CMS Provides Guidance on 30 Day Reassessment Requirements, Therapy Visit Counts

Included in the publication of the 2012 Home Health Prospective Payment (PPPS) rate update in the November 4, 2011 Federal Register (http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf) were several Centers for Medicare & Medicaid Services (CMS) responses to questions about therapy reassessment requirements. This article provides CMS’ response to concerns about 30 day therapy reassessment requirements and counting therapy visits for scheduling reassessments.

30 Day Reassessment Requirements

1. CMS responded to questions posed by home health agencies as to how to meet the every 30 day reassessment requirements when the services by a therapist are interrupted prior to day 30, but not resumed until after day 30 by pointing readers to the Therapy Q&As on the CMS website at: http://www.cms.gov/HomeHealthPPS/Downloads/Therapy_Questions_and_Answers.pdf. To the question “Are there any instances in which the 30-day reassessment can be delayed yet still be covered if the patient is unavailable due to circumstances beyond the control of the therapist” CMS responded:

   “CMS believes that the policy that requires a qualified therapist to perform the necessary therapy service, assess the patient, measure, and document the effectiveness of the therapy at least once every 30 days during a course of therapy treatment is essential to ensuring that effective, reasonable, and necessary therapy services are being provided to the patient. In the case of a home health patient where the therapy goals in the plan of care have not been met, but the doctor has instead ordered a temporary interruption in therapy, we would usually expect that the unique clinical condition of the patient would enable the home health agency to anticipate that an interruption in therapy may be needed. In such cases, the HHA should ensure that the requirements are met earlier than the end of the 30-day period to ensure the HHA meets the 30-day requirement.”

2. In response to commenters who gave hospitalizations as an example of when there should be an exception to the 30-day reassessment requirement, CMS did allow for an exception to this unexpected change in condition as follows:

   Regarding the issue of the at least every 30-days reassessment requirements…we have allowed for one exception to the 30-day reassessment requirement (that is, when there is a hold on therapy due to the patient’s hospitalization for an unexpected change in the patient’s condition).

3. Regarding questions about 30 day reassessment requirements where unexpected sudden changes in the patient’s condition result in a need to stop therapy, CMS stated:

   We would expect to see documentation and evidence in the medical record which would support an unexpected change in the patient’s condition which precludes delivery of therapy service. We will modify our manual to describe that in such documented cases, the 30-day qualified therapist visit/assessment/measurement requirement can be delayed until the patient’s physician orders therapy to resume.
4. As far as the impact of other assessments on the 30 day clock, CMS responded:

   We would like to note that every time a qualified therapist performs the therapy service, assesses the patient, measures and documents the effectiveness of the therapy service for that therapy discipline, the 30-day clock is ‘reset’. As such, a qualified therapist visit/assessment/measurement and documentation which satisfies the threshold requirement could also satisfy the 30-day requirement.

**Count of Covered Therapy Visits Only**

CMS also addressed the questions that agencies and therapists continue to have questions on how to count therapy visits to determine when the required therapy assessment visits (which are to occur close to both the 14th and 20th Medicare-covered therapy visits but no later than the 13th and 19th Medicare-covered therapy visits) should occur. In response CMS stated:

   We have provided a clarification in § 409.44(c)(2)(i)(C)(2) and § 409.44(c)(2)(i)(D)(2) that from a Medicare payment perspective, only Medicare-covered visits are to be considered and counted. Specifically, to reflect that Medicare payment policy recognizes only Medicare-covered visits, we are inserting the words, ‘‘Medicare covered’’ before the words, ‘‘therapy visit’’ in both these regulations related to multiple therapy disciplines being provided because commenters have expressed confusion over the process of counting at both of these junctures. We have also inserted the words, ‘‘the 14th Medicare-covered therapy visit’’ at § 409.44(c)(2)(i)(C)(2) and the words, ‘‘the 20th Medicare-covered therapy visit’’ at § 409.44(c)(2)(i)(D)(2) to further reinforce that the counting of therapy visits for Medicare payment purposes should include only those Medicare covered visits which are close to the 14th and 20th Medicare-covered therapy visits, but no later than the 13th and 19th Medicare-covered therapy visit. Last, to further address commenters’ confusion, we have made minor changes to the regulation text to make the language between § 409.44(c)(2)(i)(C)(2) and 409.44(c)(2)(i)(D)(2) consistent. We note that the counting of therapy visits for Medicare payment purposes might differ from how agencies and therapists would count therapy visits for a patient’s plan of care. Consequently, we have also removed the references to the patient’s ‘‘plan of care’’ in § 409.44(c)(2)(i)(C)(2) and § 409.44(c)(2)(i)(D)(2). We also note that both Medicare-covered and non-covered visits are included on the Medicare home health claim forms, where they should continue to be designated as covered or non-covered. We conclude by stating that we are committed to continuing our provider education efforts related to these therapy policies.