

using outpatient rehabilitation services for chronic degenerative diseases.

In addition, the cost of the restorative care benefit will depend importantly on how the requirement for improvement is implemented, i.e. whether as a practical matter the self certification requirement actually restrains whatever care a provider decides to render.

E. Estimated Cost

The relevant costs are for (i) the coverage of restorative therapy and to set up a program of maintenance therapy for all or some class of patients with birth defects and (ii) the cost of an extended maintenance program of professional therapy for both patients with birth defects and other types of patients using these services. The requirements related to the condition of the patient apply to all three of the primary sets of patients noted above. There are relatively few patients, however, under age 65 with illnesses that would require maintenance care, and most accident victims improve enough with physical therapy to qualify. Thus the cost is primarily related to extended therapy for persons with birth defects.

There appears to be virtually no data available on which to base estimates of the cost for either of these groups. Ideally, it would be possible to examine the claims data from an insurer offering extensive coverage of both restorative care for patients with birth defects and professional maintenance therapy. The examination would have to proceed by examining each claim that included physical, occupational and speech therapy to determine if treatment was occasioned solely by a birth defect (otherwise services are covered by being related to an illness), what class of birth defect (if distinctions are to made among different levels of carriage or birthing accidents and natural congenital defects), and to separate maintenance from restorative (and designate any care that would be found inappropriate at either level). These determinations could only be made by experts familiar with the standards of practice in each therapy specialty and would require much guesswork when working from the limited, circumstantial information typically available in a claims file. There would be the additional problems of the uneven geographic distribution of professionals and possible changes since the services recorded in a claims data base were performed (typically several years ago). Such a data file might be found, but it would require extensive resources and time to analyze it.

Clearly, however, current outlays for rehabilitation services that would not be covered under H.R. 3600 are a relatively small proportion of current health expenditures for several reasons. Relatively few families can afford to pay for extensive therapy by skilled professionals. Consequently, most of the therapists are

forced to concentrate on those patients that qualify for Medicare or insurance payments. Families who are not covered by private health insurance that covers restorative therapy and who can not afford extensive professional care must rely on the schools, Medicaid, charity (e.g. the March of Dimes) and any public resources they can find. Most maintenance care is provided by family members. As a result, there is at present only a limited supply of therapists practicing.

Data from the 1987 NMES show that expenditure recorded in the survey for the relevant therapists (including all undesignated therapists) were 16% of non-physician and non-dentist professional services for which the profession was recorded, 46% of those for chiropractors, and 2.26 times those of podiatrists. Most of this base, however, is physical therapists, for whom patients with birth defects constitute a small portion of their patients. Occupational and speech therapists by themselves constitute only 2% of the non-physician/dentist professions, and 6.5% of chiropractors. These proportions indicate a cost for all of these therapies in the $10 to $15 PMPM range in 1994, of which the fraction that is solely for conditions related to birth defects is probably less than a quarter, or in the $2 to $3 PMPM range.

Accordingly, the additional premium required in 1994 to explicitly cover outpatient rehabilitative care for patients with birth defects either for restorative therapy or for extended professional maintenance therapy would be relatively small, between 0.15% and 0.25% of premiums, and perhaps less than this.

The potential for future growth, however, would appear to be relatively large, especially if there is an extended professional maintenance benefit. The discrepancy between the services that can be made available for congenitally impaired children with adequate income to purchase what is available and what the average child receives can be measured in thousands of dollars per year. Further, there are estimates in the literature that 10% of all children have some chronic health impairment that requires extensive health services, and that 2% have conditions that are very expensive to treat, accounting for 25% of all health expenditures of children (including all medical services). Further, as a result of advances in medical science, an increasing proportion of these children survive to adulthood, and continue to require extensive care, including rehabilitative therapy. Adequate financing for the care could thus lead to a major expansion in the supply of services in the way that coverage under Medicare and Medicaid of home health agencies fueled a rapid expansion that still shows few signs of approaching equilibrium.

An idea of the order of magnitude of the potential demand can be obtained by the cost of the institutionalized population in intermediate care facilities for the mentally retarded. The states and the Federal Government spent just over $9 billion for such

institutional care in fiscal 1993, and will probably spend around $10.7 billion in calendar 1994. If the pattern of nursing home expenditures applies to the ICF/MR population, then (i) the potential demand for professional home care is larger than the cost of institutional care and (ii) less than half of the institutional care is paid for by Medicaid, i.e. the potential demand for home and community based services is more than double the expenditure on institutional care. If the distribution of inpatient and outpatient services for patients with birth defects is similar, the potential demand for rehabilitative and maintenance care would be around $20 billion in 1994. At this level, the expenditures per capita would be as high as 6.5% of premiums. This obviously is a highly speculative figure, and would substitute professional for most therapy now provided by family members. It would probably also include many services that are now provided through public schools.

At present, there are not enough licensed therapists to satisfy more than a fraction of this level of demand. Further, the professional requirements for licensing in most states require a college education and postgraduate training. With adequate, sustained demand, however, supply restraints are likely to fade over time as educational institutions react to the opportunities to train therapists, and other suppliers devote major development efforts to supply new equipment and treatment modalities. Standards are likely to be reduced as more residential, evening, correspondence and community colleges offer programs. Attracting students should not present a problem; there appear to be far more college graduates in the U.S. than there are jobs requiring a college education.

The potential for a rapid expansion of supply would appear to be particularly large if the benefit includes an extended professional maintenance level of therapy. Providing maintenance level of care does not require the extensive training now required to become a physical, occupational or speech therapist. New classes of licensed therapists are likely to appear, corresponding to licensed practical nurses, nurses aides, etc. authorized to perform these services. Vocational training institutes may offer programs.

In addition, with enough money to pay for them, new and different modes of treatment will appear, and parents and advocates will press for inclusion in the basic benefits package. Some of this expansion may begin to take place during the period between passage of legislation and the first year of operation.

One possible model may be the pattern of home health services provided under Medicare. Initially a tiny fraction of health plan outlays, expenditures expanded from a small base, compounding at rates of 40%-50% per year for the first decade of Medicare, tapering off to 15% to 25% thereafter. (The geometric average rate

of increase has been 23%.) An expenditure that expands at such a high rate will ultimately become an important component of total outlays, regardless of the size of the initial base.

Thus the order of magnitude of the cost for full coverage of outpatient rehabilitation services at both the restorative and maintenance levels would appear to be less that 1% in the first year, but doubling and redoubling every two or three years for an indefinite period of years.

F. Impact of Judicial Creep

Over the long run, the services that health plans must offer will depend almost entirely on the policies of the Health Care Board (and any court decisions or legislation directing their actions). The process will be one in which the Board states policies that intend a certain domain of coverage, court decisions tend to expand the actual coverage over time, i.e. through "judicial creep", and in reaction to the costs, new regulations are adopted or new legislation is passed to restrict coverage.

The overall impact, however, would most likely be to expand the rehabilitation services funded at the expense of other care, especially services that do not present the same highly visible plaintiffs. The cost of delivering expanded services will force health plans to economize elsewhere.

Exhibit 1. Birth Defects Covered by A Large Blue Shield Plan

- **Cleft Lip-Cleft Palate**

  Criteria: Staged surgery in the early years of life is required. The functional impairment has caused feeding problems and sometimes breathing problems.

- **Club Foot** (extremity and digit deformities)

  Criteria: A functional impairment exists that may require surgery.

- **Achondroplasia, Osteogenesis Imperfecta, etc.**

  Criteria: Functional impairment exists, usually requires surgery.

- **Diaphragmatic Hernia and Congenital Heart Defects**

  Criteria: Breathing and/or circulatory impairment exists, usually requires surgery.

- **Spine Bifida**

  Criteria: Emergency surgery is usually required.

- **Esophageal Atresia and Tracheo-Esophageal Fistula**

  Criteria: Breathing and feeding impairment exists.

AMENDMENTS ON "ILLNESS OR INJURY"

CURRENT PROVISION	PROPOSED REVISION
Section 1118. Home Health Care "(b) LIMITATIONS. Coverage for home health care is subject to the following limitations: (1) INPATIENT TREATMENT ALTERNATIVE - Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness or injury.	Amend (b)(1) to read as follows: "Such care is covered only to treat an illness, injury, disorder or other health condition [following a period of **OR** as an alternative to] hospitalization or treatment in a more restrictive or costly setting for that illness, injury, disorder or condition." [NOTE: This would allow patients receiving costly OPD or day clinic care to be treated in the home -- a less costly alternative.]

