DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services. CMS will continue to address industry questions concerning the new requirements, and will update information at http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html on the CMS web site.

MLN Matters® Number: MM7374 Revised

Related Change Request (CR) #: 7374

Related CR Release Date: May 6, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R144BP

Implementation Date: May 5, 2011

Manual Changes for Therapy Services in Home Health, Publication 100-02, Chapter 7

Note: This article was revised on October 19, 2012 to add a reference to MLN Matters® article MM8036, available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8036.pdf*, to alert providers that all requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This applies to: Part B Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), rehabilitation agencies (Outpatient Rehabilitation Facilities (ORFs), private practices, home health agencies (TOB 34X), and hospital outpatient departments. All other information remains unchanged.

Provider Types Affected

Home Health Agencies (HHAs) submitting claims to Fiscal Intermediaries (FIs), Therapists, Physicians, non-physician practitioners, Regional Home Health Intermediaries (RHHIs), and A/B Medicare Administrative Contractors (A/B MACs) for therapy services provided to Medicare beneficiaries in the home health setting are affected by this article.

Provider Action Needed

The Calendar Year (CY) 2011 Final Rule for Home Health provisions related to therapy services provided in the home health setting and corresponding regulation text changes necessitate updates to Chapter 7 of the "Medicare Benefit Policy Manual" (Home Health Services). Therapy provisions for this rule are effective April 1, 2011. Be sure your staff is aware of these changes.

Background

As mentioned, the CY 2011 Final Rule for Home Health included requirements related to how and when therapy services are to be provided in the home health setting, as well as documentation requirements for these visits. Accordingly, the "Medicare/Benefit Policy Manual" is being updated via CR7374 to document the policy revisions. Key changes of these updates are summarized as follows:

Assessment, Measurement and Documentation of Therapy Effectiveness

To ensure therapy services are effective, at defined points during a course of treatment for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

Initial Therapy Assessment

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals, in the clinical record.

Reassessment at Least Every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/ documentation (of that discipline).
- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

Reassessment Prior to the 14th and 20th Therapy Visit

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.
- Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document the effectiveness of therapy, or lack thereof.
- When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit, but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy visit.

- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit time-points relate to the sum total of therapy visits from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.

- Therapy services provided after the 13th and 19th visit (sum total of therapy visits from all therapy disciplines), are not covered until:

    - The qualified therapist(s) completes the assessment/measurement/documentation requirements;
    - The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge; and
    - If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the physician and therapist have determined therapy should be continued.

Note: Services involving activities for the general welfare of any patient (e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation) do not constitute skilled therapy. Non-skilled individuals without the supervision of a therapist can perform those services.

In order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist are needed to restore patient function;
2. The patient's condition requires a qualified therapist to design or establish a maintenance program; or
3. The skills of a qualified therapist are needed to perform maintenance therapy.

Additional Information

For complete details on these manual changes, see the official instruction, CR 7374, issued to your FI, A/B MAC, and RHHI, which may viewed at

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R144BP.pdf on the CMS website.

Therapy Questions and Answers will also soon be available on the Home Health Agency Center of the CMS web site (http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html).

If you have any questions, please contact your FI, A/B MAC, or RHHI at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.