HHS Public Access
Author manuscript
N C Med J. Author manuscript; available in PMC 2018 June 27.

Published in final edited form as:
N C Med J. 2017 ; 78(5): 312–314. doi:10.18043/ncm.78.5.312.

Insurance Coverage, Costs, and Barriers to Care for Outpatient Musculoskeletal Therapy and Rehabilitation Services

Erik Carvalho, PT, DPT, OCS,
Clinical services coordinator, Division of Ambulatory Services, Department of Physical Therapy & Occupational Therapy, Duke University Health System, Durham, North Carolina

Janet Prvu Bettger, ScD, and
Associate professor, director, Health Policy and Implementation Science, Duke Department of Orthopaedic Surgery, Duke Clinical Research Institute, Duke University School of Medicine, Durham, North Carolina

Adam P. Goode, DPT, PhD
Associate professor, Duke Clinical Research Institute, Department of Orthopedic Surgery, Duke University School of Medicine, Durham, North Carolina

Abstract

Therapy and rehabilitation services improve patients' lives. Changes in health care insurance policies and coverage substantially influence out-of-pocket costs for patients and their families. This may lead to variability in services and barriers to appropriate health care. This commentary highlights the current variability and barriers for therapy and rehabilitation services.

Musculoskeletal (MSK) conditions are the leading cause of disability in the United States (US), affecting more than 50% of the US population [1]. These conditions can range from acute onset to gradual progression of disease and can be short in duration or lifelong disorders. Prevalence increases with age, and the most common conditions include osteoarthritis (OA), rheumatoid arthritis, osteoporosis, and low back pain. Pain and activity limitations from MSK conditions result in 216 million lost workdays per year. MSK conditions are costly, accounting for 5.7% of the gross domestic product. The financial burden of MSK conditions on families is also considerable. The direct-related cost of MSK conditions was $796.3 billion in 2011, with indirect costs for loss of productivity and wages being even greater. One of the most common reasons for seeking medical care is for a MSK condition. About 85% of people with MSK conditions have at least one visit with a primary care provider and average 6 visits a year [2].

Physical therapy and rehabilitation services are an important component of the health care continuum for addressing the pain and functional limitations that typically accompany MSK conditions. MSK conditions can lead to reduced socialization and quality of life and create participation restrictions that can be disabling. Physicians who are board-certified in

Address correspondence to Mr. Adam P. Goode, Department of Orthopedic Surgery, 2200 West Main Street, Durham, NC 27707 (adam.goode@duke.edu).

Potential conflicts of interest. All authors have no relevant conflicts of interest.

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physical medicine and rehabilitation, physical therapists, and occupational therapists are the primary providers of rehabilitation services for people with MSK conditions. These providers are trained to address impairments in activities of daily living, pain, stiffness, and swelling. However, barriers to accessing physical therapy and rehabilitation outpatient care may be further contributing to the MSK-related disability in the United States. Over the past 4 decades, there have been substantial changes in the insurance coverage for therapy and rehabilitation services. The purpose of this commentary is to highlight how insurance coverage influences out-of-pocket costs and how barriers to care and coverage can also influence care for musculoskeletal health.

Health Insurance Coverage and Out of Pocket Costs

The variability in coverage between and within federal and private payers often leaves both patients and providers looking for answers. When it comes to anticipation of benefits and out-of-pocket expenses for rehabilitation of musculoskeletal complaints, patients should beware. Patients may be responsible for a co-pay, co-insurance, facility fees, and meeting a high deductible until co-insurance begins. Co-pays can reach as high as $75 per visit for therapy services. These costs can affect patients' access to services, and without therapy, some patients may not be able to return to work or engage in other activities of daily living. Patients are also subjected to arbitrary visit limits per year that do not account for initial diagnosis or severity, variability in rehabilitation progress, or complications. As a result, patients are responsible for escalating provider fees if they opt to continue receiving services beyond their insurance benefits.

For example, Medicare Part B, which covers outpatient rehabilitation services, currently has a yearly therapy cap of $1,980 for physical therapy and speech and language pathology combined, and a separate cap of $1,980 for occupational therapy [3]. Beneficiaries can be expected to pay up to 20% for services rendered unless they have a supplemental plan. Since billing may be variable from session to session, it can be unclear how many visits a patient is entitled to per year. A process for exceptions to this cap, review by a Medicare contractor, is in place through the end of 2017 for care deemed medically necessary and documented appropriately, which can extend services up to $3,700 [3]. However, it can often be unclear when a patient has reached the cap, and extra documentation is required to continue with care.

