



DEPUTY SECRETARY OF DEFENSE

1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010



AUG 6 2001

Honorable Bob Stump
Chairman, Committee on Armed Services
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to the requirements outlined in Section 762 of the Fiscal Year 2001 National Defense Authorization Act regarding Comparability of Coverage for Physical, Speech, and Occupational Therapies. Congress directed the Department to address a comparison of the coverage and reimbursement levels for physical, speech and occupational therapies under the TRICARE program to that provided under Medicare and the Federal Employee Health Benefit (FEHB) plans.

The study concludes that the types of services covered and authorization requirements are comparable for each program, but the TRICARE plan offers the most comprehensive coverage since there are no reimbursement limits imposed for rehabilitative therapies. In contrast, Medicare and the FEHB plans set reimbursement limits, although Medicare has temporarily suspended its limits until December 31, 2002.

Thank you for your continued interest in the Military Health System.

Sincerely,

Enclosure:
As stated

cc:
Honorable Ike Skelton
Ranking Democrat

Report to Congress



Report on Comparability of Coverage for Physical, Speech, and Occupational Therapies

Report to Congress on Comparability of Coverage for Physical, Speech, and Occupational Therapies

Introduction

Section 762 of the Floyd D. Spence National Defense Authorization Act (NDAA) for Fiscal Year 2001 (Pub. L. 106-398) requires DoD to conduct a study on the comparability of coverage for Physical, Speech and Occupational Therapies. Section 762 specifies that the study shall examine the following: (1) types of services covered; (2) whether prior authorization is required to receive such services; (3) reimbursement limits for services covered; and (4) whether services are covered on both an inpatient and outpatient basis. The study requires a comparison of the coverage and reimbursement levels for physical, speech and occupational therapies under the TRICARE/CHAMPUS program to that provided under the Medicare and Federal Employee Health Benefit (FEHB) plans.

In reviewing the Office of Personnel Management (OPM) FEHB Call Letter for Contract Year 2001, we note that it does not contain any specific policy guidance on the standard level of physical, occupational and speech therapy benefits that must be provided. The types of plans that participate in the FEHB Program are Fee-for-Service (FFS) plans and Health Maintenance Organizations (HMO) plans. A FFS plan is a traditional type of insurance plan. Most FFS plans also provide access to Preferred Provider Organizations (PPOs). A PPO is a FFS option that allows reduced costs for services received from certain medical providers. An HMO is a health plan that provides care through a network of physicians, hospitals, and other providers in particular geographic areas. HMOs coordinate the health care services received by its members.

For purposes of this study we contacted the Office of Personnel Management to identify the most frequently used fee-for-service and Health Maintenance Organization plans offered through the FEHB plans. The Blue Cross/Blue Shield (BCBS) Standard Option benefit plan has the greatest FEHB enrollment and is representative of a FFS plan. The BCBS FFS plan offers a PPO option. Consequently, the BCBS Standard Option was used as a proxy for the numerous FFS/PPO plans offered under FEHB. Additionally, it was determined that the Kaiser Foundation Health Plan, Inc. an HMO, has the greatest FEHB enrollment for an HMO. Kaiser is used as a proxy for the numerous HMO benefit plans offered under FEHB.

Physical Therapy

Type of Services Covered. The TRICARE Prime and Standard benefit plans both cover Physical Therapy benefits as do Medicare, BCBS Standard Option plans, and Kaiser plans (see Exhibit 1). The language is slightly different but the types of services covered are basically the same. Each plan covers the physical examination to evaluate the patient's condition as well as the prescribed therapeutic maintenance program. The TRICARE benefit plans add language specifying that such treatment and services will be covered when determined to be medically necessary for treatment of a covered condition. The Medicare benefit plan adds language that such treatment and services will be covered as long as they are needed to meet the health goal. Kaiser adds language that physical therapy will be covered when there is a total or partial loss of bodily function due to illness or injury. The BCBS Standard Option Plan does not appear to have any such language. The BCBS Standard Option plan does cover acupuncture for pain management when performed by a licensed physical therapist or physician. The other plans do not cover acupuncture. All plans exclude exercise programs.

Prior Authorization Requirements. Under the TRICARE Prime plan all Physical Therapy care must be referred from the Primary Care Manager (PCM) and authorized by the

Health Care Finder or other contractor designee. For the TRICARE Standard, Medicare and BCBS Standard Option plans, prior authorization is not specifically required. However, under these plans, physical therapy services do require a physician's written statement specifying the medical necessity of the treatment as well as the length of time needed for therapy. Under Kaiser, as is the rule for HMOs in general, a primary care physician must refer the patient for physical therapy services and such services must be provided by plan providers.

