

Statement

to the

Federal Trade Commission/Department of Justice
Joint Hearings on Health Care Competition Law and Policy

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FTC PRESENTATION

The American Physical Therapy Association (APTA) represents more than 63,000 physical therapists, physical therapist assistants, and physical therapy students. Seventy-five percent of these members are physical therapists. APTA represents approximately 42% of the universe of licensed physical therapists. We estimate that 50% of those physical therapists who are currently not members were members at some time in the past.

Who Physical Therapists Are

Physical Therapists (PTs) are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Following an examination of individuals with impairments, functional limitations, and disabilities or other health-related conditions, physical therapists design individualized plans of physical therapy care and services for each patient. Choosing from a broad array of physical therapy interventions, PTs alleviate impairments and functional limitations as well as promote and maintain optimal fitness, physical function, and quality of life as it relates to movement and health. PTs also implement services to reduce risk and prevent the onset and progression of impairments, functional limitations, and disabilities that may result from injury, diseases, disorders, and other health conditions.

What Physical Therapists Do

Physical therapists provide care to people of all ages who have functional problems resulting from, for example, back and neck injuries, sprains/strains and fractures, arthritis, burns, amputations, stroke, multiple sclerosis, birth defects such as cerebral palsy and spina bfida, and injuries related to work and sports. Physical therapy care and services are provided by physical therapists and physical therapist assistants who work under the direction and supervision of a physical therapist. Physical therapists evaluate and diagnose movement dysfunction and use interventions to treat patients/clients. Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, and physical agents and electrotherapeutic modalities.

Where Physical Therapists Practice

Physical therapists practice in hospital, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, or sub-acute facilities; patients' homes; education or research centers; schools; hospices; industrial

workplaces or other occupational environments; fitness centers; and sports training facilities.

Listed below is a breakout of the percentages of physical therapists that practice in various settings. The data are derived from APTA member surveys, but can be considered to reflect the universe of licensed physical therapists.

Settings In Which Physical Therapists Practice:

Acute care hospital	14.9%
Sub-acute rehab hospital (in-patient)	4.0%
Health system or hospital based outpatient facility or clinic	16.9%
Private out-patient office or group practice	35.4%
SNF/ECF/ICF	6.1%
Patient's home/Home care	7.8%
School system (preschool/primary/secondary)	4.7%
Academic institution (post-secondary)	4.8%
Health and wellness facility	0.6%
Research center	0.3%
Industry	0.5%
Other	3.8%

Physical Therapist Education

The current minimum educational requirement to become a physical therapist is a post-baccalaureate degree from an educational program accredited by the Commission on Accreditation of Physical Therapy Education (CAPTE). CAPTE is recognized by the United States Department of Education and the Council for Higher Education Accreditation (CHEA).

There are 204 accredited programs in the United States and 3 outside of the US. Of these accredited programs, 75 grant a Doctor of Physical Therapy (DPT) degree. Of the remaining programs, another 75 are in the process of transitioning from a master's degree to a DPT.

A typical physical therapist curriculum includes education in the foundational sciences (anatomy, histology, physiology, biomechanics and kinesiology, neuroscience and so forth) and in the clinical sciences (covering content areas in the cardiovascular/pulmonary, endocrine, gastrointestinal, genitourinary, integumentary, musculoskeletal and neuromuscular systems).

The clinical sciences also include content for individual systems related to the specific responsibilities of patient screening, examination, evaluation, diagnosis, prognosis, plan of care, intervention and outcome assessment, and evaluation. The curriculum covers areas of professional practice (such as communication, critical inquiry, clinical decision-making, and professional development), patient management (including screening, examination, evaluation, diagnosis,

prognosis, the plan of care, intervention, patient education, documentation, outcomes measurement and evaluation, and prevention and wellness) and practice management (management in various care delivery systems, administration, consultation, and social responsibility).

Each curriculum includes an extensive clinical education component.

Physical Therapist Licensure

In all 50 states, the District of Columbia, and Puerto Rico, a license is required to practice physical therapy. Licensure requirements are established by state laws and administered through the rules and regulations of a state agency that usually is an independent physical therapy licensing board.

The core requirements for licensure are graduation from a CAPTE accredited program and successful completion of a state-administered national licensure examination.

