

Out to Lunch on the \$1,500 Cap

by

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Introduction

When Congress adjourned on November 22, 2002, it seemingly left many physical, speech, and occupational therapy providers and the Medicare beneficiaries they serve “out to lunch.” With Congress’ adjournment, the \$1,500 annual cap on physical, speech, and occupational therapy, which had been suspended through the end of 2002, went into effect on January 1, 2003. As we shall see, the suspension of the cap is, for the time being, a victim of politics that have nothing to do with the cap itself.

The therapy cap, which applies to all outpatient therapy venues, with the significant exception of hospital outpatient departments, is a combined \$1,500 cap for physical and speech therapy. A separate \$1,500 cap applies to occupational therapy.¹ The cap, which is intended to apply annually per beneficiary, is based on total services paid, not just the portion that Medicare pays. Thus, under the cap, Medicare will pay \$1,200 per beneficiary per year (80 percent) and the beneficiary will pay \$300 per year (the 20 percent copayment).

History of the Cap

Concerned by perceived differences in therapy billing between hospital outpatient departments and other venues, Congress imposed the \$1,500 therapy cap on all freestanding therapy providers in the Balanced Budget Act of 1997.² Implementation problems with the cap became apparent as soon as it went into effect on January 1, 1999.

Unable to fully track payments on per beneficiary basis across the full spectrum of therapy providers, CMS imposed transitional rules requiring all providers, other than physical therapists in private practice,³ to track the cap within their facilities. Thus, the cap, which was intended as a per beneficiary cap, became, in effect, a per facility cap.

Due to these inequities—and the basic inequity of the cap itself—Congress passed a two-year moratorium on enforcement of the cap beginning on January

¹ Social Security Act § 1833(g), 42 U.S.C. § 1395l(g).

² Pub. L. No. 105-33 § 4541(c),(d).

³ At the time private physical therapy practitioners were the only provider type wherein CMS could track therapy payments on a per beneficiary basis.

1, 2000,⁴ and later passed an additional one-year extension,⁵ which carried the suspension of the cap through December 31, 2002.

The 107th Congress saw several efforts to keep the cap from going into effect after 2002, including bills introduced in both the House⁶ and the Senate⁷ that would have permanently repealed the cap. These bills, however, were tabled in favor of a compromise provision that was added to the “Medicare Prescription Drug Bill,” the Medicare Modernization and Prescription Drug Act of 2002,⁸ which would have extended the suspension of the cap an additional two years through December 31, 2004.

The therapy cap, of course, was not the controversial portion of the Medicare Prescription Drug Bill. It was partisan wrangling over the extent of the prescription drug benefit that doomed the bill in the Senate. Unfortunately, the Senate did not decide to kill the Medicare Prescription Drug Bill until just before Labor Day, and with the mid-term elections giving control of both the House and Senate to the Republicans, neither Congress nor the White House was willing to engage in any serious discussion of a new Medicare bill before the 108th Congress was seated.

Does the Cap Have a Future?

Politics has ensured that the therapy cap will take *effect* on January 1, 2003, but whether the cap will ever be *enforced* is a decidedly different question. CMS has yet to issue any program memoranda or other guidance for compliance with the cap, and given the agency’s difficulties with enforcement of the cap in 1999, it would hardly be surprising if CMS waits as long as possible to see whether Congress will eliminate the need for regulatory enforcement.

Congressional rescue should not be long in forthcoming. Funding of federal agencies will run out on January 11, 2003, so Congress will be forced to convene early in the new term. Congressional support for some type of cap relief, whether in the form of continued suspension, if not outright repeal, is strong, and rehabilitation industry representatives will be lobbying hard for early action as soon as the senators and representatives return to Washington.

Thus, early cap relief is a strong possibility. It is not, however, a certainty. It is always possible that cap relief will again fall victim to the same type of partisan politics that doomed the Medicare Prescription Drug Bill. Therefore, therapy service providers need to be prepared to comply with the law as written. In that

⁴ Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113.

⁵ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554

⁶ Medicare Access to Rehabilitation Services Act of 2002, H.R. 3834.

⁷ Medicare Access to Rehabilitation Services Act of 2001, S. 1394.

⁸ H.R. 4954.

regard, providers may wish to consider two therapy service venues that offer shelter from the cap's effect on their reimbursement: Provider-based facilities and CORFs.

