Caps are Back: Are You Provider Based?

By

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Introduction

On January 1, 2006 financial limitations on non-hospital therapy services required by the Balanced Budget Act of 1997, known as "therapy caps", were reinstated after an almost seven year hiatus.

Congress first enacted annual caps on therapy services as part of the Balanced Budget Act of 1997. Included in the Balanced Budget Act of 1997, was a provision that payments for outpatient therapy services for Medicare beneficiaries would be subject to an annual financial limitation (cap). Hospital services (inpatient and outpatient) were excluded from this limitation.

The caps were subject to a series of moratoriums, the most recent of which expired on December 31, 2005. As a result, caps on outpatient rehabilitation coverage took effect on January 1, 2006. The 2006 statutory cap for each patient is $1,740 for physical therapy and speech therapy services (combined) and $1,740 for occupational therapy services. The cap does not apply to therapy services furnished in hospital outpatient departments, except if those services are provided to SNF residents occupying a Medicare-certified bed and billed under PPS/consolidated billing.

Are You Provider Based?

As a result of the expired moratoriums, hospital-based facilities that provide physical, occupational and/or speech therapy must now meet Medicare's "provider-based requirements" to be exempt from the therapy caps. Hospitals are not subject to the caps like independent therapy providers. To assure full payment for any therapy services, hospital-based therapy facilities must be "provider based," or face significantly diminished reimbursement.

Whether a therapy provider qualifies as provider-based depends, in part, upon its proximity to the hospital whose Medicare provider number it uses. The hospital is called the main provider in these instances. Qualification for provider status also depends upon compliance with individual state's healthcare facility licensure laws. The therapy site must be geographically close enough to the hospital that they both serve the same patient population. If therapy sites are within 35 miles of the main provider hospital the geographic requirement is assumed to be met. In addition, some states provide either mandatory or optional common licensure for therapy sites and the hospitals from which they are based. In these states, provider-based entities must comply with both the CMS requirements and state

requirements for common licensure. The ramifications of common licensure in some states can mean that off-site therapy clinics must meet tougher hospital licensing and building requirements than what is required for independent therapy clinics.

The provider-based entity must be included in the accreditation of the provider from which it is based and recognized as a department of the hospital. For example, if a Joint Commission on Accreditation of Healthcare Organizations-accredited hospital wishes to have a provider-based outpatient therapy clinic, the clinic must be recognized by the Joint Commission as part of the hospital and must comply with the Joint Commission's accreditation requirements. The Joint Commission will issue a single accreditation award for the hospital and the hospital-based clinic. However, the hospital and clinic must be integrated operationally, organizationally and for performance improvement purposes.

CMS requires that provider-based entities not on the campus of the main provider hospital be operated under common ownership and control as their main providers. To comply with this requirement, the entity must be subject to the same bylaws and organizational documents that govern the provider. In addition, the provider must have the final authority to approve or reject decisions impacting the entity. For example, a hospital would have the authority to determine which personnel and medical staff could work at the hospital's provider-based entity. The entity must function as a department of the main provider. As a department, the entity should commonly use the same equipment, service personnel and, where possible, buildings of the main provider on a daily basis.

A provider-based entity must not merely be under the control of the primary hospital; the clinic's director, key staff, and personnel must also be under the direct day-to-day supervision of the hospital. To evidence this day-to-day supervision, the entity director must be required to have a daily reporting relationship with the chief executive officer or his or her designee appropriate within the organizational structure of the hospital. Compliance with this requirement can be illustrated by using daily call logs, meeting agendas and written reports of the entity's activities. Other administrative functions of the therapy site such as laundry and housekeeping should be integrated with the main provider.

Similar to the requirement that entities and their main providers are administratively integrated, provider-based entities must also be clinically integrated with their main provider hospitals. To be clinically integrated, it is necessary that the professional staff of the entity have clinical privileges at the main provider. In addition, the entity's medical director or clinical leadership should have a daily reporting relationship with the medical director of the provider.

Clinical integration of the therapy site and its hospital impacts patients as well as the professional staff. Medical records of patients treated at the entity must be integrated with those of the main provider. Patients of the entity are considered patients of the main provider and, as such, must have full access to the healthcare services offered by the main provider.

Another provider-based requirement involves the manner in which the entity is presented to the public. Provider-based entities generally must be held out to the public as part of the main provider so that patients know they are actually patients of the main provider and that they will be billed as patients of the main provider. Patients may be informed that they are being treated in part of the main provider in various ways. For instance, facility signage and marketing materials as well as patient forms such as treatment consents, could all include statements explaining that the therapy site is an integral part and department of the hospital provider.

As discussed above, a provider-based entity and its main provider must be both organizationally and clinically integrated. However, they must also exhibit financial integration as well. This means that a provider-based entity and its main provider have an agreement in place for sharing the income and expenses of their operations. When seeking Medicare reimbursement, the provider-based entity must also report its costs on the main provider's cost report and use the same accounting system and cost reporting period as the main provider.

Temporary Relief for Non-Provider Based Rehabiltation Facilities

While non-provider based, independent therapy facilities, are not exempt from the therapy caps, Congress is providing some temporary financial relief for such facilities. On February 1, 2006, Congress passed the Deficit Reduction Act ("DRA"), signed into law by the President on February 8, 2006. This Act required HHS to develop a process for determining exceptions to the 2006 cap. According to the DRA, the therapy cap exceptions process is only available for services provided during calendar year 2006. Providers may qualify for one of two types of exceptions, **automatic** or **manual**.

Automatic Exception

CMS identified more than ninety (90) conditions and complexities that qualify for an automatic exception to the therapy cap limitation. According to CMS, diagnoses qualify for an automatic exception if the condition "*has a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medical necessary*."

An automatic exception may be assumed by the provider if the condition being treated is among those for which extended periods of therapy may be medically necessary, or if there are comorbidities that would prolong the time required to achieve maximal benefit from the therapy. Both the conditions and complexities

meeting these standards are included in a separate list of diagnoses provided by CMS and distributed by the carrier. Additional circumstances justifying the assumption of an automatic exception include discharge from a hospital or SNF within 30 days of starting an episode of outpatient therapy; or the patient having another generalized musculoskeletal, or a mental, or cognitive condition, that will *directly* and *significantly* affect the rate of recovery.

Manual Exception

Manual exceptions require a written request by the beneficiary or provider/supplier for patients that do not have a condition or complexity that allows an automatic exception, but believe the therapy services which exceed the therapy cap are medically necessary. The manual exception request may be made for up to fifteen (15) treatment days of service beyond the therapy cap by faxing a request, including all supporting documentation, to the CMS contractor responsible for processing the claim. The CMS contractor will then conduct a medical review and make a decision based on the information submitted. The CMS contractor is required make all determinations on manual exception requests within ten (10) business days of the request. If the CMS contractor does not make a decision within the ten (10) business period, the DRA requires that the exception be granted.

Conclusion

After the expiration of the therapy cap moratoriums last December, therapy providers are faced with a myriad of complexities. Hospital based-facilities must ensure that the provider-based regulations are met in order to be exempt from the caps. Unfortunately, independent therapy providers are only provided with temporary relief from the caps this year through the exception process discussed above. Ultimately, the therapy caps are back and currently they seem here to stay unless there is sufficient outcry from the field and patients for whom they provide service.

About the Author:

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