Payment For Physical Therapist Services

The payment sources for physical therapist services are many and diverse. They include:

- Private Pay
- Government Programs
 - Medicare
 - Medicaid
 - Veterans Administration
 - Individuals with Disabilities Educational Assistance
 - Workers' Compensation
- Private Insurance
 - Blue Cross/Blue Shield
 - Aetna
 - United Healthcare
 - Others

Coverage for physical therapist services is fairly comprehensive in both managed care and fee-for-service programs.

As with other health care services, physical therapist services are subject to visit limitations under managed care plans and to payment limitations, as for example under the Physician Fee Schedule that is employed under Medicare.

Most physical therapist services in outpatient settings are billed using the CPT coding system. Within this system, substantially all physical therapist services are billed using the 97000 series. Following is a sample list of some 97000 codes:

97001 Physical Therapy Evaluation

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

97110 Therapeutic procedure, one of more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

97504 Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes

A Major Obstacle

There is one major obstacle for patients seeking access to physical therapists: the requirement that the patient receive a referral from a physician before being permitted to see a physical therapist. This requirement is still written in law in 13 states. It does, however, have a much more expansive impact in the insurance industry in which the majority of plans require some form of physician certification before payment will be made for physical therapist services.

The legal requirement of a physician referral is something of an anachronism that is slowly being removed from, or modified in, state laws. As a result of legislative changes during the past 40 years—most of which have occurred since 1985—patient direct access (in some form) to physical therapist treatment is permitted by state law in 37 states. In 14 of these states the direct access is without any limitation. In the other 23 states, some limitations do exist- (e.g., that the patient have a pre-existing medical diagnosis, or that treatment under direct access be limited to a specific time duration after which the patient would have to see a physician, or that the physical therapist have specified years of practice experience before practicing in a direct access mode). In 47 states patients can go directly to physical therapists for evaluations without first securing a physician referral.

Although the legal obstacle to securing direct access to physical therapists is slowly being removed, the payment barrier looms quite large. Insurers are very

reluctant to do away with the physician gatekeeper concept, even though there is evidence to suggest that, in the context of physical therapy, treatments provided in situations where there is a physician referral are more extensive and more costly than those provided under direct access. In a study published in Physical Therapy in 1997¹, researchers found that relative to physician referral episodes, “direct access episodes encompassed fewer numbers of services (7.6 versus 12.2 physical therapy office visits) and substantially less cost (\$ 1,004 versus \$2,236).” This study used paid claims data for the period 1989 to 1993 from Blue Cross-Blue Shield of Maryland.

Although legalizing direct access practice for physical therapists must be the first step in the process, very few patients will be able to take advantage of these legislative reforms unless and until insurance policies accept these changes in state law. It has often been said that in health care “payment shapes practice.” Perhaps nowhere is the truth of that statement more evident than in this situation in which patients and the health care system are deprived of the benefits of direct access to physical therapists because outdated insurance rules bar payments for services delivered in this way.

Not all insurance programs have remained blind to the benefits of direct access. Insurers in Maryland have long reimbursed for these services and in recent years so have insurance plans in Arizona, North Dakota, North Carolina and other states. These insurers have focused on the quality, utilization, and cost effective outcomes that direct access practice produces as justification for their payment for services delivered in this manner. Currently there is legislation pending in Congress that would permit Medicare payment for physical therapist services in a direct access context, provided that state law so permits.

Direct and unfettered patient access to physical therapists needs to be the rule of the day.

A Resultant Problem—Physician Owned Physical Therapist Services

As a result of the mandated physician control over access to physical therapists—be it by law or by insurance decree—traditional physician-physical therapist relationships can be seriously disrupted, especially at times when physician revenues are adversely affected by managed care or government policies. Traditionally, when a physician’s patient needs physical therapy, the physician sends the patient to an independent entity that provides the physical therapist service. In the outpatient setting, that entity might be an independent physical therapist, a physical therapist clinic, a rehabilitation agency, or an outpatient hospital department. The patient receives the needed physical therapy and close communication with the physician is maintained. There is no financial connection between the physician and the setting in which the physical therapy is provided. Frequently in these traditional scenarios longstanding

relationships are forged based on a mutual respect for each practitioner's expertise and the successful outcomes that are achieved.