Is Provider-Based a Solution?

Under CMS regulations,⁹ a “provider-based entity” is a facility or organization owned and operated by a main provider (usually a hospital) to provide health care services of a different type than are offered by the main provider itself. Physician practices, cancer centers, minor care centers, rural health clinics, outpatient diagnostic centers, and diabetes education centers are a few examples of the types of facilities for which CMS has granted provider-based status. The regulations state that CMS will not make provider-based determinations for facilities where such status will not affect either the facility's reimbursement or the beneficiary's copayment liability. As long as the \$1,500 therapy cap was suspended, a facility's payment for outpatient physical, speech, or occupational therapy was unaffected by whether or not the facility was hospital-owned, and CMS would not make provider-based determinations for facilities offering only those therapies. With the cap coming into effect, however, provider-based status can make a significant difference in reimbursement, because hospital outpatient departments are exempt from the cap limits.

Being wholly acquired by a hospital, however, is not a realistic option for the vast majority of rehabilitation practices, and except in rare cases,¹⁰ 100 percent ownership by the hospital is a requirement for provider-based status. Moreover, provider-based facilities are subject to a number of CMS requirements that do not apply to free-standing facilities, including ensuring that the appropriate reporting relationships exist between the outpatient department staff and the main hospital's administration, that the medical director of the outpatient department maintains the appropriate reporting relationship with the chief medical officer of the main hospital, that the outpatient department can be separately identified in the main hospital's Medicare cost report, that the patient records of the outpatient department and the main hospital are fully integrated, and that, in its advertising, billing, and correspondence, the outpatient department is held out to the public as part of the main hospital and not as a separate entity.

⁹ 42 C.F.R. § 413.65.

¹⁰ Although joint venture ownership of a provider-based facility is possible, it is subject to severe restrictions, not the least of which is the requirement that the facility be physically located on the main provider's campus.

The CORF Advantage

A CORF—Comprehensive Outpatient Rehabilitation Facility—is not subject to the restrictions placed on provider-based facilities regardless of whether the CORF is freestanding or wholly or partially owned by a hospital. In fact, because all CORFs are reimbursed by Medicare under the same fee schedule regardless of ownership, they are specifically excluded from provider-based status.¹¹ Although a CORF is not exempt from the therapy cap, it is unique among all therapy providers in its ability to ameliorate the effects of the cap without compromising the quality of patient care.

Unlike other therapy practice venues, with limited reimbursable services of physical therapy, speech therapy, and, perhaps, occupational therapy, social services, and vocational adjustment services, a CORF has the ability to bill Medicare directly for nursing, psychology, DME, drugs and biologicals, immunizations, and respiratory therapy in addition to social services, physical therapy, occupational therapy, and speech therapy. In terms of the therapy cap, this broad range of reimbursable services allows the CORF to draw from a patient population that is not completely dependent on physical or occupational therapy. Moreover, even for patients that do require such therapy, the CORF's ability to diversify services, allows its clinical staff to design a rehabilitation program for the patient which maximizes a favorable outcome without putting unnecessary pressure on the physical and occupational therapy components of the plan. In other words, of all free-standing therapy venues, the CORF is in the best position to weather the effects of the therapy cap without a commensurate reduction in the quality of services afford to patients.

In this regard, it should also be noted that CORFs enjoy a key medical management advantage over other venues such as rehabilitation agencies. CMS regulations applied to rehabilitation agencies require physicians to review the patient's plan of care at least every 30 days, whereas a CORF requires a physician to review the plan of care every 60 days. This ability to plan a longer range, more complex rehabilitation program enhances the CORF's ability to shift some of the reimbursement burden away from physical and occupational therapy without compromising the quality of care offered to Medicare beneficiaries.

Conclusion

The most likely outcome of the return of the therapy cap is that Congress will soon take action to re-impose the suspension of, if not outright eliminate, the \$1,500 cap on physical, speech, and occupational therapy. In the event that Congressional relief is not forthcoming, for the vast majority of rehabilitation providers for whom provider-based status is not a viable option, the CORF format, with its diversification of services, will be the venue of choice for

¹¹ 42 C.F.R. § 413.65(a)(1).

maximizing patient care while minimizing the damaging financial impact of these draconian limits.

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