Section 1119. Extended Care Services	
"(b) LIMITATIONS. -- Coverage for extended care services is subject to the following limitations: (1) HOSPITAL ALTERNATIVE -- Such services are covered only ... after an illness or injury."	"(b) LIMITATIONS. -- Coverage for extended care services is subject to the following limitations: (1) HOSPITAL ALTERNATIVE -- Such services are covered only ... after an <u>illness, injury, disorder or other health condition.</u>"
"(c) DEFINITIONS -- (1) REHABILITATION FACILITY -- The term "rehabilitation facility" means an institution ... for rehabilitation from illness or injury." (2) SKILLED NURSING FACILITY -- The term "skilled nursing facility" means an institution ... (B) for rehabilitation from illness or injury.	"(c) DEFINITIONS -- (1) REHABILITATION FACILITY -- The term "rehabilitation facility" means an institution ... and rehabilitation services." (2) SKILLED NURSING FACILITY -- The term "skilled nursing facility" means an institution ... (B) rehabilitation services. [NOTE: There is no reason to define the institutions as providing services only for illness, injury, etc. The limitation is already included in the definition of the service.]

Section 1123. Outpatient Rehabilitation Services "(a) COVERAGE. -- The outpatient rehabilitation services described in this section are -- (3) outpatient speech pathology services .... for the purpose of attaining or restoring speech. "(b) LIMITATIONS. -- Coverage for outpatient rehabilitation services is subject to the following limitations: (1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS. -- Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury."	"(a) COVERAGE. -- The outpatient rehabilitation services described in this section are -- . . . (3) outpatient respiratory therapy; (4) outpatient speech-language pathology services and audiology services. "(b) LIMITATIONS. -- Coverage for outpatient rehabilitation services is subject to the following limitations: (1) TREATMENT PURPOSES. -- Such services include only items or services used to achieve developmentally appropriate activities of daily living, restore functional capacity, minimize limitations on, or prevent further deterioration of physical and cognitive functions as a result of illness, injury, disorder or other condition."
	Rehabilitation provisions (Cont.) (2) REEVALUATION. -- At the end of each 60-day period (or such other period specified by a health professional primarily responsible for providing the rehabilitation services, which may exceed 60 days, the need for continued services shall be reevaluated....Additional periods of care are covered only if such professional determines that the requirements of paragraph (1) are satisfied."

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From: Name: Dr. Charlie Bullock Fax #: (919) 962-0544

Date: 3/8/94

Subject: Information on Recreational Therapy -

Number of Pages With Cover: 5

Message: Hugh -
I hope this helps - If you need additional info, let me know. Say hello to Ann for me -
Charlie Bullock

IF RETRANSMISSION IS NECESSARY, TELEPHONE (919) 962-0534

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Comments: Hope this helps.

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individual needs. The ability to meet the physical and psychosocial needs of the person affected by a disability is critical to the pursuit of independent productivity in vocational and avocational endeavors.

RECOMMENDATIONS IN HEALTHCARE REFORM

The American Therapeutic Recreation Association is in support of a healthcare package which ensures coverage for all Americans. This healthcare package should include cooperative efforts between public and private health insurance programs. **The healthcare reform package should also include standard coverage of a range of rehabilitative services including recreational therapy services.** Current practices restrict the range of rehabilitation services that are identified as standard reimbursable services under Part A of the Medicare and Medicaid Guidelines (e.g. physical therapy, occupational therapy, speech therapy and respiratory care). **Through inclusion of recreational therapy services under Part A and Part B of the Medicare and Medicaid Guidelines (or future healthcare plans), the healthcare provider will have access to additional options to meet the treatment needs of the consumer.** The availability of a broader base of outcome oriented therapies and the application of a proper combination of therapeutic modalities will offer several dramatic benefits:

- The specific needs of the consumer can be better met with the greater availability of disciplines.
- Proper mixes of therapies in a managed care and managed competition system offers a more cost-effective means to meet consumer needs.
- This approach responds in the most effective and efficient manner to the critical shortage of healthcare practitioners by expanding the pool of available professionals.

The inclusion of recreational therapy offers an opportunity for accessing these treatment options to meet the "personal assistance services" of the healthcare consumer. This approach would provide expanded options and service mixes which will prove more cost-effective. For instance: At the current time, if an individual is receiving rehabilitation services for a cerebral vascular accident (stroke), the individual will likely be involved in 1:1 (one on one) physical therapy services to improve range of motion. Should there be an option of inclusion of recreational therapy services (frequently prescribed in group format), the person could receive 60% physical therapy 1:1 services and 40% recreational therapy services in aquatic therapy groups. The result is a mix that is in the best interest of the consumer and will prove to be more cost-effective.

CONCLUSION

In conclusion, the American Therapeutic Recreation Association is in support of cost-effective healthcare opportunities for all citizens. The growing need to ensure basic services to all of America's citizens is evident. The number of Americans requiring health and rehabilitation services continues to increase due to an aging population, disabling conditions, improved treatment services, and greater survival rates. The need to access a broad range of services, therefore is crucial. The intent should be the expansion of effective treatment options as standard services under a national healthcare program. Recreational therapy should be included as a viable option to meet the needs of consumers with disabilities. Ultimately, the availability of greater healthcare options which respond to the unique treatment needs of individuals with disabilities will prove cost-effective. Inclusion of a comprehensive system that responds to individual healthcare consumer needs will reduce the length of hospital stay, reduce hospital recidivism, and maximize on the productivity of the individual. Recreational therapy has been and should continue to be included as an effective treatment discipline in the provision of quality, cost-effective healthcare services.

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patients and thus save the American economy $17,000 per year per patient. Recreational therapy services play a significant role in the comprehensive rehabilitation effort.

- Recreational therapy services are an effective means for improving the functioning, independence, and quality of life of persons with illness or disability. The provision of recreational therapy services, in concert with related disciplines such as occupational therapy, physical therapy, and speech therapy, offer the client or patient comprehensive rehabilitation services. The proper mix of services and the therapist-client relationship proves to be of maximum benefit to the consumer.
- Expenditures in comprehensive rehabilitation services are an investment in human potential and are cost-effective. Recreational therapy services utilize both individual and small group intervention strategies, therefore, staff/patient ratios are cost-effective. More patient treatment hours per therapist can be generated through the use of such small group interventions. Furthermore, recreational therapy services for older Americans are equally cost-effective. Recreational therapists play a significant role in assisting older adults to maintain current skills and re-establish previous levels of functioning in the least restrictive environment possible. Recreational therapists work in concert with and provide complement to other treatment modalities.
- Recreational therapy plays a primary role in enhancing the quality of life and productivity of the consumer. Enjoyable activities and social relations are significant in promoting the quality of life and productivity of the individual with a disability. Recreational therapists offer individuals with disabilities the opportunity to resume normal life activities and to establish/re-establish skills for successful social integration. In addition, the therapist will employ activity treatment modalities which promote physical skill development, enhance feelings of well-being, foster successful experiences, facilitate continued involvement in the rehabilitation process, and establish new life activities for continued growth.

INCLUSION OF RECREATIONAL THERAPY SERVICES AS A STANDARD SERVICE IN HEALTHCARE REFORM

Recreational therapy as a member of the core rehabilitation treatment team

Recreational therapy is listed as one of the physical rehabilitation services in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. Recreational therapists are standard treatment team members in psychiatric rehabilitation, substance abuse treatment, and physical rehabilitation services. In addition, recreational therapists are designated as members of the comprehensive core treatment team in the acute brain injury, the post-acute brain injury, and the inpatient rehabilitation standards of the Commission on Accreditation of Rehabilitation Facilities (CARF).

Since the 1940's, recreational therapists have served as active members of the interdisciplinary treatment team addressing the psychosocial and physical rehabilitation needs of the consumer. Recreational therapy will certainly have an active role in a managed care and managed competition system with emphasis on providing opportunities for meeting rehabilitation goals, accessing life skills and opportunities, and providing quality services in the most cost-efficient manner. These functions must be performed on an on-going basis in concert with other allied health fields such as physical therapy, occupational therapy, and speech therapy and audiology. Although some overlap occurs between all disciplines in areas such as activities of daily living, vocational and avocational adjustment, and application of motor performance skills in the natural environment, the disciplines mutually complement each other in the rehabilitation environment. For instance, each discipline may work on the development of physical skills and activities of daily living. Much of the responsibility for community integration efforts in the rehabilitation setting, however, has become the charge of the recreational therapist. In addition, recreational therapists assist the consumer in developing or re-developing social skills, discretionary time skills, decision making skills, coping abilities, self-advocacy, discharge planning for re-integration, and skills

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UNDERSTANDING RECREATIONAL THERAPY

What is recreational therapy?

