Physical Therapy Services

Beginning July 1, 1973, the amendment broadens the coverage under supplementary medical insurance of outpatient physical therapy to include the home and office services of the physical therapist in independent practice. Such physical therapist must meet licensing and other standards prescribed by the Secretary in regulations. In addition, the services would have to be furnished under such conditions relating to health and safety as the Secretary may find necessary. Incurred expenses for these services could not exceed $100 in a calendar year. Payment for the reasonable charges for the covered services, less coinsurance and any deductible amounts due, would be made either to the beneficiary or, on assignment, directly to the physical therapist.

This extension of covered services to the therapist's office or the beneficiary's place of residence is designed to make physical therapy services more accessible to the beneficiary than under the present coverages. The concern of the Congress about the increasing cost of physical and other therapy services led to the inclusion of the $100 limitation.

Coverage of a self-employed physical therapist in independent practice, under the conditions specified, provides benefits for services which many beneficiaries require and for which, under prior law, coverage sometimes was dependent primarily upon where the therapy was given. For example, under prior law the services of a physical therapist in independent practice working under an arrangement with and under the supervision of a clinic were covered when furnished on the clinic's premises, but not covered if those same patients received the services in the therapist's office (which often is more accessible for beneficiaries than the facility). The amendment provides coverage of outpatient physical therapy in the therapist's office or the patient's home under a physician's plan.

Effective October 30, 1972, the new law also authorizes a participating hospital or skilled nursing facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive these services after his inpatient benefits have expired or if he is not eligible for hospital insurance benefits. Under prior law, situations arose where inpatients of hospitals and skilled nursing facilities needed physical therapy services but had used up their inpatient benefit or for other reasons were not entitled to have payment made under HI. In order for such inpatients to receive covered physical therapy services without leaving the hospital or skilled nursing facility, it was necessary for the facility to arrange for an outside provider of physical therapy to treat the patient. While the new law eliminates this situation, it does not change the outpatient requirements with regard to other providers. Thus, providers of outpatient physical therapy services having inpatient facilities other than hospitals and skilled nursing facilities may not furnish covered outpatient therapy services to their own inpatients.

With one exception, the amendments have not altered the requirements for the content of the physician certification and/or recertification statement for outpatient physical therapy services. While the requirement that the physician certification must state that the physical therapy services are or were required by the patient is retained, the statement that they were required "on an outpatient basis" has been deleted.

Effective with cost reporting periods beginning on or after January 1, 1973, reimbursement for the reasonable cost of physical and other therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a home health agency under arrangements with others will be limited to amounts equivalent to the salary and other costs that would have been incurred by a provider if the services had been performed in an employment relationship, plus other costs an individual not working as an employee might have, such as maintaining an office, travel expenses, and similar costs.

establish procedures necessary to its operation in accordance with regulations established by the Secretary of Health, Education, and Welfare.

Under the House bill, any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary to the Board where the amount at issue is $10,000 or more. The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination. The committee modified this portion of the provision by including two additional situations which could serve as a basis for provider appeals. The first provision would enable groups of providers to appeal adverse final decisions of the fiscal intermediary to the Board where the amount at issue aggregates $10,000 or more. The second modification enables any provider which believes that its fiscal intermediary has failed to make a timely cost determination on its annual cost report, if such report is susbtantially in proper order, or a timely determination on an acceptable supplemental filing where the initial filing was deficient, to appeal to the Board where the amount involved is $10,000 or more. Implementation of the intermediary determinations would not be held in abeyance pending the Board's decision.

The provider shall have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing. It may be represented by counsel and introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary. Reasonable opportunity to examine and cross-examine witnesses shall be provided. All decisions by the Board shall be based upon the record made at such hearing which may include any evidence submitted by the Department. Such evidence shall include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, such Board may find in whole or in part for the provider or the Government (including a finding based upon the evidence before it that the provider or Government owes sums in addition to the amount raised in the appeal).

A decision of the Provider Reimbursement Review Board would be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies the Board's decision adversely to the provider. In any case where such reversal or modification occurs, the provider of services would have the right to obtain a review of such a decision by the United States District Court for the district in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedures Act, notwithstanding any other provision in section 205 of the Social Security Act.

The amendment would become effective with respect to accounting periods beginning on or after July 1, 1972

Physical Therapy and Other Therapy Services Under Medicare

(Sec. 251 of the bill)

Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating

hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to outpatients. The physical therapist may either be an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The House bill would provide for coverage, under the supplementary medical insurance program, of up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or in the patient's home under a physician's plan. Reimbursement for the reasonable charges for the covered services rendered by the physical therapist would be made either to the beneficiary or, on assignment, directly to the physical therapist.

The committee has been advised by the Department of Health, Education, and Welfare that the House provision would be difficult to administer in terms of assuring the provision of appropriate services, or of effectively enforcing the health, safety, and quality safeguards embodied in present law, since physical therapists would be furnishing services outside the controlled environment of an institutional setting or responsibility. Moreover, this provision would compound the already costly and troublesome problem of restraining overutilization and inappropriate utilization of physical therapy services. The committee agrees with the Department that at the present time whatever advantage might accrue to beneficiaries from increased availability of services would be at the expense of higher benefit and administrative costs. For these reasons, the committee has deleted this special $100 feature of the House bill.

The committee is concerned about the few cases under present law where an inpatient exhausts his inpatient benefits or where he is otherwise ineligible for hospital insurance inpatient benefits and can continue to receive supplementary medical insurance reimbursement for physical therapy treatment only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. The House bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients in the above categories. The committee concurs with the House bill on this provision and the effective date for this subsection would make the provision effective for services furnished after enactment of the bill.

The House bill also includes a provision for controlling program expenditures and for preventing abuses. Under this provision payment for the reasonable cost of physical, occupational, and speech therapy services, or the services of other health specialists, furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency under arrangements with others to supply such services, may not exceed an amount equivalent to the salary and other costs which would reasonably have been payable if the services had been performed in an employment relationship, plus the cost of such expenses an individual not working as an employee might have, such as maintaining an office, traveltime and expense, and similar costs.

The committee concurs with the House amendment, which reflects the changes made by the committee during its consideration of H.R. 17550, the Social Security Amendments of 1970. The committee

expects—as does the Committee on Ways and Means—that the Secretary will, in establishing the criteria for determining the reasonable cost of such services, consult with the professions directly affected and give thorough consideration to procedures used in other public and private plans that may be local, regional, or national in scope. Further, the committee expects that the Secretary will establish salary equivalents by appropriate geographic areas (including, where appropriate and feasible rural and urban distinctions) and that such amounts will be set at the 75th percentile of the range of salaries paid in the area to therapists working full-time in an employment relationship, with such additional or adjusted allowance for salaries paid to therapists whose duties are supervisory or administrative in nature, as the Secretary finds to be appropriate. To the extent feasible, timely, and accurate, salary data compiled by the Bureau of Labor Statistics would be used in determining the 75th percentile level of salaries in an area. If a provider requires the services of a physical therapist on a limited part-time basis or only to perform intermittent services the Secretary may make payment on the basis of a reasonable rate per unit of service greater per unit of time than salary equivalent amounts where he finds that such greater payment is in the aggregate less than would have resulted if the provider employed a therapist on a full or part-time salaried basis.

The above provision would be effective with respect to accounting periods beginning on or after January 1, 1973.

Collection of Supplementary Medical Insurance Premiums From Individuals Entitled to Both Social Security and Railroad Retirement Benefits

(Sec. 263 of the bill)

Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enrollment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards—one showing entitlement to benefits under part A only and the other showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected, are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing of medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad