

## **PPS2011Q&A**

### **Therapy Services**

Question: When calculating the therapy reassessment visits for patients with multiple therapies, do we count combined visits? Do you still have to look at total visits but each discipline has to do a reassessment at the 13th and 19th

ANSWER: CMS' goal is to ensure that the qualified therapist for each discipline that is providing services assesses the patient before the TOTAL number of therapy visits reaches the 14<sup>th</sup> and 20<sup>th</sup> visit therapy threshold. Therefore, this is a combined therapy count.

Question: Is rural area defined by the CBSA code?

ANSWER: Yes

Question: How does CMS propose that we do a therapy evaluation at the last possible visit before we hit a threshold and still meet all of the advance discharge notice rules?

ANSWER: Ideally the Expedited Determination notice of non-coverage should be given two days in advance of termination of services. Since this notice must be given at the point in time that non-coverage is determined, failure to give the notice two days notice does not make nullify its effectiveness.

Question: In your therapy example you used PT and OT. What if the patient also had ST. How would those visit impact the visit count?

ANSWER: Speech therapist visits must be included in the count.

For example PT 4/1, OT 4/2, SLP 4/3, PT 4/4, OT 4/5, SLP 4/6, PT 4/7, OT 4/8, SLP 4/9, PT 4/10, OT 4/11, SLP 4/12, PT 4/13 =13<sup>th</sup> therapy visit.

In this situation a qualified OT must assess on 4/11 and an SLP must assess on 4/12. CMS told NAHC and APTA verbally that, in multiple therapy cases, they will permit some flexibility so the qualified PT may assess the patient on the scheduled visit nearest the 13<sup>th</sup> and 19<sup>th</sup> visit. Therefore, the qualified PT may visit either 4/10 (i.e. the scheduled PT visit near the 13<sup>th</sup> combined therapy visit) or 4/13 (i.e. the 13<sup>th</sup> combined therapy visit). We encourage agencies to wait until CMS puts a statement about "flexibility" in writing in the manual update before finalizing their policies. This information corrects the NAHC Report article.

Question: For the therapy reassessment, does the reassessment need to be done at the 13th and 19th visit for each episode? Is this only the initial and then every 30 days after?

ANSWER: That is correct. An assessment must be conducted before or on the 13<sup>th</sup> and 19<sup>th</sup> combined therapy visits (i.e. before the 14th and before the 20th visit thresholds) by each discipline treating the patient in every episode. Furthermore, another re-assessment is required for patients that remain on service for 30 day beyond the threshold assessments. Even patients that do not meet the 14<sup>th</sup> and 20<sup>th</sup> visit thresholds must have an assessment by each therapy discipline, at a minimum, every 30 days. For example, a patient who is admitted to service 4/1 for PT 1x/wk and OT 1x/wk will not reach a

payment threshold within the first 30 days of the episode. Both the PT and OT must conduct functional re-assessments of the patient by day 30 of that episode.

Question: We understood the regulations for the therapy reassessment visits to require such reassessments for each discipline separately (page 110 of final rule). On the NAHC presentation slide number 34, it appears to state that therapy reassessments are crossing disciplines to reach the total threshold which contradicts the regulations. Please clarify that slide.

ANSWER: If more than one therapist is providing service, a visit to conduct a functional assessment and provide treatment must be completed prior to the reaching the 14<sup>th</sup> and 20<sup>th</sup> therapy visit thresholds in an episode by qualified therapists for all therapy disciplines caring for the patient. Each discipline must document the findings of the assessment and progress toward the goals established to justify continued therapy by that discipline. The qualified therapist(s) for all therapy disciplines caring for the patient must visit and functionally assess the patient on the regularly scheduled visit due to take place as near as possible to, but not after the 13<sup>th</sup> and 19<sup>th</sup> total therapy visits. Payment will be withheld for therapy services until the qualified therapist assessment is conducted.

Question: Please clarify the discrepancy between the NAHC newsletter that the 4/1/11 delay in therapy requirements is limited to assessments provisions only.

ANSWER: All of the therapy provisions (with the exception of G codes) will be delayed until 4/1/2011 to provide home health agencies with adequate time to prepare.

Question: To clarify, in regards to maintenance therapy, may a therapy assistant provide these visits or only a PT/OT?

ANSWER: Therapy assistants may not provide maintenance therapy. On page 124 if the display copy of the PPS Update notice, CMS made the following statement: "Maintenance therapy has a will continue to be covered in the HH setting when the unique condition of the patient requires the complex services, which can only be provided effectively and safely by a qualified therapist. Furthermore, the maintenance therapy G codes are defined as provided by a "qualified therapist."

Question: Where is it in writing that only functional issues need to be assessed during the re-assessment? We may see surveyors that interpret this information differently and I will like to have it in writing.

ANSWER: On page 452 of the display copy of the PPS Update notice, CMS wrote: Our clarifications include requirements to: document necessity for a course of therapy (§409.44(c)(1)); include clinic notes which reflect progress toward goals, which incorporate the **functional assessment and reassessments** (emphasis added), which justify medical necessity, which describe the content of progress notes, and which include objective evidence of the expectation that the patient's condition will improve (§409.44(c)(2)(i)); document any variable factors that influence the patient's condition or affect the patient's response to treatment, and include objective measurements of progress toward goals in the clinical record (409.44(c)(2)(iv)).

Question: How will we treat therapy visits on episodes that began prior to April 1 2011?

ANSWER: We must await the manual update from CMS. However, we anticipate CMS will require home health agencies to comply with qualified therapy assessment(s) requirements for all episodes whereby the combined therapy visits reach the 13<sup>th</sup> or 19<sup>th</sup> total therapy visit or 30 days of therapy service for each discipline as of April 1, 2011 or after.

Question: Please talk more about maintenance therapy and give us examples on proper usage of codes.

ANSWER: The Code of Federal Regulations at 409.44 (iii) states; There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program. If the services are for the establishment of a maintenance program, they may include the design of the program, the instruction of the beneficiary, family, or home health aides, and the necessary infrequent reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a physical therapist, speech-language pathologist, or occupational therapist is required.(iv) The amount, frequency, and duration of the services must be reasonable.

According to the Federal Register notice of the PPS final rule: The intent of language in the proposed rule was to clarify that, in order for the establishment of a maintenance therapy program to be considered covered therapy, the specialized skills, knowledge, and judgment of a therapist would be required in developing a maintenance program. Services would be covered to design or establish the plan, to ensure patient safety, to train the patient, family members and/or unskilled personnel in carrying out the maintenance plan, and to make periodic reevaluations of the plan.

The Medicare Benefit Policy Manual describes maintenance therapy as follows:

E. Maintenance Therapy Where repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. If the judgment and skill of a physical therapist is required to safely and effectively treat the illness or injury, the services would be covered as physical therapy services.

EXAMPLE: Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

Establishment of a maintenance program is a skilled physical therapy service where the specialized knowledge and judgment of a qualified physical therapist is required for the program to be safely carried out and the treatment of the physician to be achieved.

EXAMPLE: A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function. The initial evaluation of the patient's needs, the designing of a

maintenance program appropriate to their capacity and tolerance and the treatment objectives of the physician, the instruction of the patient, family or caregivers to carry out the program safely and effectively and such reevaluations as may be required by the patient's condition, would constitute skilled physical therapy.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out alone or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.