Recreational therapy, also referred to as therapeutic recreation, is defined by the United States Department of Labor as a profession of specialists who utilize activities as a form of treatment for persons who are physically, mentally or emotionally disabled (Paraphrased, *Occupational Outlook Handbook*, U.S. Department of Labor, Bureau of Labor Statistics, April 1991). Differing from diversional or recreational services, recreational therapy utilizes various activities as a form of "active treatment" to promote the independent physical, cognitive, emotional, and social functioning of persons disabled as a result of trauma or disease, by enhancing current skills and facilitating the establishment of new skills for daily living and community functioning.

Who delivers recreational therapy services?

Recreational therapy services are delivered by qualified professionals with training and education in therapeutic recreation/recreational therapy service delivery and professionally certified by the National Council for Therapeutic Recreation Certification (NCTRC).

The professional certification designation is Certified Therapeutic Recreation Specialist (CTRS). The credential requires a bachelor's degree or higher from an accredited institution of higher education in the area of therapeutic recreation (recreational therapy), an approved internship under the supervision of a professionally credentialed CTRS, and the passing of a national certification examination administered for NCTRC by the Educational Testing Service (ETS).

What is the projected demand for recreational therapy?

According to the United States Department of Labor's *1992 Occupational Outlook Handbook*, **"Employment of recreational therapists is expected to grow faster than the average for all occupations through the year 2005, because of the anticipated expansion in long-term care, physical and psychiatric rehabilitation, and services for the disabled."** There are approximately 32,000 employment positions in the United States and the growth rate is projected at 39% through the year 2005. It is important to note that employment is available in a wide variety of settings, working with individuals with varying types of disabilities and illnesses.

Where are recreational therapy services delivered?

Recreational therapy services are delivered in a variety of settings depending on the needs of the consumer. Settings in which services are traditionally delivered include freestanding rehabilitation hospitals, rehabilitation units in general hospitals, long-term care or skilled nursing facilities, comprehensive outpatient rehabilitation facilities, inpatient and outpatient mental health/psychiatric facilities, substance abuse rehabilitation facilities, home healthcare services, and residential facilities for persons with disabilities.

What are the benefits of recreational therapy services?

Research indicates that recreational therapy services, provided by qualified professionals, offer a diversity of rehabilitation benefits addressing the needs of individuals with a range of disabling conditions. A recent conference, sponsored by Temple University and funded through the National Institute on Disability and Rehabilitation Research (NIDRR), evaluated the efficacy of therapeutic recreation services as a treatment modality on rehabilitation outcomes. Research has demonstrated the value of recreational therapy services for individuals with a range of diagnoses.

Recreational therapy is a component of comprehensive rehabilitation. Such comprehensive rehabilitation services have proven to be cost-effective. A survey conducted by the Health Insurance Association of America indicated a savings of $11 for every $1 spent on rehabilitation. In addition, other studies have indicated that

Recreational Therapy: An Integral Aspect of Comprehensive Healthcare

The American Therapeutic Recreation Association, the largest national organization representing recreational therapy professionals, has prepared this statement to facilitate the understanding of the critical role recreational therapists play in comprehensive rehabilitation, to express its support for national healthcare reform, and to facilitate the recognition of the cost-effective nature of utilizing recreational therapy services to ensure the total rehabilitation and quality of life for persons with disabilities.

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ATRA AMERICAN THERAPEUTIC RECREATION ASSOCIATION

TALKING POINTS

"ILLNESS AND INJURY"

- First, and most importantly, the President has proposed a strong comprehensive acute care benefit package that will be guaranteed for all Americans, regardless of their medical condition.

- In addition, outlawing pre-existing condition exclusions will help all children have access to health insurance and to a full range of acute care medical services, regardless of their medical condition.

- It is important to understand that this package is intended to cover acute illnesses, not provide chronic care for the chronically ill.

- There are three specific benefits that are limited to treatment following an "illness or injury": outpatient rehabilitation services, extended care services, and home health care. This restriction is typically spelled out in health plans to indicate that they are acute care benefits.

- The term "illness and injury" is not defined in the Health Security Act. However, insurance has traditionally excluded birth defects from the definition.

- The Health Security Act never intended to exclude a particular diagnosis from coverage from any benefit. If our use of the term "illness and injury" appears to have this effect, we are eager to work with child health advocates to assure that this benefit serves the acute care needs of all children.

- In the meantime, it is critical to understand that any child born with a birth defect that requires surgery, professional services, etc. will have full coverage for those services. In addition, if rehabilitative services are necessary following such services, that will be covered within the parameters of the benefit.

- We know that this acute care benefit will not meet all of the long-term support needs for some children. To help address this, two additional programs have been proposed:

    - a new federal program for poor children which will include Medicaid services that are not included in the comprehensive benefit package, such as hearing aids, transportation, and some therapies.

- a major new expansion in community-based long-term care that provides a range of community supports to people with severe disabilities, regardless of their age or income.

In responding to questions about why the benefit package is structured the way it is, here are some additional points that can be made:

* The administration's goal was to structure/design a comprehensive benefit package that meets the acute care needs of all persons;

* The current insurance market appears to use at least 3 options to structure rehabilitative services to meet acute needs. These options are:

  - using illness or injury to define when these services are covered;
  - imposing annual day/visit limits on the services;
  - imposing specific reassessment criteria so that continued services are based on demonstrable and significant improvement in the past treatment period and an expectation of continued signficant improvement in the short term.

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Comments: Cheryl wanted me to Fax this to you, and wanted like to discuss

rehab education — as part of regular ~~case~~ training

NARF NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

SUMMARY OF MODIFICATIONS TO THE HEALTH SECURITY ACT, S. 1757, H.R. 3600 PROPOSED BY THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

The following recommendations regarding the Health Security Act as presented to the Congress by President Clinton were approved by the Board of the National Association of Rehabilitation Facilities on October 29, 1993. A more extensive paper on these and other points is available upon request.

1. Coverage of Inpatient Rehabilitation.

Coverage of inpatient rehabilitation services should be clarified. Section 1111 (page 34) covers inpatient and outpatient hospital services. The term "hospital" is defined, by reference to the Section 1861(e) Medicare Act, to include "an institution ... primarily engaged in providing ... rehabilitation services for the rehabilitation of injured, disabled or sick persons." Services of rehabilitation units in general hospitals would be covered by the more generic definition of "hospital" in 1861(e). NARF supports the coverage of inpatient rehabilitation hospitals and units in the hospital services benefit.

Recommendation: Final conference language should include an explicit reference to coverage of rehabilitation hospitals and units services under this benefit.

Section 1119 (page 64) covers extended care services of up to 100 days per calendar year in a skilled nursing or rehabilitation facility. Such coverage is "only as an alternative to inpatient treatment in a hospital after an illness or injury" (1119(b)(1)). The term "rehabilitation facility" is defined to mean "an institution or distinct part of an institution which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness or injury." (1119(c)(1), page 65). This definition is similar to that of a hospital in 1861(e) of the Medicare Act.

Thus, the bill contains an anomaly with respect to the extended care benefit. The benefit is available only as an alternative to hospitalization, while the definition of a "rehabilitation facility" that can provide it is similar to that of a hospital.

Recommendation:

This anomaly can be resolved by modification of 1119(b)(1) (page 65) as follows: "Such services are covered only as an alternative to inpatient treatment under Section 1111". This modification would allow rehabilitation hospitals and units to provide services under the extended care benefit to patients who no longer require the intensity of nursing, medical and therapy services normally associated with a hospital setting. To do so provides continuity of care for patients requiring rehabilitation services, without disrupting the patient. Rates to be negotiated with health plans would reflect these differing levels of services.

2. Coverage of Outpatient Rehabilitation Services.

Section 1123 (page 69) covers outpatient rehabilitation services in the form of physical therapy, occupational therapy and speech therapy "to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury." Outpatient rehabilitation services are broader than the three therapies listed and generally also include psychology, nursing, social services, audiology (including hearing tests) and cognitive therapy. The value of comprehensive services is recognized in the Medicare Act which includes coverage of comprehensive outpatient rehabilitation facility (CORF) services. The CORF benefit was added to the Medicare Act to permit provision of comprehensive outpatient services by purely outpatient facilities, such services being already covered when provided by a hospital. It also

recognizes that rehabilitation is the coordinated application of therapies and other services, rather than a series of individual services.