Reimbursement Limits. Neither TRICARE Prime nor TRICARE Standard has limits on the level of covered services, although beneficiaries must pay outpatient cost sharing. In contrast, Medicare has a reimbursement limit of \$1,500 per year which applies to both physical therapy and speech-language pathology services. This limit has been temporarily suspended until December 31, 2002. Under Medicare, beneficiaries must also pay Part B cost sharing, which requires a 20 percent payment by beneficiaries after the deductible. The BCBS Standard option plan has a limit of 50 visits per year. There is also cost sharing on these services. Under Kaiser, an initial course of physical therapy is covered for up to two months. Subsequent courses of physical therapy for up to two months may be covered if there is a significant improvement in the condition. There is a \$10 per office visit copay when provided on an outpatient basis.

Covered Services. TRICARE Prime, TRICARE Standard, Medicare BCBS, and Kaiser all cover Physical Therapy benefits on both an inpatient and an outpatient basis.

Speech Therapy

Type of Services Covered. The TRICARE Prime and Standard benefit plans both cover Speech Therapy benefits as do Medicare, BCBS, and Kaiser plans (see Exhibit 2). The language is slightly different but the type of services covered are basically the same. Each plan covers services necessary for the diagnosis and treatment of speech and language disorders.

The TRICARE plan benefit language specifically notes that Speech Therapy benefits are covered only when specifically related to illness or injury. The Medicare plan benefit language provides for coverage whenever the speech or language disorder results in communication disabilities or from the swallowing disorder dysphagia. The BCBS plan benefit language seems only to require that the rehabilitative therapy be performed by a speech therapist or physician in order to be covered. Under Kaiser, services are provided by plan providers to restore speech when there is a partial loss of functional speech due to illness or injury.

Prior Authorization Requirements. Under the TRICARE Prime plan all Speech Therapy care must be referred from the Primary Care Manager (PCM) and authorized by the Health Care Finder or other contractor designee. For the TRICARE Standard, Medicare and BCBS plans, prior authorization is not specifically required. However, under these plans, speech therapy services do require a physician's written statement specifying the medical necessity of the treatment as well as the length of time needed for therapy. Kaiser allows speech therapy services provided by plan providers and when referred for such services by a primary care physician.

Reimbursement Limits. Neither TRICARE Prime nor TRICARE Standard has limits on the level of covered services, although beneficiaries must pay outpatient cost sharing. In contrast, Medicare has a reimbursement limit of \$1,500 per year for both physical therapy and speech-language pathology services. This limit has been temporarily suspended until December 31, 2002. Under Medicare, beneficiaries must also pay Part B cost sharing, which requires a 20 percent payment by beneficiaries after the deductible. The BCBS Standard option plan has a limit of 25 visits per year which includes both speech and occupational therapy. There is also cost sharing on these services. Kaiser provides an initial course of speech therapy for up to two months when a primary care physician refers the member for speech therapy. Subsequent courses of speech therapy for up to two additional months may be covered if there is a

significant improvement is the condition. There is a \$10 copay per office visit when provided on an outpatient basis.

Covered Services. TRICARE Prime, TRICARE Standard, Medicare, BCBS and Kaiser all cover Speech Therapy benefits on both an inpatient and an outpatient basis.

Occupational Therapy

Type of Services Covered. The TRICARE Prime and Standard benefit plans both cover Occupational Therapy benefits as do the Medicare, BCBS plans, and Kaiser plans (see Exhibit 3). The language is slightly different but the types of services covered are basically the same. Each plan covers medically prescribed treatment to improve or to restore functions impaired by illness or injury. The TRICARE benefit language is the most comprehensive and proactive. It provides coverage for specific purposeful activities or interventions designed to promote health as well as to prevent and to treat injury or disability which results from cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disabilities. Neither Medicare, BCBS, or Kaiser seem to have this emphasis on health promotion and preventive care in their Occupational Therapy benefit language. Kaiser covers Occupational Therapy provided by occupational therapists to assist in achieving and maintaining self-care and improved functioning in other activities of daily life.

Prior Authorization Requirements. Under the TRICARE Prime plan all Occupational Therapy care must be referred from the Primary Care Manager (PCM) and authorized by the Health Care Finder or other contractor designee. For the TRICARE Standard, Medicare and plans, prior authorization is not specifically required. However, under these plans, occupational therapy services do require a physician's written statement specifying the medical necessity of the treatment as well as the length of time needed for therapy. Under Kaiser, the member must be referred for services by a primary care provider.