This traditional relationship sometimes changes when the rein on the health care dollar is drawn tighter and practitioners look for ways to make up for revenue shortfalls. For some physicians and medical practice management consultants, physical therapy is seen as a readily available means of negating some of the revenue losses. What frequently follows, then, is an "either-or" option rendered to the physical therapist by the physician (or group of physicians) that he or she either join the physician practice as an employee or contractor or be content to know that no more referrals will be coming his or her way. The major change in the traditional pattern is that the physician will not just be the referrer, but will also benefit financially from the services provided as a result of that referral.

Whether it is mandated by law or by insurance policies, the requirement that patients obtain a physician referral for a patient to receive services from a physical therapist, clearly creates an unfair and unlevel playing field between physician owned physical therapist practices and practices owned by physical therapists. Under these arrangements, the physician has financial incentives to refer the patient to his/her own practice rather than a practice in which he/she has no such interest. Because the physician controls the referral, it makes it difficult for physical therapists who own and operate their own practices to compete for patients whose access to these physical therapists is controlled by the physician.

Studies have demonstrated that POPTS arrangements may have a significant adverse economic impact on consumers, third party payers, and physical therapists. Specifically, a well-publicized study appeared in the *Journal of the American Medical Association* in 1992.² Coauthored by Jean M. Mitchell, PhD, and Elton Scott, the study documented the higher utilization and higher costs associated with services provided in POPTS situations in the state of Florida. In summary, the study revealed the following:

- "Visits per patient were 39% to 45% higher in joint venture facilities.
- "Both gross and net revenue per patient were 30% to 40% higher in facilities owned by referring physicians.
- "Percent operating income and percent markup were significantly higher in joint venture physical therapy and rehabilitation facilities.
- "Licensed physical therapists and licensed therapist assistants employed in non-joint venture facilities spend about 60% more time per visit treating physical therapy patients than licensed therapists and licensed therapist assistants working in joint venture facilities.
- "Joint ventures also generate more of their revenues from patients with well-paying insurance."

At about the same time, another study that was in the *New England Journal of Medicine*,³ documented the higher costs associated with physical therapy care under the California Workers' Compensation program when the services were provided in POPTS situations. Although the mean cost per case was about 10% lower in POPTS settings, the utilization was twice as high - as that in non-POPTS settings. The study, which also included psychiatric services and MRI scans, concluded:

This study demonstrates that self-referral increases the cost of medical care under workers' compensation for each of the three types of service studied, but by a different mechanism in each instance: by substantially increasing the percentage of injured workers who receive physical therapy (which more than offsets the slight decrease in cost per case)....

In a subsequent address by two of the study's authors (Johnson and Swedlow), it was noted that physical therapy accounted for an estimated \$575 million per year in California workers' compensation costs. In the study, the authors stated that the higher cost per case for services rendered in non-POPTS settings resulted in an increase of \$143,672, whereas in their subsequent address they stated that the "phenomenon" of self-referral or POPTS "generates approximately \$233,000,000 in services delivered for economic rather than clinical reasons."

As noted, studies have found that physicians who had ownership or investment interests in entities to which they referred ordered more services (including physical therapy services) than physicians without those financial relationships. This correlation between financial ties and increased utilization was the impetus for Congress to enact the "Stark I" law in 1989 (Section 6204 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239), which was added as Section 1877 of the Social Security Act. The "Stark I" law applied to physician referrals to clinical laboratories. In 1993, Congress enacted the "Stark II law," which expanded the list of services for which the law applies to include other services, among them, physical therapy services. (Section 13562 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66)).

Specifically, the law states that if a physician or a member of a physician's immediate family member has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services (including physical therapy services) under the Medicare program, unless an exception applies.

After the law was enacted, many physicians divested physical therapy from their practices. The Center for Medicare and Medicaid Services (formerly HCFA) issued final regulations implementing the law on January 4, 2001 (66 Fed. Reg. 856). These regulations broadly defined the exceptions to the law to enable physicians to structure their practices in order to furnish physical therapy in their

offices without violating the law. Since these regulations were issued, there has been an expansion of physician owned physical therapy practices.

The removal of the referral requirement from state laws will allow patients direct access to physical therapists and its removal from insurance policies will make the access complete and permit physical therapists to compete with physicians on a level playing field.

1. Mitchell JM, de Lissovoy G: A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy. *Phys Ther.* 1997;77:10-18.
2. Mitchell JM, Scott E. Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics. *JAMA.* 1992; 268:19-23.
3. Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California Workers' Compensation System as a result of self-referral by physicians. *N Engl J Med.* 1992;327:1502-1506.

