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Eli's Rehab Report

Industry News: Therapy Reassessment Confusion Continues

Apparently home health agencies aren't the only ones confused over the timeline for therapy reassessments. Starting last year, agencies must reassess patients both every 30 days and on the 13th and 19th therapy visit time-points (with some exceptions for rural and multi-discipline cases).

But what happens if agencies miss the 13- and 19-visit assessment? The PPS final rule for last year and manual guidance indicate that agencies can bill for the 13th or 19th visit, then resume billing the visit after the assessment visit. So if the reassessment visit is the 14th one, billing may resume for the 15th visit. But the Centers for Medicare & Medicaid Services revealed at a recent industry conference presentation that the 13th and 19th visits also wouldn't be billable.

NAHC will seek clarification on this issue, NAHC's **Mary St. Pierre** told conference attendees.

Therapy Recommendations by MedPAC

The industry does seem generally to agree on MedPAC's recommendation to increase CMS's fraud fighting efforts by increasing medical review in high-utilization counties, among other activities.

Visiting Nurse Associations of America (VNAA) goes a step further by calling for targeted moratoriums on HHA and hospice enrollment. VNAA also supports MedPAC's suggestion to remove therapy utilization from the PPS case mix system. But "any such revisions must be done in a way that does not harm vulnerable patients," the trade group cautions.

Watch for: While it didn't make a recommendation about the rural add-on, MedPAC did note that many of the high-margin counties are rural.

"Medicare's add-on payments based solely on rural designation are not as well targeted as they could be," the report suggests. A MedPAC recommendation on that element could be forthcoming in future years, observers suspect.

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