Recommendation:

1. The list of services covered under "Outpatient rehabilitation services" in Section 1123 should be expanded to include a new subsection 1123(a)(4) as follows: "psychology, social services and rehabilitation nursing when provided by a Comprehensive Outpatient Rehabilitation Facility, as defined in 1861(cc) of the Social Security Act."

2. In addition, cognitive therapy, audiology and hearing tests should be added as a new Section 1123(a)(5).

3. Congenital disabilities should be added to "illness and injury" as the qualifying conditions for services in 1123(b)(1).

3. Standards for Health Plans/Determination of Medical Necessity.

The bill would encourage the use of HMOs and other types of managed care plans, which is of great concern to rehabilitation facilities because of negative experiences with HMOs.

Recommendation:

In the absence of standards for care, specialty services such as rehabilitation may be inappropriately denied to persons who should receive them. Section 1402(b) should be amended to add a new "(6)" as follows:

> "(6) impose standards for delivery of care that deny or inhibit receipt of medically necessary services. Medical necessity for hospital-level rehabilitation services should be governed by the coverage guidelines for inpatient hospital rehabilitation services under the Medicare program."

A copy of such guidelines is attached.

4. Proposed Reductions in Medicare Spending.

The bill proposes to reduce Medicare spending by $124 billion over five years.

Recommendation:

NARF has proposed adoption of a Medicare PPS for rehabilitation effective 10/1/96 and rebasing of TEFRA limits for rehabilitation hospitals and units for a two-year period. A copy of that proposal is attached. It should be adopted in lieu of any possible reductions in Medicare updates.

5. Workers Compensation/Automobile Insurance.

Section 10001 (page 13115) provides for integration of workers compensation and automobile insurance with benefits under the bill. Health care services to injured workers are to be covered by health plans which would be reimbursed by the responsible workers compensation or automobile insurance carrier. Health plans are to arrange to provide "workers compensation services to ... enrollees" (10001(a)(1)). The bill assumes that all services for which an injured worker is eligible are medical in nature (See 10001(a)(2)) and that coverage of health plans and workers compensation policies are the same. This is not the case, since the coverages provided by workers compensation and auto insurance plans vary, and most workers compensation plans cover vocational rehabilitation services as well as medical services. If health plans

are to be responsible for case management of services to persons covered by workers compensation, they should administer all service benefits to provide for continuity of treatment.

Recommendation:

1. Section 10001(a)(1)(A) should be amended to insert the word "all" before "workers" on line 6, and also before "automobile" in 10101(a) (Line 24).
2. The definition of a "specialized workers compensation provider" Section 1000(2) (line 10), should be amended to read "medical and vocational rehabilitation providers, occupational health and occupational therapy."
3. Rehabilitation must be included in the mission of the Commission on Integration of Health Benefits and Integration (Section 10201).

6. Definition of Employee For Purposes of the Coverage Mandate.

The employer mandate for provision of health insurance is the core element of the bill. Title I, Subtitle G, Page 303. A core issue is who is an employee. This is an issue for rehabilitation facilities which provide training and job experience to persons with physical, mental and emotional disabilities. Many such individuals are provided work experience by rehabilitation facilities, are there for therapeutic reasons and receive nominal wages incident to the receipt of services. This has been recognized by the Internal Revenue Service which has excluded persons performing work for therapeutic reasons from the definition of employee under Revenue Ruling 65-165.

The definitions of employee contained in Section 1901(a)(1)(B) would exclude persons who are covered by this revenue ruling. In addition, however, many persons who have limited productivity by virtue of physical or mental disabilities are provided sheltered or supported employment by rehabilitation facilities. Most have been found to be disabled and thereby qualified for Social Security Disability Insurance (SSDI) assistance or Supplemental Security Income (SSI). SSDI recipients are covered by Medicare (after a waiting period) and SSI recipients are covered by Medicaid. Assistance through these programs is terminated if an individual's income is in excess of certain periodically-adjusted levels of income. Any person earning less than such levels is regarded by the Social Security Administration as not having substantial gainful activity. Such persons should not be deemed to be employees for purposes of the employer mandate in the bill.

Taking this course raises another issue. Under current law there is a two-year waiting period for Medicare coverage after a determination of disability. By definition such persons are not engaged in substantial gainful activity and destined for eventual coverage by Medicare. It does not make sense to put them in a health alliance for a time and then shift coverage to Medicare.

Recommendation:

Accordingly, the two-year waiting period for Medicare by persons determined to be disabled under SSDI should be eliminated and the definition of employee that appears in 1901(a)(1)(B) should be modified to read as follows:

> "the term employee has the meaning given such term under subtitle C of such Code, provided, however, that it shall not include a disabled SSI recipient (as defined in Section 1902(13)) or a recipient of benefits under Social Security Disability Insurance."

7. Rates of Payment to Providers.

The bill does not prescribe a method of payment for services. It leaves rates of payment to be negotiated between health plans and providers of services. There should be a standard to govern such negotiations.

Recommendation:

The bill should be modified to include a requirement that payments to providers for services covered under the Plan conform to the standard now governing state plans under Section 1903(a)(13) of the Medicaid Act (the Boren Amendment). To this end, Section 1203(a)(2) should be modified to include a new "(E)" as follows:

> "(E) payment to providers of services at rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations and quality and safety standards."

8. Risk Assessment.

Section 1541 provides for development of a risk adjustment methodology by the National Health Board. Disability should be added to the factors to be considered under 1541(b)(2).

9. Quality Management.

Subtitle A of Title V (page 835) creates a National Quality Management Program to establish performance standards and monitor quality of care, including outcomes. Data collection and outcomes research on the efficacy of health care should include work on rehabilitation. Rehabilitation providers should be included in the design and conduct of such research, which should, at least with respect to rehabilitation, focus on the resulting quality of life of patients as well as more narrow indicators of functional ability.

Recommendation:

To this end, subsection 5003(c)(2) (Page 840) should be revised by adding a paragraph"(I)", as follows:

> "(I) When a measure relates to the improvement of physical and/or cognitive function through rehabilitation the process shall be linked to the restoration of such functions and the resultant quality of life of patients."

10. Home and Community Based Program of Long Term Care, Title II, Subtitle B.

Section 2101 et. seq. authorizes $65 million over five years (1996-2000) to begin a personal assistance services program. This is a good start for a new service system that could eventually be comprehensive.

Recommendations:

1. Refine the eligibility criteria by modifying the definitions of severe for the different populations to use functional criteria instead of scores on a test. (Section 2103(1))
2. Mandate that states offer a full range of Personal Assistance Services. (Section 2104(c)(g))
3. Place a cap on out-of-pocket co-payments. (Section 2105)
4. Clarify the eligibility criteria for children by using a functional definition of disability which is age-appropriate, such as that used by SSI. (Section 2103(4))
5. Expand the definition of personal assistance so that it covers more than just personal care and includes all of the services currently listed as optional. (Section 2104(g))
6. Provide psychiatric services required over time which are beyond those covered by the comprehensive benefits package. (Section 2104(d))
7. Resolve issues regarding state medical practice and nurse practice acts in relation to health-related tasks preformed by personal assistance providers such as medication administration and catheterization.

11. Tax Incentives to Assist People with Disabilities to Work.

Section 7901 would provide tax credits that would cover 50% of Personal Assistance Services expense up to a maximum of $15,000 per year, or a maximum credit of $7500. The tax credits for working individuals with disabilities will be the difference for many people that will enable them work. Now they can afford to work due to the cost of the personal assistance required for them to hold jobs.

Recommendation:

NARF supports this provision, and recommends these tax credits be extended to families with disabled children.

12. Reforms in Private Long Term Care Insurance and Tax Incentives for Purchasers.

The Administration proposes changes to insurance regulations that will promote private long term services insurance for individuals. In Section 7701(g)(1), qualified long term care services include diagnostic, preventive, therapeutic, rehabilitation services and maintenance or personal care services.

This provision must not become another retirement program where people's only option is to stay home receiving compensation when they could return to work if given rehabilitation. This is part of the problem with the current SSDI system, in that there are not enough incentives for employment.

Recommendation:

NARF supports inclusion of diagnostic, therapeutic, rehabilitative, maintenance, and personal care services in this insurance program.

