Sitting on Capitol Hill

The therapy cap repeal, therapy without referral, and expansion of Medicare coverage are important legislation awaiting passage.

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Will It Happen?

Passage of a great deal of the rehabilitation-related legislation pending in Congress would unequivocally be a relief to rehab service providers, *if* it is enacted. That "if" remains precarious with the 107th Congress set to adjourn in December and much of this legislation currently stuck in committee with no action scheduled.

However, one of the more dramatic regulations related to inpatient rehabilitation has been implemented as of January, 2002. The PPS for inpatient rehab is without doubt the most significant change for rehab providers to date. For many this change has been financially beneficial or at least budget neutral. Providers are looking forward to this trend continuing unabated for the next several years.

It does appear that key legislation to benefit rehab service providers should be implemented. In particular, the outlook for the permanent repeal of the outpatient therapy caps and the elimination of the physician referral requirement for PT looks very favorable since all parties appear to be disposed for passage. From a procedural standpoint, the bills are very simply worded and should not require much work by committee staff. We anticipate enactment of this legislation, hopefully within this session. With that in mind, the following is a review of some of the most important rehab-related legislation currently pending.

Therapy Cap Repeal

The bill to permanently repeal Medicare's $1,500 reimbursement cap on outpatient PT and OT, *The Medicare Access to Rehabilitation Services Act of 2001,* was introduced in the Senate by Senator John Ensign (R-NV) on September 4, 2001,[1] and in the house by Representative Phil English (R-PA) on March 4, 2002.[2] Both bills have identical language, and would operate by simply deleting the section of the Social Security Act that contains the cap.[3] Time is especially critical for this legislation, because the temporary suspension of the

[1] S. 1394.
[2] H.R. 3834, *The Medicare Access to Rehabilitation Services Act of 2002.*
[3] Social Security Act section 1833(g), 42 U.S.C. § 1395*l*(g).

therapy cap expires at the end of the year. Both bills are pending in committee: the Senate bill in the Health Care subcommittee (chaired by Senator John Rockefeller IV (D-WV)) of the Finance Committee ((chaired by Senator Max Baucus (D-MT)) and the House bill in the Subcommittee on Health (chaired by Representative Michael Bilirakis (R-FL)) of the Energy and Commerce Committee (chaired by Representative W.J. Tauzin (R-LA)).

Therapy Without Referral

Almost as important in its implications for the business of rehab service providers as the repeal of the therapy caps, is *The Medicare Patient Access to Physical Therapists Act of 2001*,[4] introduced by Representative Philip Crane (R-IL) on November 28, 2001, that would authorize Medicare reimbursement for physical therapy without the requirement of a physician referral. The bill would operate in three ways. First, it would delete from Medicare's definition of a patient who qualifies for physical therapy the language requiring the patient to be "under the care of a physician."[5] Second, it would add language allowing a qualified physical therapist to review the PT plan developed for the patient.[6] Finally, it would delete from the definition of a qualifying rehabilitation agency the requirement that one or more physicians develop the agency's policies.[7] This bill is pending in the Energy and Commerce Committee's Subcommittee on Health.

In the same vein, but somewhat less sweeping in its implications for the business of rehab service providers, is a bill introduced by Senator Daniel Inouye (D-HI) on January 22, 2001 that would remove the physician supervision requirement for clinical psychologists or clinical social workers in a comprehensive outpatient rehabilitation facility (CORF) setting.[8] This bill would add to Medicare's definition of a qualifying CORF[9] language that a patient receiving qualified psychologist services may be under the care of a clinical psychologist instead of a physician and that a patient receiving clinical social worker service may likewise be under the care of a clinical social worker instead of a physician. This bill is currently in the Senate Committee on Finance.

Expansion of Medicare Coverage

Several of the bills pending before Congress would expand Medicare coverage of rehab services in various ways. Among the most important of these is *The Medicare Occupational Therapy Coverage Act of 2001,*[10] introduced by

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[4] H.R. 3363.
[5] Social Security Act section 1861(p)(1), 42 U.S.C. § 1395x(p)(1).
[6] Social Security Act section 1861(p)(2), 42 U.S.C. § 1395x(p)(2).
[7] Social Security Act section 1861(p)(4)(A)(ii), 42 U.S.C. § 1395x(p)(4)(A)(ii).
[8] S. 51, *To amend title XVIII of the Social Security Act to remove the restriction that a clinical psychologist or clinical social worker provide services in a comprehensive outpatient rehabilitation facility to a patient only under the care of a physician.*
[9] Social Security Act section 1861(cc)(2)(E), 42 U.S.C. § 1395x(cc)(2)(e).
[10] H.R. 2071.