Reimbursement Limits. Neither TRICARE Prime nor TRICARE Standard has limits on the level of covered services, although beneficiaries must pay outpatient cost sharing. In contrast, Medicare has a reimbursement limit of \$1,500 per year. This limit has been temporarily suspended until December 31, 2002. Under Medicare, beneficiaries must also pay the Part B cost sharing, which requires a 20 percent payment by beneficiaries after the deductible. The BCBS Standard option plan has a limit of 25 visits per year which includes both speech and occupational therapy. There is also cost sharing on these services. Kaiser provides an initial course of occupational therapy for up to two months when a primary care physician refers the member for occupational therapy. Subsequent courses of occupational therapy for up to two additional months may be covered if there is a significant improvement in the condition. There is a \$10 copay per office visit when provided on an outpatient basis.

Covered Services. TRICARE Prime, TRICARE Standard, Medicare, BCBS and Kaiser all cover Occupational Therapy benefits on both an inpatient and an outpatient basis.

Summary

In response to Section 762 of the FY01 NDAA, we have compared the coverage and reimbursement limits for physical, speech and occupational therapies under the TRICARE/CHAMPUS program to those provided under the Medicare and FEHB plans. We determined that while all five plans cover these rehabilitative therapies, they do so to varying degrees. The TRICARE plans offer the most comprehensive coverage in that there are no reimbursement limits imposed for rehabilitative therapies. In contrast, Medicare, BCBS and Kaiser set reimbursement limits, although Medicare has temporarily suspended its limits until December 31, 2002.

Exhibit 1: Physical Therapy

	TRICARE Prime	TRICARE Standard/CHAMPUS	Medicare	BCBS Standard Option	Kaiser Foundation
Type of Services Covered:	Physical evaluation and the prescribed therapeutic treatment and services determined to be medically necessary for treatment of a covered condition. Acupuncture is not covered.	Physical evaluation and the prescribed therapeutic treatment and services determined to be medically necessary for treatment of a covered condition. Acupuncture is not covered.	Covers examinations, evaluations of the patient's condition, preparation of the maintenance program and training on how to use special equipment or to do daily activities. Acupuncture is not covered.	Covers costs associated with rehabilitative therapy including acupuncture for pain management when performed by licensed physical therapist or physician	Covers an initial course of therapy for up to two months for physical therapy provided by a qualified physical therapist to restore bodily function when there is a total or partial loss of bodily function due to illness or injury.
Prior Authorization Requirements:	Required. All PT care must be referred from the PCM and authorized by the Health Care Finder or other contractor designee	Not required. However, services must be prescribed by a physician, medically necessary, professionally administered and part of a comprehensive treatment plan in order to be covered.	PT physician must provide written treatment plan specifying type, amount, frequency and duration of PT services as well as dx and anticipated goals; patient must see physician a minimum of 30 days; service provided while under physicians care must be reasonable and customary.	PT services do not appear to require prior approval although PT claims do require physician's written statement specifying the medical necessity for the service or supply as well as length of time needed for therapy	The member must be referred for Physical Therapy by a primary care physician. As such, care is categorized as pre-authorized.
Reimbursement Limits: Beneficiary Copayments/Costs-Shares	No limits. ADFM: No copays except Point of Service copays and pharmacy copays.	No limits. Outpatient cost sharing applies: ADFM: 20% of CMAC after ded. Retirees: 25% of CMAC after ded. <u>Annual Deductible:</u> E1-E4: \$50/\$100 (Indiv./Family) E5-Above: \$150/\$300 Retirees: \$150/\$300	\$1,500 per year for both physical therapy and speech-language pathology services. This limit is suspended until December 31, 2002. Outpatient cost sharing applies: Patient pays \$100/cal yr Part B deductible and 20% coinsurance	Maximum of 50 visits per year. All services (I/P and O/P) subject to \$250 cal yr deductible	An initial course of physical therapy is covered for up to two months. Subsequent courses of physical therapy for up to two additional months may be covered if there is a significant improvement in the condition.
Covered Services: Inpatient:	Yes	Yes	Yes	Yes	Yes
Outpatient:	Yes	Yes	Yes	Yes	Yes