13. Demonstrations to Improve the Integration of Acute and Long Term Services.

A demonstration program to integrate models of acute and long term services for individuals with disabilities and chronic illness are required. The demonstrations will be used to determine the appropriateness of including these models as program options in the managed competition structure, as well as ways to smooth the transition from acute care to the community.

Rehabilitation providers would be ideal participants in the demonstration programs.

Recommendation:

NARF supports these demonstrations in Section 2601.

FOR FURTHER INFORMATION CALL: Carolyn C. Zollar, NARF, (703) 648-9300
For information on the long term care program for persons with disabilities call Yo Bestgen, NARF, (703) 648-9300.

ATTACHMENTS:
Medicare Inpatient Rehabilitation Hospital Guidelines

NARF Proposal to Modify TEFRA And Move To A Prospective Payment System for Rehabilitation Hospitals and Units

narf_9\common\hill.mod
revised 12/9/93

[Soc. Sec. Act § 1834(c)(4), (5).] The Secretary is responsible for assuring that quality standards for safety and accuracy are satisfied. [Soc. Sec. Act § 1834(c)(3).]

[¶ 381] Physical, Occupational, and Speech Therapy Services

The Part B program covers physical, occupational, and speech therapy services. This benefit includes the following types of therapy services [Soc. Sec. Act § 1861(g), (p), (s)(2)(D)]:

(1) *outpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency;

(2) therapy *in the therapist's office or the patient's home*, in the case of a qualified physical or occupational therapist in independent practice; and

(3) *inpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency to an inpatient of a hospital or skilled nursing facility.

In order for the therapy services to be covered, the patient must be under the care of a physician, a plan of treatment must be developed by either the physician or the therapist, and the plan must be periodically reviewed by the physician. Any item or service that would be excluded as an inpatient hospital benefit would also be excluded as a therapy benefit. [Soc. Sec. Act § 1861(p).]

Physical, occupational, and speech therapy services are also covered under Part B as incident to physician services (¶ 351), provided, in general, they are furnished under the direct supervision of the physician, or as comprehensive outpatient rehabilitation facility services (¶ 385).

"Therapy Services" Defined

Physical, occupational, and speech therapy services for Medicare purposes are those services furnished a patient that are reasonable and necessary to treat an illness or an injury and that also meet all of the following conditions [*Medicare Carriers Manual* § 2210]:

(1) The services must be considered under standards of medical practice to be a specific and effective treatment for the patient's condition;

(2) The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or under a therapist's supervision;

(3) The services must be provided with the expectation, based on the physician's assessment of the patient's restorative potential after any needed consultation with the therapist, that the patient will improve significantly in a reasonable, and generally predictable, period of time, or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

(4) The amount, frequency, and duration of services must be reasonable.

A podiatrist can be considered a "physician" for purposes of the physical, occupational, and speech therapy benefit. [Soc. Sec. Act § 1861(p)(1).]

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical or occupational therapy for Medicare purposes.

Examples of the more common physical therapy modalities and procedures used in the treatment of patients include: (1) hot pack, hydrocollator, infrared treatments, and whirlpool baths, (2) gait training, (3) ultrasound, short-wave, and microwave diathermy treatments, (4) range of motion tests, and (5) generally therapeutic exercises. [*Medicare Carriers Manual* § 2210.3.]

Restorative Therapy. As indicated above, to constitute physical, occupational, and speech therapy a service furnished an individual must be reasonable and necessary to the treatment of his illness. If an individual's expected restoration potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, the physical therapy is not considered reasonable and necessary to the treatment of the individual's illness or injury. Accordingly, there must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the physician's assessment of the patient's restoration potential after any needed consultation with the qualified therapist. This expectation may not always prove to be valid, and the realization that restoration will not occur can and should also be reached in a reasonable and generally predictable period of time. [*Medicare Carriers Manual* § § 2210.1, 2216.]

Maintenance Therapy. Generally speaking, the repetitive services required to maintain function do not involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a qualified therapist are not required for the safe and effective rendition of such services. However, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program if the program is to be safely carried out and the treatment aims of the physician achieved. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to the maintenance of his present level of function. In these situations, the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or family members in the carrying out of such program and such infrequent reevaluations as may be required would constitute physical therapy under the program. When a patient has been under a restorative therapy program, the therapist will regularly re-evaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of family members to maintain the function being restored. Consequently, in such situations, as of the point it is determined that no further restoration is possible, the therapist will have already designed the maintenance program required and instructed the patient or family members in the carrying out of the program. [*Medicare Carriers Manual* § § 2210.2, 2216.]

Independently Practicing Therapists

Physical and occupational therapy (but not speech pathology) are also covered when provided by a therapist in independent practice, when furnished by or under his direct supervision in his office or in the patient's home. These services are covered only if furnished under licensing and other conditions relating to health and safety the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment, established by a physician or a qualified physical or occupational therapist that prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to state licensure. [Soc. Sec. Act § 1861(p); Reg. 42 CFR § § 405.1730 *et seq.*, 410.60(c).]

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A qualified physical or occupational therapist will be considered to be in independent practice when he renders services on his own responsibility and free of the administrative and professional control of an employer, such as a physician, institution, agency, etc.; the persons he treats are his own patients; and he has the right to collect fees for the services he renders. While the therapist need not be in full-time private practice, he must be engaged in private practice on a regular basis, i.e., recognized as a private practitioner and for that purpose maintaining at his own expense an office or office space and the necessary equipment to provide an adequate therapy program. [*Medicare Carriers Manual* § 2215.]

The services must be provided either by or under the direct supervision of the therapist, and the services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be in the employ of the independent therapist. [*Medicare Carriers Manual* § 2215.]

Limitation on Payment for Independent Therapy Services

When the outpatient physical or occupational therapy services are furnished by a licensed physical or occupational therapist in independent practice, payment may be made either directly to the beneficiary for the incurred expenses or on his behalf (that is, upon assignment by him) to the therapist who furnished the services. However, *no more than $750 in any calendar year may be considered as incurred expenses, and hence reimbursable for physical or occupational therapy services furnished by a therapist in independent practice.* [Soc. Sec. Act § 1833(g).] This payment is subject to the deductible and coinsurance provisions of the supplementary medical insurance program (see ¶ 335).

Clinic or Agency Standards

A physical therapy clinic or agency must (i) provide an adequate program of physical therapy services for outpatients and have the facilities and personnel required for the supervision of such a program, and (ii) have policies established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the physical therapy services. A public health agency need only satisfy the Secretary that it has adequate health and safety standards in order to qualify for outpatient physical therapy payments. [Soc. Sec. Act § 1861(p)(4).]

The conditions of participation for rehabilitation agencies, clinics, and public health agencies are contained in Subpart Q of the Medicare regulations (42 CFR Ch. IV, Subch. B, Part 405).

[¶ 382] Rural and Community Health Clinic Services

Part B covers services furnished by a physician assistant, nurse practitioner, clinical social worker, and clinical psychologist in rural health clinics and community health centers, whether or not the clinic is under the full-time direction of a physician, provided the physician assistant or nurse practitioner is legally authorized under state law to perform such services. [Soc. Sec. Act § 1861(s)(2)(E), (aa)(4).] Services and supplies which are furnished "incident to" the services of a physician assistant, nurse practitioner, and clinical psychologist in the clinic are also covered, if they would otherwise be covered when provided as an incident to a physician's service (see ¶ 351)—for example, bandages and traditional nursing services. Nurse-midwife services, pneumococcal vaccine, and hepatitis B vaccine are also covered as rural health clinic services. [Soc. Sec. Act § 1861(aa)(1); Reg. 42 CFR § 405.2401(b)(10).]

Item 4. Earlier CBO Questions as to whether premium estimates include certain provisions in the bill (This may have already been taken care of)

- o Section 1204, page 101, Financial Solvency: Fiscal Oversight Guaranty Fund. "State may require each regional alliance health . . . to pay an assessment to the state in an amount not to exceed 2% . . ."

- o Section 11007, page 1326 - 1330, National Transitional Health Insurance Risk Pool, assessment specified in (f)(3). In addition to the basic question of is this assessment cost included in premium estimates, the CBO staff person asked:

  -- Is 1/2% sufficient?
  -- Is it only a transition issue, don't we need reinsurance beyond transition?

- o Section 1323, pages 135 - 145, have the estimates accounted for costs associated with unenrolled individuals.

