CMS Responds to Open Door Forum Q&As
Agency Clarifies Responses on Therapy Assessments

The Centers for Medicare & Medicaid Services (CMS) answered questions posed by the National Association for Home Care & Hospice (NAHC) during the May Home Health, Hospice, and Durable Medical Equipment Open Door Forum regarding therapy reassessment and face-to-face encounter requirements.

**Therapy Reassessment**

**Q:** Should the CMS web question and answer (Q&A) regarding therapy reassessments answer to question six read “The 30-day clock resets after every therapy ‘assessment’” rather than “visit”?

**CMS:** Yes, we are talking about therapy assessment visits. We will be revising our response (to that below) to more fully, and accurately, respond to the question asked:

**Question Six:** If the 13th and 19th therapy assessment visits occur before the 30-day reassessment, when does the 30-day clock reset?

**Answer Six:** The 30-day clock resets after every therapy assessment visit (per discipline). Therapy assessment visits can only be performed by qualified therapists. A therapy assessment visit includes providing the actual therapy service(s), functionally assessing/reassessing the patient, measuring progress to determine if the goals have been met, documenting measurement results and corresponding therapy effectiveness in the clinical record.

**Q:** Should the answer to the CMS web Q&A question 15 read: “the visit prior to the ‘13th’ visit would satisfy the requirement” rather than the “19th visit”?

**Question 15:** When multiple therapy disciplines are ordered, if the frequency of one ordered therapy by the doctor is so low that no scheduled visit should occur between the 13th and 19th visits (e.g., no scheduled OT visit would occur between the 13th and 19th visits), should the therapist make another visit to meet this requirement?

**Answer 15:** No, because therapists should visit patients only as ordered in the patient’s plan of care. We provide flexibility for multiple-discipline therapy cases to account for such scenarios. In multiple-discipline therapy cases, the visit can occur close to the 13th and 19th visits. If no visit is ordered for one discipline between the 13th and 19th visits, the visit prior to the 19th visit would satisfy the requirement.

**CMS:** Yes. While the response, as written, is not incorrect, it would be more accurate to say “the visit prior to the 13th visit”. More importantly, to more fully and accurately respond to the question, we will be revising that portion of the response to read as follows:
“In multiple-discipline therapy cases, the therapy assessment visit can occur close to the 13th and 19th visits. If no therapy visit is ordered for one discipline between the 13th and 19th visits, the therapy visit prior to the 13th visit would satisfy the requirement so long as a qualified therapist performed the required reassessment on that visit.”

Q. Would CMS consider establishing of a policy allowing agencies to bill 30-day reassessments that are late as a result of circumstances outside of the agency’s control? We’ve received reports of numerous problems related to late 30-day reassessments as a result of circumstances outside of the home health agency’s control. Examples presented to us include: patient hospitalization or medical emergency, visit cancellations by patients for a variety of medical and nonmedical reasons and temporary relocation.

Examples:

A patient was in the hospital on the 30th day. May the home health agency bill Medicare for the therapy reassessment visit that was conducted upon the patients’ return home even though it was after day 30?

A patient was not available on the day for the planned 30 day reassessment (e.g. patient cancelled because not feeling well, temporarily taken to family member home, unplanned MD or ER visit, etc.). May the home health agency bill Medicare for the therapy reassessment visit that was conducted even though it was after day 30?

CMS: CMS believes that its policy regarding 30 day assessments is appropriate. CMS policy states that an assessment visit by a qualified therapies (per discipline) is required at least every 30 days. As such, therapy visits provided in absence of that requirement being met, would not be considered covered therapy services under the Medicare home health benefit. Once a late 30-day assessment visit by a qualified therapist occurs, coverage of therapy services resumes, and the 30-day clock is reset.

Face-to-Face Encounter

Q: Our request for written guidance for home health agencies in cases where Medicare start of care dates are amended as a result of encounters that take place beyond day 30 is attached.

CMS: Yes, once the encounter has occurred, the agency would cancel the original OASIS submission (Medicare was not the payer when that OASIS was done), establish a new start of care date, and complete a new OASIS (or use one completed during the “revised” 60-day episode to reflect the patient’s condition on or after the new Medicare start of care date (As published by CMS in the April 2011 Q&As)

Q: We admit a patient for service, understanding that the patient will have their face-to-face on day 25. We complete the SOC comprehensive assessment; send the OASIS to the state and it is accepted. Potentially other OASIS assessments may be submitted, depending on the patient situation, e.g. other F/U, transfer/ ROC. Now, by day 30 after the SOC, the patient does not have their F2F with the physician and we discharge the patient, due to not meeting coverage criteria.
1. What do we do with the OASIS submitted to the state?

2. Is another OASIS now required at discharge?

**CMS:** If the individual was determined to not be eligible for services, no OASIS data collection would be required. No data would be transmitted to the State agency. Since, in this case the OASIS had already been submitted to the state, the OASIS assessment should be deleted, not inactive.

You may reference the “New Outcome and Assessment Information Set (OASIS) Correction Policy for Home Health Agencies” (April 2001) for guidance related to deleting assessments. It is located at:


Since the patient was determined not eligible for services, no discharge OASIS is required. The HHA should be advised to maintain good clinical record documentation of care provided and reason for discharge.