Exhibit 2: Speech Therapy

	TRICARE Prime	TRICARE Standard/CHAMPUS	Medicare	BC/BS Standard Option	Kaiser Foundation
Type of Services Covered:	Medical services that provide evaluation, treatment, (re)habilitation of speech, language and voice dysfunctions resulting from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders	Medical services that provide evaluation, treatment, (re)habilitation of speech, language and voice dysfunctions resulting from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders.	Covers services necessary for the diagnosis of speech and language disorders which result in communication disabilities and those services necessary for the dx and treatment of swallowing disorders (dysphagia). All services must be provided under a written plan of treatment established by speech pathologist (SP)	Covers costs associated with rehabilitative therapy when performed by speech therapist or physician	Covers an initial course of therapy for up to two months for speech therapy provided by a qualified speech therapist when there is a total or partial loss of bodily function due to illness or injury.
Prior Authorization Requirements:	Required. All ST care must be referred from the PCM and authorized by the Health Care Finder or other contractor designee	Not required. However, services must be prescribed by a physician, medically necessary, professionally administered and part of a comprehensive treatment plan in order to be covered.	ST must provide written treatment plan specifying type, amount, frequency and duration of ST services as well as dx and anticipated goals; patient must see physician min of every 30 days; services provided while under physicians care must be reasonable and customary	ST claims require written physician's statement specifying the medical necessity for the service or supply as well as length of time needed for therapy	The member must be referred for speech therapy by a primary care physician. As such care is categorized as preauthorized.
Reimbursement Limits: Beneficiary Copayments/Cost-Shares	No limits. ADFM: No copays except Point of Service copays and pharmacy copays.	No limits. Outpatient cost sharing applies: ADFM: 20% of CMAC after ded. Retirees: 25% of CMAC after ded. <u>Annual Deductible:</u> E1-E4: \$50/\$100 (Indiv./Family) E5-Above: \$150/\$300 Retirees: \$150/\$300	\$1,500 per year for both physical therapy and speech-language pathology services. This limit is suspended until December 31, 2002. Outpatient cost sharing applies: Patient pays \$100/cal yr. Part B deductible and 20% coinsurance	Maximum of 25 visits per year which includes both speech and occupational therapy. All services (I/P and O/P) subject to \$250 cal yr. deductible	An initial course of speech therapy is covered for up to two months. Subsequent courses of speech therapy for up to two additional months may be covered if there is a significant improvement in the condition.
Covered Services:					
Inpatient	Yes	Yes	Yes	Yes	Yes
Outpatient	Yes	Yes	Yes	Yes	Yes

Exhibit 3: Occupational Therapy

	TRICARE Prime	TRICARE Standard/CHAMPUS	Medicare	BC/BS Standard Option	Kaiser Foundation
Type of Services Covered:	The prescribed use of specific purposeful activity or interventions designed to promote health, prevent injury or disability which develop, improve, sustain or restore functions lost or reduced as result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disability (ies)-highest possible level of independent functioning	The prescribed use of specific purposeful activity or interventions designed to promote health, prevent injury or disability which develop, improve, sustain or restore functions lost or reduced as result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disability (ies)-highest possible level of independent functioning	Medically prescribed treatment to improve or restore functions impaired by illness/injury. OT may involve (re)evaluation of patient's level of function, selection/teaching of task-oriented therapeutic activities to restore physical, mental or sensory-integrative functions	Covers costs associated with rehabilitative therapy when performed by occupational therapist or physician	Covers an initial course of therapy for up to two months for occupational therapy provided by a qualified occupational therapist when there is a total or partial loss of bodily function due to illness or injury
Prior Authorization Requirements:	Required. All OT care must be referred from the PCM and authorized by the Health Care Finder or other contractor designee	Not required. However, services must be prescribed by a physician, medically necessary, professionally administered and part of a comprehensive treatment plan in order to be covered	OT must provide written treatment plan specifying type, amount, frequency and duration of OT services as well as dx and anticipated goals; patient must see physician min of every 30 days; services provided while under physician's care must be reasonable and customary	OT claims require written physician's statement specifying the medical necessity for the service or supply as well as length of time needed for therapy	The member must be referred for occupational therapy by a primary care physician. As such care is categorized as preauthorized.
Reimbursement Limits: Beneficiary Copayments/Cost-Shares	No limits. ADFM: No copays except Point of Service copays and pharmacy copays.	No limits. Outpatient cost sharing applies: ADFM: 20% of CMAC after ded. Retirees: 25% of CMAC after ded. <u>Annual Deductible:</u> E1-E4: \$50/\$100 (Indiv./Family) E5-Above: \$150/\$300 Retirees: \$150/\$300	\$1,500 per year. This limit is suspended until December 31, 2002. Outpatient cost sharing applies: Patient pays \$100/cal yr. Part B deductible and 20% coinsurance	Maximum of 25 visits per year which includes both speech and occupational therapy. All services (I/P and O/P) subject to \$250 cal yr. deductible	An initial course of occupational therapy is covered for up to two months. Subsequent courses of occupational therapy for up to two additional months may be covered if there is a significant improvement in the condition.
Covered Services: Inpatient	Yes	Yes	Yes	Yes	Yes
Outpatient	Yes	Yes	Yes	Yes	Yes