- o Section 1352, page 176, Alliance Administrative Allowance Percentage

- o Section 1353, page 176, Payments to the Federal Government for Academic Health Centers and Graduate Medical Education. In addition to the basic question of is this in the premium estimate, is how was the 1.5% derived? Is it a weighted average including Medicare? Is the 1.5% of national premium equivalent to the cost of running the academic centers? How does this work during the transition?

- o Encounter reporting - how was this new cost to plans taken into account? In particular for existing HMOs that do not have encounter data systems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: ~~Jennifer Kline~~ Sharman Stephens

To: Jennifer Kline

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(202) 690-6870

FAX: (202) 401-7321

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Fax: _____

Number of Pages (Including Cover): 13

Comments: Medicare statute
→ Medicare Explained ← most relevant
Medicare regs
on therapies

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services[666]

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services

[666] P.L. 101-234, §101(a)(1), added subsection (i), effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1) or (3) of section 1861(r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health

agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice

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Medicare Explained

By CCH Business Law Editors

COMMERCE CLEARING HOUSE, INC.
4025 WEST PETERSON AVENUE CHICAGO, ILLINOIS 60646

[Soc. Sec. Act § 1834(c)(4), (5).] The Secretary is responsible for assuring that quality standards for safety and accuracy are satisfied. [Soc. Sec. Act § 1834(c)(3).]

[¶ 381] Physical, Occupational, and Speech Therapy Services

The Part B program covers physical, occupational, and speech therapy services. This benefit includes the following types of therapy services [Soc. Sec. Act § 1861(g), (p), (s)(2)(D)]:

(1) *outpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency;

(2) therapy *in the therapist's office or the patient's home,* in the case of a qualified physical or occupational therapist in independent practice; and

(3) *inpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency to an inpatient of a hospital or skilled nursing facility.

In order for the therapy services to be covered, the patient must be under the care of a physician, a plan of treatment must be developed by either the physician or the therapist, and the plan must be periodically reviewed by the physician. Any item or service that would be excluded as an inpatient hospital benefit would also be excluded as a therapy benefit. [Soc. Sec. Act § 1861(p).]

Physical, occupational, and speech therapy services are also covered under Part B as incident to physician services (¶ 351), provided, in general, they are furnished under the direct supervision of the physician, or as comprehensive outpatient rehabilitation facility services (¶ 385).

"Therapy Services" Defined

Physical, occupational, and speech therapy services for Medicare purposes are those services furnished a patient that are reasonable and necessary to treat an illness or an injury and that also meet all of the following conditions [*Medicare Carriers Manual* § 2210]:

(1) The services must be considered under standards of medical practice to be a specific and effective treatment for the patient's condition;

(2) The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or under a therapist's supervision;

(3) The services must be provided with the expectation, based on the physician's assessment of the patient's restorative potential after any needed consultation with the therapist, that the patient will improve significantly in a reasonable, and generally predictable, period of time, or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state;

(4) The amount, frequency, and duration of services must be reasonable.

A podiatrist can be considered a "physician" for purposes of the physical, occupational, and speech therapy benefit. [Soc. Sec. Act § 1861(p)(1).]

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical or occupational therapy for Medicare purposes.

Examples of the more common physical therapy modalities and procedures used in the treatment of patients include: (1) hot pack, hydrocollator, infrared treatments, and whirlpool baths, (2) gait training, (3) ultrasound, short-wave, and microwave diathermy treatments, (4) range of motion tests, and (5) generally therapeutic exercises. [*Medicare Carriers Manual* § 2210.3.]

Restorative Therapy. As indicated above, to constitute physical, occupational, and speech therapy a service furnished an individual must be reasonable and necessary to the treatment of his illness. If an individual's expected restoration potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, the physical therapy is not considered reasonable and necessary to the treatment of the individual's illness or injury. Accordingly, there must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the physician's assessment of the patient's restoration potential after any needed consultation with the qualified therapist. This expectation may not always prove to be valid, and the realization that restoration will not occur can and should also be reached in a reasonable and generally predictable period of time. [*Medicare Carriers Manual* § § 2210.1, 2216.]

Maintenance Therapy. Generally speaking, the repetitive services required to maintain function do not involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a qualified therapist are not required for the safe and effective rendition of such services. However, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program if the program is to be safely carried out and the treatment aims of the physician achieved. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to the maintenance of his present level of function. In these situations, the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or family members in the carrying out of such program and such infrequent reevaluations as may be required would constitute physical therapy under the program. When a patient has been under a restorative therapy program, the therapist will regularly re-evaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of family members to maintain the function being restored. Consequently, in such situations, as of the point it is determined that no further restoration is possible, the therapist will have already designed the maintenance program required and instructed the patient or family members in the carrying out of the program. [*Medicare Carriers Manual* § § 2210.2, 2216.]

Independently Practicing Therapists

Physical and occupational therapy (but not speech pathology) are also covered when provided by a therapist in independent practice, when furnished by or under his direct supervision in his office or in the patient's home. These services are covered only if furnished under licensing and other conditions relating to health and safety the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment, established by a physician or a qualified physical or occupational therapist that prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to state licensure. [Soc. Sec. Act § 1861(p); Reg. 42 CFR § § 405.1730 *et seq.*, 410.60(c).]

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The services must be provided either by or under the direct supervision of the therapist, and the services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be in the employ of the independent therapist. [*Medicare Carriers Manual* § 2215.]

Limitation on Payment for Independent Therapy Services

When the outpatient physical or occupational therapy services are furnished by a licensed physical or occupational therapist in independent practice, payment may be made either directly to the beneficiary for the incurred expenses or on his behalf (that is, upon assignment by him) to the therapist who furnished the services. However, *no more than $750 in any calendar year may be considered as incurred expenses, and hence reimbursable for physical or occupational therapy services furnished by a therapist in independent practice.* [Soc. Sec. Act § 1833(g).] This payment is subject to the deductible and coinsurance provisions of the supplementary medical insurance program (see ¶ 335).

Clinic or Agency Standards

A physical therapy clinic or agency must (i) provide an adequate program of physical therapy services for outpatients and have the facilities and personnel required for the supervision of such a program, and (ii) have policies established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the physical therapy services. A public health agency need only satisfy the Secretary that it has adequate health and safety standards in order to qualify for outpatient physical therapy payments. [Soc. Sec. Act § 1861(p)(4).]

The conditions of participation for rehabilitation agencies, clinics, and public health agencies are contained in Subpart Q of the Medicare regulations (42 CFR Ch. IV, Subch. B, Part 405).

[¶ 382] Rural and Community Health Clinic Services

Part B covers services furnished by a physician assistant, nurse practitioner, clinical social worker, and clinical psychologist in rural health clinics and community health centers, whether or not the clinic is under the full-time direction of a physician, provided the physician assistant or nurse practitioner is legally authorized under state law to perform such services. [Soc. Sec. Act § 1861(s)(2)(E), (aa)(4).] Services and supplies which are furnished "incident to" the services of a physician assistant, nurse practitioner, and clinical psychologist in the clinic are also covered, if they would otherwise be covered when provided as an incident to a physician's service (see ¶ 351)—for example, bandages and traditional nursing services. Nurse-midwife services, pneumococcal vaccine, and hepatitis B vaccine are also covered as rural health clinic services. [Soc. Sec. Act § 1861(aa)(1); Reg. 42 CFR § 405.2401(b)(10).]

code of federal regulations

Public Health

42

PARTS 400 TO 429

Revised as of October 1, 1992

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.63.

(3) They are furnished—

(i) By a provider, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the direct supervision of a physical therapist in independent practice who is licensed by the State in which he or she practices and who meets the qualifications specified in § 405.1702(d) of this chapter.

(b) *Outpatient physical therapy services to certain inpatients of a hospital or SNF.* Medicare Part B pays for outpatient physical therapy services furnished to an inpatient of a hospital or a SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by physical therapists in independent practice*—(1) *Who is a physical therapist in independent practice.* A physical therapist in independent practice is one who—

(i) Engages in the practice of physical therapy on a regular basis;

(ii) Furnishes services on his or her own responsibility without the administrative and professional control of an employer;

(iii) Maintains, at his or her own expense, office space and the necessary equipment to provide an adequate program of physical therapy;

(iv) Furnishes services only in office space maintained at his or her expense, or in the patient's home; and

(v) Treats individuals who are his or her own patients and collects fees or other compensation for the services furnished.

