Therapy Questions and Answers – Revised February 28, 2013

Question 1: Does the January 1, 2013 effective date for the therapy reassessment changes in the CY 2013 HH PPS Final Rule mean that these changes are effective for episodes beginning on or after January 1, 2013?

Answer 1: Yes

Question 2: Is the 13th/19th visit reassessment requirement per episode?

Answer 2: Yes

Question 3: How are therapy visits counted when trying to determine when the required 13th, 19th, and "at least every 30 days" therapy reassessment visits are to be performed? How is the counting of therapy visits affected, when any one of those required therapy reassessment visits does not occur?

Answer 3: For the purpose of determining when certain required therapy reassessment visits need to occur; only Medicare-covered visits are counted. Non-covered therapy visits are not to be included in the counting of therapy visits for the purpose of determining when certain required therapy reassessment visits need to occur. If a required therapy reassessment visit is not performed timely (or does not meet the therapy reassessment visit requirements), that visit and all subsequent therapy visits are considered non-covered and would not contribute towards the counting of Medicare-covered visits used to determine when certain therapy reassessment visits are to be performed. Once the therapy reassessment visit requirements have been met, the reassessment visit and subsequent therapy visits are considered Medicare- covered and are counted for the purpose of determining when certain required therapy reassessment visits need to occur.

We also note the following: (1) the classifications of Medicare-covered and non- Medicare covered visits refer to how the visits would be reported on the claim; (2) agencies and therapists should not change the number of therapy visits a patient receives based on whether prior visits were Medicare-covered or not; and (3) patients should only receive the number of therapy visits called for in the patient's plan of care. We do note that it is important for HHAs to track Medicare-covered visits on an ongoing basis.

Question 4: In the case of a patient receiving more than one type of therapy, how is the count handled for the 13th and 19th visits?

Answer 4: The count is cumulative and includes all therapy disciplines. Therefore, if someone were, for example, receiving physical therapy (PT) three times a week and occupational therapy (OT) once a week, the 13th therapy visit would presumably be at the beginning of the fourth week.

Question 5: Is the "at least every 30-days" reassessment requirement measured by episode or the patient's full course of treatment?

Answer 5: The patient's full course of treatment (i.e., starting from the therapist's first assessment/visit and continuing until the patient is discharged from home health). Note that because this requirement is designed to ensure that at a minimum, a home health patient is visited by a therapist (rather than an assistant) at least once every 30 days, the intent is not for a therapist to wait until the 30th day to visit a patient, but instead to ensure that a therapist rather than a therapy assistant is assessing a home health patient at least once during a given 30-day period.

Question 6: When does the "at least every 30-days" reassessment clock begin?

Answer 6: It begins with the therapist's first visit. (Note: In cases where more than one type of therapy is being provided, each therapy discipline has its own separate count or clock.)

Question 7: How should home health agencies and providers count therapy visits to ensure that they are meeting the "at least every 30 days" visit requirement?

Answer 7: For determining when the next therapy reassessment visit by a qualified therapist (for each discipline if multiple types of therapists are caring for the patient) would be required as it relates to the "at least every 30 days-requirement, the counting should begin the day after the service is provided. For example, if a therapist conducted and documented an assessment of a patient during a visit on April 1, the count would begin on April 2. In this case, to meet the requirement of making at least one visit every 30 days, the therapist rather than an assistant would need to return by May 1. The therapist then conducted and documented an assessment of the patient during a visit on May 1, the clock resets and the next 30-day count would begin May 2. We note that the intent of the policy is to ensure that at a minimum, a patient sees a therapist rather than an assistant at least once every 30 days. Also, this requirement is in addition to the 13th and 19th visit requirements that occur for each episode that a beneficiary receives home health services.

Question 8: If the 13th and 19th therapy visits occur before the "at least every 30-days" reassessment, when does the 30-day clock reset?

