

GOOD NEWS FROM THE HILL

by

Cherilyn G. Murer, J.D., C.R.A.

Calendar year 2003 saw major changes affecting rehabilitation providers come down from Capitol Hill in the form of legislation. Specifically, Congressional action has altered the reimbursement and regulatory landscape in three key areas: The therapy caps for physical therapy, occupational therapy and speech, physician ownership of specialty hospitals, and the 75 Percent Rule. In two of these areas, the therapy caps and the 75 Percent Rule, Congress has provided nothing but good news for providers. The therapy caps are suspended for another two years, and Congress is taking a firm stand on the side of providers in their battle with CMS over the proposed changes to the 75 Percent Rule. At first blush, Congress' action regarding specialty hospitals may appear problematic, but an in-depth examination of the legislation reveals that it should have relatively little effect on the rehabilitation provider community.

Physician-Owned Specialty Hospitals: From Stark to Breaux

When we last visited the subject of physician-owned specialty hospitals,¹ Senator Breaux of Louisiana had introduced into the Medicare Prescription Drug, Improvement, and Modernization Act of 2003² amendments to the Stark Physician Self-Referral Law³ that carved out designated specialty hospitals from the "whole hospital exception" to the Stark prohibition on self-referrals. The amendments defined "specialty hospital" as a hospital "that is primarily or exclusively engaged in the care and treatment of one of the following categories:

- (i) Patients with a cardiac condition.
- (ii) Patients with an orthopedic condition.
- (iii) Patients receiving a surgical procedure.
- (iv) Any other specialized category of services that the Secretary

designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section."

¹ Cherilyn G. Murer, J.D., C.R.A., *Stark Revelations*, Rehab Management pp. 46-49 (October 2003).

² Public Law No. 108-173.

³ 42 U.S.C. § 1395nn(h).

Rehabilitation hospitals do not fall within the first three categories, and, considering the concerns that lead Senator Breaux to introduce the amendments, it is unlikely that CMS will include rehabilitation hospitals within any future category. As evidenced by statements made by Representative Pete Stark, the author of the Stark Self-Referral Law, and other members of Congress, the amendments are a response to concerns raised by general, community hospitals that the presence of physician-owned specialty hospitals had the effect of depriving the general hospitals of their most profitable acute care patients, i.e., cardiac, orthopedic, and surgical patients. None of the discussion surrounding physician-owned specialty hospitals involved post-acute or sub-acute venues. Furthermore, rehabilitation hospitals, one of the long-standing, traditional forms of “specialty” hospitals, generally have not been a component of the boom in “boutique” hospitals that triggered the push for the amendments on the part of general hospitals. For these reasons it appears unlikely that rehabilitation hospitals would be included in any future category of excluded “specialty hospitals.”

The Conference Committee on the Prescription Drug Act also decided to make the prohibition on physician-owned specialty hospitals a temporary moratorium, at least for now. The legislation provides that the moratorium will extend 18 months from the date of the law’s enactment (December 8, 2003). During the moratorium period, the Medicare Payment Advisory Commission (MedPAC) is directed to conduct a study related to the financial impact of physician-owned specialty hospitals on local, full-service, community hospitals and the Department of Health and Human Services is directed to conduct a study related to how ownership affect’s the physicians’ referral patterns and the differences, if any, in the quality of care in physician-owned specialty hospitals and local, full-service, community hospitals. Presumably, Congress will use the results of these studies to determine whether the moratorium should be made permanent or be allowed to expire.

The End of the Therapy Caps?

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 also includes a provision suspending the \$1,590 caps on outpatient physical therapy, occupational therapy and speech pathology services from December 8, 2003 (the date of the law’s enactment) through calendar year 2005. This was not the first time a Medicare prescription drug bill had contained a provision placing a moratorium on the therapy caps. The 2002 bill, also contained similar language, but when that bill died in the Senate, the caps nominally went into effect on January 1, 2003. Responding to providers’ concerns and litigation, and obviously expecting Congress to take action, CMS delayed implementation of the caps until September 1, 2003, with the full amount of the caps to be effective until the end of the year.⁴ On December 8th, CMS published a revision to the Medicare Claims Processing Manual, placing a moratorium on enforcement of the caps from that

⁴ CMS Transmittal 30, Change Request 2973 (November 14, 2003).

date through December 31, 2005.⁵ As a result, the therapy caps were actually in effect from September 1st through December 7th, but it is highly doubtful that any Medicare beneficiary was actually affected by the caps during that brief period of time.