(2) *Limitation on incurred expenses.* Not more than $500 of reasonable charges incurred in a calendar year are recognized as incurred expenses.[2]

(d) *Excluded services.* No service is included as an outpatient physical therapy service if it would not be included as an inpatient hospital service if furnished to an inpatient of a hospital.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 56 FR 8852, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

§ 410.61 Plan of treatment requirements for outpatient physical therapy and speech pathology services.

(a) *Basic requirement.* Outpatient physical therapy services (including services furnished by a qualified physical therapist in independent practice), and outpatient speech pathology services must be furnished under a written plan of treatment that meets the requirements of paragraphs (b) through (e) of this section.

(b) *Establishment of the plan.* The plan is established before treatment is begun by one of the following:[1]

(1) A physician.

(2) A physical therapist who will furnish the physical therapy services.

(3) A speech pathologist who will furnish the speech pathology services.

(c) *Content of the plan.* The plan prescribes the type, amount, frequency, and duration of the physical therapy or speech pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan—

(1) Are made in writing and signed by one of the following:

(i) The physician or the physical therapist or speech pathologist who furnishes the services.

(ii) A registered professional nurse or a staff physician, in accordance with oral orders from the physician,

[2] Before 1982, not more than $100 was recognized as incurred expenses.

[1] Before January 1981, only a physician could establish a plan of treatment for physical therapy or speech pathology services. Speech pathologists were authorized to establish a plan effective January 1, 1981; physical therapists, effective July 18, 1984.

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(2) The changes are incorporated in the plan immediately.

(e) *Review of the plan.* (1) The physician reviews the plan as often as the individual's condition requires, but at least every 30 days.

(2) Each review is dated and signed by the physician who performs it.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 54 FR 38680, Sept. 20, 1989; 54 FR 46614, Nov. 6, 1989; Redesignated at 56 FR 8854, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

§ 410.62 Outpatient speech pathology services: Conditions and exclusions.

(a) *Basic rule.* Medicare Part B pays for outpatient speech pathology services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine or osteopathy.

(2) They are furnished under a written plan of treatment that—

(i) Is established by a physician or, effective January 1, 1982, by either a physician or the speech pathologist who will provide the services to the particular individual;

(ii) Is periodically reviewed by a physician; and

(iii) Meets the requirements of § 410.63.

(3) They are furnished by a provider or by others under arrangements with, and under the supervision of, a provider.

(b) *Outpatient speech pathology services to certain inpatients of a hospital or SNF.* Medicare Part B pays for outpatient speech pathology services furnished to an inpatient of a hospital or SNF who requires them but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Excluded services.* No service is included as an outpatient speech pathology service if it would not be included as an inpatient hospital service if furnished to an inpatient of a hospital.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 56 FR 8852, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

§ 410.63 Hepatitis B vaccine and blood clotting factors: Conditions.

Notwithstanding the exclusion from coverage of vaccines (see § 405.310 of this chapter) and self-administered drugs (see § 410.29), the following services are included as medical and other health services covered under § 410.10, subject to the specified conditions:

(a) *Hepatitis B vaccine: Conditions.* Effective September 1, 1984, hepatitis B vaccinations that are reasonable and necessary for the prevention of illness for those individuals who are at high or intermediate risk of contracting hepatitis B as listed below:

(1) *High risk groups.* (i) End-Stage Renal Disease (ESRD) patients;

(ii) Hemophiliacs who receive Factor VIII or IX concentrates;

(iii) Clients of institutions for the mentally retarded;

(iv) Persons who live in the same household as a hepatitis B carrier;

(v) Homosexual men;

(vi) Illicit injectable drug abusers; and

(vii) Pacific Islanders (that is, those Medicare beneficiaries who reside on Pacific islands under U.S. jurisdiction, other than residents of Hawaii).

(2) *Intermediate risk groups.* (i) Staff in institutions for the mentally retarded and classroom employees who work with mentally retarded persons;

(ii) Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work (including workers who work outside of a hospital and have frequent contact with blood or other infectious secretions); and

(iii) Heterosexually active persons with multiple sexual partners (that is, those Medicare beneficiaries who have had at least two documented episodes of sexually transmitted diseases within the preceding 5 years).

(3) *Exception.* Individuals described in paragraphs (a) (1) and (2) of this section are not considered at high or intermediate risk of contracting hepatitis B if they have undergone a prevaccination screening and have been found to be currently positive for antibodies to hepatitis B.

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(1) Works under the direction of an anesthesiologist;

(2) Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and

(3) Is a graduate of a medical school-based anesthesiologist's assistant educational program that—

(A) Is accredited by the Committee on Allied Health Education and Accreditation; and

(B) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Anesthetist includes both an anesthesiologist's assistant and a certified registered nurse anesthetist.

Certified registered nurse anesthetist means a registered nurse who:

(1) Is licensed as a registered professional nurse by the State in which the nurse practices;

(2) Meets any licensure requirements the State imposes with respect to nonphysician anesthetists;

(3) Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and

(4) Meets the following criteria:

(i) Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or

(ii) Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(i) of this definition.

[57 FR 33896, July 31, 1992]

Subpart C—Home Health Services Under SMI

§ 410.80 Applicable rules.

Home health services furnished under Medicare Part B are subject to the rules set forth in subpart E of part 409 of this chapter.

Subpart D—Comprehensive Outpatient Rehabilitation Facility (CORF) Services

§ 410.100 Included services.

Subject to the conditions and limitations set forth in §§ 410.102 and 410.105, CORF services means the following services furnished to an outpatient of the CORF by personnel that meet the qualifications set forth in § 485.70 of this chapter.

(a) *Physicians' services.* The following services of the facility physician constitute CORF services: consultation with and medical supervision of non-physician staff, establishment and review of the plan of treatment, and other medical and facility administration activities. Those services are reimbursed on a reasonable cost basis under part 413 of this chapter. Diagnostic and therapeutic services furnished to an individual patient are not CORF physician's services. If covered, payment for these services would be made by the carrier on a reasonable charge basis subject to the provisions of subpart E of part 405 of this chapter.

(b) *Physical therapy services.* (1) These services include—

(i) Testing and measurement of the function or dysfunction of the neuromuscular, musculoskeletal, cardiovascular and respiratory systems; and.

(ii) Assessment and treatment related to dysfunction caused by illness or injury, and aimed at preventing or reducing disability or pain and restoring lost function.

(2) The establishment of a maintenance therapy program for an individual whose restoration potential has been reached is a physical therapy service; however, maintenance therapy itself is not covered as part of these services.

(c) *Occupational therapy services.* These services include—

(1) Teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities.

(2) Evaluation of an individual's level of independent functioning.

(3) Selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and

(4) Assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

(d) *Speech-language pathology services.* These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

(e) *Respiratory therapy services.* (1) These are services for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

(2) These services include—

(i) Application of techniques for support of oxygenation and ventilation of the patient and for pulmonary rehabilitation.

(ii) Therapeutic use and monitoring of gases, mists, and aerosols and related equipment;

(iii) Bronchial hygiene therapy;

(iv) Pulmonary rehabilitation techniques such as exercise conditioning, breathing retraining and patient education in the management of respiratory problems.

(v) Diagnostic tests to be evaluated by a physician, such as pulmonary function tests, spirometry and blood gas analysis; and

(vi) Periodic assessment of chronically ill patients and their need for respiratory therapy.

(f) *Prosthetic device services.* These services include—

(1) Prosthetic devices (excluding dental devices and renal dialysis machines), that replace all or part of an internal body organ or external body member (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning external body member or internal body organ; and

(2) Services necessary to design the device, select materials and components, measure, fit, and align the device, and instruct the patient in its use.

(g) *Orthotic device services.* These services include—

(1) Orthopedic devices that support or align movable parts of the body, prevent or correct deformities, or improve functioning; and

(2) Services necessary to design the device, select the materials and components, measure, fit, and align the device, and instruct the patient in its use.

(h) *Social services.* These services include—

(1) Assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility;

(2) Casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and

(3) Assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

(i) *Psychological services.* These services include—

(1) Assessment, diagnosis and treatment of an individual's mental and emotional functioning as it relates to the individual's rehabilitation;

(2) Psychological evaluations of the individual's response to and rate of progress under the treatment plan; and

(3) Assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment.

(j) *Nursing care services.* These services include nursing services specified in the plan of treatment and any other nursing services necessary for the attainment of the rehabilitation goals.

(k) *Drugs and biologicals.* These are drugs and biologicals that are—

(1) Prescribed by a physician and administered by or under the supervision of a physician or a registered professional nurse; and

(2) Not excluded from Medicare Part B payment for reasons specified in § 410.29.