Medicaid, designed to serve low-income Americans, has significant variability between states for outpatient rehabilitation, as it is an "optional benefit" [4]. For example, in North Carolina, Medicaid beneficiaries 21 years of age and older are entitled to one therapy evaluation per year between physical, occupational, and speech therapy. Exceptions to this rule include a patient within 60 days of a post musculoskeletal procedure who may be entitled to one evaluation and 3 treatment visits. Post-operative joint replacements, hip fractures, or recipients of upper extremity or lower extremity prostheses may be entitled to up to 2 therapy evaluations and 8 treatment visits within a certain time frame. Unfortunately, the Medicaid visit restrictions vary by state and diagnosis and are often not sufficient for patients. Approval for additional visits is reviewed on a case-by-case basis. Prior approval is always required at the outset of services to be covered by Medicaid [5]. Restrictions on visits

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have led to many practices closing their doors to Medicaid beneficiaries, as these patients will unlikely be able to afford the high out of pocket fees for therapy services when their benefits are exhausted. Ethical questions need to be answered for those patients who undergo a procedure such as a rotator cuff repair, for which Medicaid covers one evaluation and 3 treatment visits, but who often require 3 to 6 months of rehabilitation.

When exploring out-of-pocket costs for patients with private insurances, the variability of plans and benefits within payers can often be confusing for patients. In an ever-changing health care atmosphere, patients are often unaware of changes in their benefits from year-to-year, particularly for unexpected new onset conditions. Increased premiums lead to assumptions that benefits may stay the same or improve; however, this is often not the case, and patients may be unaware of the right questions to ask when exploring their benefits for services. For example, some plans will vary greatly for patients' out-of-pocket costs based on where their services are rendered. A patient may be instructed over the phone that they would only be responsible for a $35 co-pay for physical therapy or occupational therapy, but when they receive their bill from a hospital-based clinic for a much larger amount, they do not realize that the information they had been given pertained to services received in a community-based private practice. Although the billing codes may be the same between the two facilities, the charges by the provider are different, leading to further confusion.

Barriers to Care

Although cost and a limit to health insurance coverage for the number of needed visits are both significant barriers to care, several additional issues can limit access. Health care providers can be limited geographically, especially in more rural states or rural areas within a state. Even in the New England states with the highest concentration of physical therapists and occupational therapists, there are still regions within each state in which these occupations are below the national average. North Carolina is above the national average and employs close to 6,000 physical therapists, 3,200 occupational therapists and over 4,000 speech-language pathologists [6]. However, North Carolina is a geographically diverse state with many rural regions, including the coastal islands, that may be limited in accessibility to health care [7]. This has been found to be true with chronic low back pain, one of the most common MSK conditions, where patients living in rural areas of North Carolina have decreased accessibility to physical therapy services [7].

The workforce gaps for occupational therapists may not be fully appreciated as there many areas of the United States where employment data are not provided. Access to rehabilitation providers is an important part of the equation for addressing the burden of MSK conditions. In time, the use of digital health technology may address access issues due to distance, availability of providers and specialists, impaired mobility, and lack of transportation. Clinical assessments and the delivery of rehabilitation services over the internet and telecommunication networks are being tested in various forms, from smart phone applications to virtual therapists. The different options allow for services at a distance by connecting clinician-to-clinician and clinician-to-patient for consultations. The connection can be in "real-time" as a live interaction or asynchronous. The provision of telerehabilitation adheres to the same code of ethics, scope of practice, and state and federal

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laws as if care were delivered in person, but the quality and effectiveness of different forms of telerehabilitation for MSK conditions have yet to be confirmed.

Financing and reimbursement for services aside, the use of digital health technologies for MSK rehabilitation introduces its own unique set of barriers. Individual states have their own laws on which providers can deliver telemedicine. The exchange of health care data requires a level of encryption to protect information and authorized use, and once a secure connection is possible, bandwidth and capacity of the network needs to be confirmed to ensure high quality visual and auditory data transmission [8]. While trends suggest general optimism toward improved technology literacy across all ages, races and ethnicities, levels of educational attainment, and income, for now the use of technology for MSK rehabilitation will need to continue to augment with face-to-face therapy visits to ensure equitable access to effective care.