Answer 8: The 30-day clock resets after every therapy reassessment visit (per discipline). Therapy reassessment visits can only be performed by qualified therapists. A therapy reassessment visit includes providing the actual therapy service(s), functionally assessing the patient, measuring progress to determine if the goals have been met, documenting measurement results, and corresponding therapy effectiveness in the clinical record.

Question 9: If a therapist's reassessment that satisfies the "at least every 30 days" therapy reassessment requirement occurs before the required 13th therapy reassessment visit, is the qualified therapist still required to perform the 13th therapy reassessment visit?

Answer 9: Yes, the therapist would need to perform the therapy service/reassessment/measurement/documentation at the 13th visit. We note that conversely, if the therapist had completed and documented the reassessment for the 13th visit within the 30 days, the "at least every 30 days" reassessment requirement would have been met. We also note that there is some flexibility for the timing of the 13th and 19th therapy visits for patients living in rural areas and for patients receiving more than one type of therapy, or when documented exceptional circumstances that prevented the therapist from completing the 13th/19th visit exist.

Question 10: In multiple-therapy discipline situations, which therapist is responsible for reassessing the patient for the 13th/19th visit reassessment requirements?

Answer 10: If a patient is receiving more than one type of therapy, all therapists must do their respective assessments after the 10th visit, but no later than the 13th visit to satisfy the 13th visit reassessment requirement. In instances where the frequency of a particular discipline, as ordered by the physician, does not make it feasible for the reassessment to occur during the specified timeframes without providing an extra unnecessary visit or delaying a visit, then it is acceptable for the qualified therapist from that discipline to reassess the patient on the visit scheduled to occur closest to, but no later than the 13th Medicare-covered visit. Likewise, all therapists must do their respective assessments after the 16th visit, but no later than the 19th visit to satisfy the 19th visit reassessment requirement. In instances where the frequency of a particular discipline, as ordered by the physician, does not make it feasible for the reassessment to occur during the specified timeframes without providing an extra unnecessary visit or delaying a visit, then it is acceptable for the qualified therapist from that discipline to reassess the patient on the visit scheduled to occur closest to, but no later than the 19th Medicare-covered visit. It is important for HHAs to track Medicare-covered visits on an ongoing basis.

Question 11: In cases where the patient is receiving one type of therapy, if the therapist misses the required 13th reassessment visit and does not reassess the patient until the 15th visit, which visits are non-covered?

Answer 11: In the example above, the 13th and 14th visits would be non-covered. The 15th visit would be covered and would now be counted as the 13th covered visit. It is important for HHAs to track Medicare-covered visits on an ongoing basis.

Question 12: Under the following scenario, what visits would be non-covered?

- The patient is receiving PT and OT.
- OT completes the reassessment on visit 12, makes visit 15, makes visit 17, completes the reassessment on visit 18, makes visit 20, and on visit 22 determines that the patient no longer has a need for OT.
- PT misses the reassessment on visit 13, makes visit 14, completes the reassessment on visit 16, completes the reassessment on visit 19, makes visit 21, and on visit 23 determines the patient no longer has a need for PT.

Answer 12:

- OT Visit 12 – Medicare-covered, OT reassessed patient within 11-13 timeframe.
- PT Visit 13 – Non-covered as the PT missed reassessing the patient between the 11 - 13 visits.
- PT Visit 14 – Non-covered as the PT missed reassessing the patient between the 11 - 13 visits and did not reassess patient during this visit.
- OT Visit 15 – This becomes the Medicare-covered 13th visit.
- PT Visit 16 – This becomes the 14th Medicare-covered visit where the PT completed the late reassessment.
- OT Visit 17- This becomes the Medicare-covered 15th visit.
- OT Visit 18- This becomes the Medicare-covered 16th visit. Although the OT reassessed the patient on this visit, because prior visits are non-covered, this becomes visit 16 and does not count towards reassessing the patient between the 17-19 visits.
- PT visit 19 – This becomes the Medicare-covered 17th visit. The PT still reassessed the patient within the appropriate timeframe for the 19th visit reassessment requirement (17-19).
- OT Visit 20 – This visit is non-covered as the OT did not reassess the patient between the 17-19 visits.
- PT Visit 21 –This becomes the Medicare-covered 18th visit
- OT visit 22 – This visit is non-covered as the patient was not assessed within the 17-19 visit timeframe.
- PT Visit 23 – This becomes the Medicare-covered 19th visit.