(l) *Supplies, appliances, and equipment.* These include—

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(1) Non-reusable supplies such as oxygen and bandages;
(2) Medical equipment and appliances; and
(3) Durable medical equipment of the type specified in § 410.38, (except renal dialysis systems) for use outside the CORF, whether purchased or rented.
(m) *Home environment evaluation.* This is a single home visit to evaluate the potential impact of the home situation on the rehabilitation goals.

[51 FR 41339, Nov. 14, 1986; 52 FR 4499, Feb. 12, 1987]

§ 410.102 Excluded services.

None of the services specified in § 410.100 is covered as a CORF service if the service—
(a) Would not be covered as an inpatient hospital service if furnished to a hospital inpatient;
(b) Is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. An example would be services furnished as part of a maintenance program involving repetitive activities that do not require the skilled services of nurses or therapists.

§ 410.105 Requirements for coverage of CORF services.

Services specified in § 410.100 and not excluded under § 410.102 are covered as CORF services if they are furnished by a participating CORF (that is, a CORF that meets the conditions of subpart B of part 485 of this chapter, and has in effect a provider agreement under part 489 of this chapter) and if the following requirements are met:
(a) *Referral and medical history.* The services must be furnished to an individual who is referred by a physician who certifies that the individual needs skilled rehabilitation services, and makes the following information available to the CORF before or at the time treatment is begun:
(1) The individual's significant medical history.
(2) Current medical findings.
(3) Diagnosis(es) and contraindications to any treatment modality.
(4) Rehabilitation goals, if determined.
(b) *When and where services are furnished.* (1) All services must be furnished while the individual is under the care of a physician.
(2) Except as provided in paragraph (b)(3) of this section, the services must be furnished on the premises of the CORF.
(3) *Exceptions.* (i) Physical therapy, occupational therapy, and speech pathology services may be furnished away from the premises of the CORF.
(ii) The single home visit specified in § 410.100(m) is also covered.
(c) *Plan of treatment.* (1) The services must be furnished under a written plan of treatment that—
(i) Is established and signed by a physician before treatment is begun; and
(ii) Prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals.
(2) The plan must be reviewed at least every 60 days by a facility physician who, when appropriate, consults with the professional personnel providing the services.
(3) The reviewing physician must certify or recertify that the plan is being followed, the patient is making progress in attaining the rehabilitation goals, and the treatment is having no harmful effects on the patient.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8841, Mar. 1, 1991]

Subpart E—Payment of SMI Benefits

§ 410.150 To whom payment is made.

(a) *General rules.* (1) Any SMI enrollee is, subject to the conditions, limitations, and exclusions set forth in this part and in parts 405, 416 and 424 of this chapter, entitled to have payment made as specified in paragraph (b) of this section.
(2) The services specified in paragraphs (b)(5) through (b)(11) of this section must be furnished by a facility that has in effect a provider agreement or other appropriate agreement to participate in Medicare.

1992

Medicare Explained

By CCH Business Law Editors

COMMERCE CLEARING HOUSE, INC.
4025 WEST PETERSON AVENUE CHICAGO, ILLINOIS 60646

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[Soc. Sec. Act § 1834(c)(4), (5).] The Secretary is responsible for assuring that quality standards for safety and accuracy are satisfied. [Soc. Sec. Act § 1834(c)(3).]

[¶ 381] Physical, Occupational, and Speech Therapy Services

The Part B program covers physical, occupational, and speech therapy services. This benefit includes the following types of therapy services [Soc. Sec. Act § 1861(g), (p), (s)(2)(D)]:

(1) *outpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency;

(2) therapy *in the therapist's office or the patient's home,* in the case of a qualified physical or occupational therapist in independent practice; and

(3) *inpatient* therapy services furnished by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency to an inpatient of a hospital or skilled nursing facility.

In order for the therapy services to be covered, the patient must be under the care of a physician, a plan of treatment must be developed by either the physician or the therapist, and the plan must be periodically reviewed by the physician. Any item or service that would be excluded as an inpatient hospital benefit would also be excluded as a therapy benefit. [Soc. Sec. Act § 1861(p).]

Physical, occupational, and speech therapy services are also covered under Part B as incident to physician services (¶ 351), provided, in general, they are furnished under the direct supervision of the physician, or as comprehensive outpatient rehabilitation facility services (¶ 385).

"Therapy Services" Defined

Physical, occupational, and speech therapy services for Medicare purposes are those services furnished a patient that are reasonable and necessary to treat an illness or an injury and that also meet all of the following conditions [*Medicare Carriers Manual* § 2210]:

(1) The services must be considered under standards of medical practice to be a specific and effective treatment for the patient's condition;

(2) The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or under a therapist's supervision;

(3) The services must be provided with the expectation, based on the physician's assessment of the patient's restorative potential after any needed consultation with the therapist, that the patient will improve significantly in a reasonable, and generally predictable, period of time, or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state;

(4) The amount, frequency, and duration of services must be reasonable.

A podiatrist can be considered a "physician" for purposes of the physical, occupational, and speech therapy benefit. [Soc. Sec. Act § 1861(p)(1).]

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical or occupational therapy for Medicare purposes.

Examples of the more common physical therapy modalities and procedures used in the treatment of patients include: (1) hot pack, hydrocollator, infrared treatments, and whirlpool baths, (2) gait training, (3) ultrasound, short-wave, and microwave diathermy treatments, (4) range of motion tests, and (5) generally therapeutic exercises. [*Medicare Carriers Manual* § 2210.3.]

Restorative Therapy. As indicated above, to constitute physical, occupational, and speech therapy a service furnished an individual must be reasonable and necessary to the treatment of his illness. If an individual's expected restoration potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, the physical therapy is not considered reasonable and necessary to the treatment of the individual's illness or injury. Accordingly, there must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the physician's assessment of the patient's restoration potential after any needed consultation with the qualified therapist. This expectation may not always prove to be valid, and the realization that restoration will not occur can and should also be reached in a reasonable and generally predictable period of time. [*Medicare Carriers Manual* § § 2210.1, 2216.]

Maintenance Therapy. Generally speaking, the repetitive services required to maintain function do not involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a qualified therapist are not required for the safe and effective rendition of such services. However, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program if the program is to be safely carried out and the treatment aims of the physician achieved. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to the maintenance of his present level of function. In these situations, the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or family members in the carrying out of such program and such infrequent reevaluations as may be required would constitute physical therapy under the program. When a patient has been under a restorative therapy program, the therapist will regularly re-evaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of family members to maintain the function being restored. Consequently, in such situations, as of the point it is determined that no further restoration is possible, the therapist will have already designed the maintenance program required and instructed the patient or family members in the carrying out of the program. [*Medicare Carriers Manual* § § 2210.2, 2216.]

Independently Practicing Therapists

Physical and occupational therapy (but not speech pathology) are also covered when provided by a therapist in independent practice, when furnished by or under his direct supervision in his office or in the patient's home. These services are covered only if furnished under licensing and other conditions relating to health and safety the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment, established by a physician or a qualified physical or occupational therapist that prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to state licensure. [Soc. Sec. Act § 1861(p); Reg. 42 CFR § § 405.1730 *et seq.*, 410.60(c).]

Definition of Rehab

Aetna Short-term rehab: provided on an inpatient or outpatient for up to 90 days/episode of acute illness or injury if significant improvement can be expected within 90 days. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

US Health Care of Delaware Short-term rehab is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

BC/BS Physical, Occupational and Speech Therapy cover 50 visits per person per calendar year for physical therapy, and up to 25 visits per person per calendar year for occupational and speech therapy. Not covered - maintenance or palliative physical, occupational or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified therapists, except during acute exacerbations of the disease or condition. Excluded Recreational or educational therapy and any related diagnostic testing, except as provided by a hospital as part of a covered inpatient stay or through an approved home health care program.

MDIPA Short-term Rehab (physical, speech, occupational, chiropractic, and acupuncture) is provided on an inpatient or outpatient basis for up to two months or up to 60 visits (whichever is more) per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Health Plus Short-term rehab is provided up to a maximum of two months per condition, when a Plan doctor has determined that provision of therapy will result in a significant improvement in the member's condition within two months of the date of the first treatment.

APWU Rehab Care is treatment that reasonably can be expected to restore and/or substantially restore a bodily function that was impaired as a result of trauma or disease.