Whether this finally marks the end of the therapy caps remains to be seen. The bill to permanently repeal the caps, The Medicare Access to Rehabilitation Services Act, as of this writing, has garnered 242 cosponsors in the House⁶ and 50 cosponsors in the Senate,⁷ but there has been no move to bring the legislation to the floor of either chamber for a vote since it was introduced in March 2003. With the immediate crisis of cap enforcement averted until the end of 2005, there may not be the impetus to get the permanent repeal passed that previously existed. Hopefully the provider community will continue its work to keep Congressional awareness of this issue fresh and immediate.

75 Percent Rule Reform

Our last article,⁸ which discussed CMS' proposed changes to the 75 Percent Rule for inpatient rehabilitation facilities, noted that, contrary to vociferous arguments of rehabilitation providers, the proposed rule made it quite clear that CMS does not regard inpatient rehabilitation as an appropriate venue for the typical knee or hip replacement patient. Taking their cue from CMS, several fiscal intermediaries quickly published proposed local medical review policies (LMRPs) that effectively ruled out payment for most inpatient hip and knee replacement patients. These actions set off a firestorm of protest within the rehabilitation provider community. Not content to write letters of comment on the proposed rules, the providers turned to Congress for relief, where they found a sympathetic ear. In the Conference Report for the year-end appropriations bill,⁹ Congress inserting the following paragraph, which would effectively put a halt to both the proposed changes to the 75 Percent Rule and the LMRPs:

“The conferees are concerned that the proposed Medicare “75% Rule,” classifying inpatient rehabilitation facilities (IRFs), would have severe consequences for access to inpatient rehabilitation services. The conferees concur with the Medicare payment Advisory Commission (MedPAC) finding that further analysis should be conducted to identify which criteria are clinically appropriate for inclusion in the calculation of the rule used to determine eligibility for reimbursement under the IRF prospective payment system. The conferees direct CMS to contract with the Institute of Medicine to issue a report, in consultation with a panel of

⁵ CMS Transmittal 42, Change Request 3005 (December 8, 2003).

⁶ H.R. 1125.

⁷ S. 569.

⁸ Cherilyn G. Murer, J.D., C.R.A., *The 65/75 Split*, Rehab Management pp. 42-43 (November 2003).

⁹ FY 2004 Omnibus Appropriations Bill, H.R. 2673.

independent experts in the field of physical medicine and rehabilitation, to establish clinically appropriate qualification criteria for IRFs. During the study period the conferees expect the Secretary to delay implementation of the 75% rule, delay implementation of the local medical review policies concerning medical necessity, and not accept new IRF applications until the report is finished.”¹⁰

The Conference Report was approved by the House of Representatives prior to Congress' holiday recess. The Senate is expected to take up the bill as soon as Congress resumes in January. Regardless of what action the Senate eventually takes, it appears that CMS has gotten the message. In the proposed revision to the 75 Percent Rule, CMS had stated that it planned to have the final rule become effective on January 1, 2004. However, through the fourth week of December, no final rule has appeared, effectively ruling out the January 1st target date. CMS apparently has decided that Congress clearly does not approve of its plans. As a result, one can only assume that the moratorium on enforcement of the existing 75 Percent Rule, which has been in effect since July 2002, will remain in effect until CMS formulates a rule that will pass Congressional muster.

Conclusion

Rehabilitation providers have ample reason to be pleased with Congress' actions during 2003. The therapy caps are gone for at least another two years, and it is clear that inpatient providers will eventually get a revision to the 75 Percent Rule that they will find much more palatable than that proposed by CMS. Furthermore, the moratorium on physician-owned specialty hospitals should have little, if any, impact on the rehabilitation provider community.

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based health care management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on web site: <http://www.murer.com>

¹⁰ Conference Report on the FY 2004 Omnibus Appropriations Bill, H.R. 2673.