In addition to distance-based barriers and limited provider availability, the inability to directly access a physical therapist or occupational therapist remains a necessary interruption in needed care. Every state has a law that permits direct access to licensed physical therapists for evaluation and treatment without a referral from a physician. A law allowing direct access to occupational therapists just passed in North Carolina, but the regulations for implementation have not yet been developed [9]. Many states are still much more restrictive. Several scenarios override the general principle of direct access. People with health insurance coverage provided by Medicare or Medicaid must have therapy services referred by and certified by a physician [10]. This level of oversight, required by Medicare and Medicaid—but not by other insurance providers—creates delays in evaluation and treatment, unnecessary costs for the referring physician, burden on the primary care system, and can lead to underuse of effective therapist-led care. People who choose, or are required, to visit a physician prior to accessing a therapist for the MSK-related pain and limitations are further dependent on the physician's knowledge and attitudes toward MSK evaluation and clinical guidelines for involvement of therapy or rehabilitation services. In addition, requiring a physician referral to therapy services for a primary MSK complaint may actually increase costs. Among the small proportion of patients receiving a referral to therapy services, additional health insurance restrictions on the types of treatment covered, number of visits, and out-of-pocket expenses have led to increased barriers to accessing MSK care provided by therapist.

Rapidly Changing Health Care Environment

Coverage for therapy and rehabilitation services has been a dynamic process over the past several decades. In our rapidly changing health care system, access has also changed, and it is difficult to predict the impact that changes to state level Medicaid services or Medicare caps will have on patient outcomes. Consistently, health care policy has been focused on quantity and costs with little attention to quality or outcomes. The shift toward value-based payment has signaled a change to this long-standing practice. Alternative payment models for MSK care—such as the Comprehensive Care for Joint Replacement Model—drew attention to quality, costs, and outcomes with a requirement for health systems to address high cost complications and readmissions [11]. Therapy and rehabilitation services are

considered part of the joint replacement bundled payment, and the impact of payment reform on the provision of therapy and rehabilitation is unknown. Despite the changing landscape of health insurance coverage, therapy and rehabilitation services continue to be necessary for improving function and quality of life for patients with MSK conditions.

Acknowledgments

A.G. is supported by the Foundation for Physical Therapy's Center of Excellence in Physical Therapy Health Services and Health Policy Research and Training Grant.

A.G. also receives funds from the NIH Loan Repayment Program, National Institute of Arthritis Musculoskeletal and Skin Diseases (1-L30-AR057661-01) and CTSA grant (UL1TR001117).

References

1. Storheim K, Zwart JA. Musculoskeletal and the global burden of disease study. Ann Rheum Dis. 2014; 73(6):949–950. [PubMed: 24790065]
2. Centers for Disease Control and Prevention. [Accessed July 10, 2017] NIOSH Data and Statistics. CDC website. https://www.cdc.gov/niosh/data/default.html. Updated December 22, 2015
3. Medicare.gov. [Accessed July 10, 2017] Your Medicare Coverage. Medicare.gov website. https://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html
4. Medicaid.gov. [Accessed July 10, 2017] Benefits. Medicaid.gov website. https://www.medicaid.gov/medicaid/benefits/index.html
5. North Carolina Division of Medical Assistance. [Accessed July 10, 2017] Medicaid Services. NC DMA website. https://dma.ncdhhs.gov/medicaid/get-started/apply-for-medicaid-or-health-choice/medicaid-services
6. United States Department of Labor. Occupational employment statistics. Bureau of Labor Statistics website; https://www.bls.gov/oes/current/map_changer.htm [Accessed July 10, 2017]
7. Goode AP, Freburger JK, Carey TS. The influence of rural versus urban residence on utilization and receipt of care for chronic low back pain. J Rural Health. 2013; 29(2):205–214. [PubMed: 23551651]
8. National Research Council (US) Committee on Enhancing the Inter-net for Health Applications. Networking Health: Prescriptions for the Internet. Vol. Chapter 3. Washington DC: National Academies Press (US); 2000. Technical Requirements and Implementation Strategies. Technical Challenges
9. North Carolina General Assembly G.S. 58-50-30(b). [Accessed on August 22, 2017] Right to choose services of certain providers pursuant to Article 18D of Chapter 90 of the General Statutes. https://legiscan.com/NC/text/H208/2017
10. Centers for Medicare and Medicaid Services. [Accessed July 10, 2017] Medicare benefit policy manual. Ch 15, Covered medical and other health services, Sec 220. CMS website. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
11. Centers for Medicare and Medicaid Services. [Accessed August 15, 2017] Comprehensive Care for Joint Replacement Model. CMS website. https://innovation.cms.gov/initiatives/cjr