Note: For the purpose of determining when certain required therapy reassessment visits need to occur; only Medicare-covered visits are counted. It is important for HHAs to track Medicare-covered visits on an ongoing basis.

Question 13: Regarding the non-coverage of therapy visits when more than one type of therapy is being provided, using an example of more than 13 visits to be provided by 2 therapy types (e.g., OT and PT), if the OT completes the reassessment visit on visit 12, but the PT does not do the reassessment until visit 17, would visits 13 (PT), 14 (OT), 15 (PT), and 16 (OT), possibly be covered?

Answer 13: All the OT visits in this example would be considered covered visits. The PT visits on the 13th and 15th visits are non-covered and the PT visit that occurred on the 17th visit would be considered a covered visit and would now be counted as the 15th covered visit. It is important for HHAs to track Medicare-covered visits on an ongoing basis.

Question 14: Does the non-coverage policy apply for both the 30-day requirement and the 13th/19th visit reassessment requirements?

Answer 14: Yes

Question 15: What tools can therapists use to do the objective assessments?

Answer 15: CMS does not want to be prescriptive regarding which tools should be used and instead recommends that therapists look to their respective national and state associations and accrediting bodies for such resources.

Question 16: What happens if a doctor does not order multiple types of therapy at the start of care, but instead orders another type of therapy after the patient has been in home health for a few weeks. For example, if a patient receives PT for a couple weeks and then the doctor adds OT to the orders; how is the count adjusted?

Answer 16: The sum of all therapy provided, from all disciplines, must be considered when counting visits. In this case, if the 13th or 19th visit occurred before the OT was ordered, only PT was required to perform the service and reassess the patient. If OT was ordered before the 13th/19th visit, the OT and PT are required to do their respective assessments after the 10th but no later than the 13th visit or after the 16th, but no later than the 19th visit (cumulative count).

Question 17: Are there any instances in which the "at least every 30-days reassessment can be delayed yet still be covered if the patient is unavailable due to circumstances beyond the control of the therapist?

Answer 17: 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 "at least every 30-days" period to ensure the HHA meets this requirement.

Where unexpected sudden changes in the patient's condition result in a stop therapy order, we would expect to see documentation and evidence in the medical record (including a physician order to stop therapy) which would support an unexpected change in the patient's condition which precludes delivery of the 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.

Question 18: Which scenarios do the 11th to 13th and 17th to 19th Medicare-covered visit ranges apply to?

Answer 18: (1) Cases where only one type of therapy is being provided and there is a documented exceptional circumstance that prevented the therapist from seeing the patient; (2) cases where only one type of therapy is being provided and the patient resides in a rural area; and (3) cases where a patient is receiving more than one type of therapy.

Question 19: When does a multiple-therapy case become a single therapy case for the purposes of when the patient should be reassessed for the 13th/19th visit reassessment requirements?

Answer 19: When the patient's plan of care has been changed to reflect that only one type of therapy is to be provided. For example, if a patient was receiving PT and OT through the Medicare-covered 16th visit, and it was determined during the 16th visit that the patient no longer has a continuing need for OT, at that point in time, this case would become a single therapy case. The next required therapy assessment for PT must occur on the 19th Medicare-covered visit. We note that there is some flexibility for the timing of the 13th and 19th therapy visits for patients living in rural areas and or when documented exceptional circumstances that prevented the therapist from completing the 13th/19th visit exist.