Representative Robert Andrews (D-NJ) on June 6, 2001, that would provide home health coverage of occupational therapy on the same basis as physical and speech therapy. This bill would strike from Medicare's definition of eligible occupational therapy in home health setting the requirement that the patient had been previously furnished home health services, but no longer needs skilled nursing care or physical or speech therapy,[11] and would make occupational therapy available simply on the basis of need. This bill is pending in the Subcommittee on Health (chaired by Representative Nancy Johnson (R-CT)) of the House Committee on Ways and Means (chaired by Representative William Thomas (R-CA)).

The Medicare Vision Rehabilitation Services Act of 2001[12] would expand Medicare Part B coverage to include outpatient vision rehabilitation services by adding these services Medicare's coverage list.[13] This bill is important for rehab service providers because it provides coverage for vision rehab services if they are delivered under a plan of care established by either a qualified physician *or* a by qualified occupational therapist whose plan of care is periodically reviewed by the qualified physician. The bill also provides that the services may be delivered in any appropriate setting, including the patient's home, and may be delivered by a qualified physician, a qualified occupational therapist, or a "vision rehabilitation professional." Included in the bill's definition of "vision rehabilitation professional" are orientation and mobility specialists, rehabilitation teachers, and low vision therapists. Reimbursement would be under the Physician Fee Schedule,[14] and would be exempted from the Outpatient Prospective Payment System.[15]

The Medicare Vision Rehabilitation Services Act is currently pending in the Health subcommittees of both the House Ways and Means and Energy and Commerce committees. Identical legislation was introduced in the Senate by Senator John Kerry (D-MA) on February 26, 2002,[16] where it was referred to the Committee on Finance.

Similar coverage for hearing rehabilitation would be added by *Medicare Aural Rehabiliation (sic) and Hearing Aid Coverage Act of 2001,*[17] which was introduced by Representative Foley (R-Fla) on September 21, 2001. This bill would add coverage of hearing aids to Medicare's list of covered DME,[18] permit the hearing aid to be supplied by either a physician or qualified audiologist, add aural rehabilitation services to Medicare's list of covered services,[19] and include counseling on hearing loss, speech reading, and auditory training in the definition of

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[11] Social Security Act sections 1814(a)(2)(C) and 1835(a)(2)(A), 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A).
[12] H.R. 2484.
[13] Social Security Act section 1861, 42 U.S.C. § 1395x.
[14] Social Security Act section 1848(j), 42 U.S.C. § 1395w-4(j).
[15] Social Security Acton section 1833(t), 42 U.S.C. § 1395*l*(t)
[16] S. 1967, *The Medicare Vision Rehabilitation Services Act of 2002.*
[17] H.R. 2934,
[18] Social Security Act section 1861(s)(8), 42 U.S.C. § 1395x(s)(8).
[19] Social Security Act section 1861, 42 U.S.C. § 1395x.

services supplied with a hearing aid. This bill is also pending in the Health subcommittees of both the House Ways and Means and Energy and Commerce committees since its introduction.

Last on the list of bills that would expand Medicare coverage is *The Medicare Medical Nutrition Therapy Amendment Act of 2001,* which was also introduced in both the House and the Senate.[20] This bill would add beneficiaries with cardiovascular disease, which the bill would define to include congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia, to the beneficiaries with diabetes or renal disease who are already eligible for such therapy.[21] Like other legislation discussed in this article, these bills are pending in the Health subcommittees of both the House Ways and Means and Energy and Commerce committees and the Senate Committee on Finance.

The Future of Specialty Hospitals

In a previous article,[22] we discussed how the Hospital Investment Act of 2001,[23] introduced by Representatives Stark (D-Cal) and Kleczka (D-Wis) on July 12, 2001, could impact the continued trend toward development of physician-owned specialty hospitals by amending the Stark Anti-Kickback law to required that ownership interests offered to physician investors by "purchased on the same terms generally available to the public at the time." The fate of this act, however, is just as uncertain as all other legislation discussed in this article, because it too has been pending in the Health subcommittees of both the House Ways and Means and Energy and Commerce committees since its introduction. However, in light of the ambiguous nature and timing of the proposed legislation, physician-owned specialty hospitals remain a high visibility trend in health care.

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[20] H.R. 2117 and S. 960,.
[21] Social Security Act section 1861(s)(2)(V), 42 U.S.C. § 1395x(s)(2)(V).
[22] Cherilyn G. Murer, JD, CRA, *As the Focus Narrows*, Rehab Management (February 2002).
[23] H.R. 2490.