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Eli's Rehab Report

Therapy Assessment: HHAs Get Answers to Therapy Reassessment Questions

Should you bill with no assessment?

Although Medicare's therapy reassessment requirement went into effect back in April, many home health agencies have unresolved questions about the rule.

For example: "If the therapy reassessment was not completed timely and there are therapy services that were done, should these be billed even though they wouldn't be covered?" an HHA asked HHH Medicare Administrative Contractor NHIC.

The answer to that is "yes," NHIC says on its website in a question-and-answer set. "The home health claim should reflect all services that were provided to a patient during the home health episode. The therapy billed for the episode would then reflect covered and non-covered services," the MAC explains at www.medicarenhic.com/RHHI/billing/J14%20HHH%20ACT8311QAs.pdf.

Another question: One MAC is telling agencies that "qualified therapist reassessments in a multiple therapy case must be 'AS CLOSE TO' the 13th and 19th visits as possible, implying no flexibility," the National Association for Home Care & Hospice notes in its member newsletter. But earlier guidance from the Centers for Medicare & Medicaid Services indicated the requirement would be less rigid.

The reassessment doesn't have to be on the visit directly before the 13th or 19th visit, CMS confirms to NAHC. "Because we have not defined 'close to,' in the 13th/19th-visit regulations for patients receiving more than one type of therapy, the reassessment visits could be done by the therapist as you described (i.e., the visit before the closest visit)," CMS tells the trade group, according to NAHC.

Therapists in multiple-discipline cases must perform the reassessment visits "close to but no later than the 13th and 19th therapy visit," CMS says in the Medicare Benefit Policy Manual update issued April 15.

Manual guidance for counting therapy visits in multi-discipline episodes grants much-needed flexibility to the reassessment visit scheduling process, but it also sowed confusion amongst home health agencies, reported therapist and consultant **Cindy Krafft** with Fazzi Associates.

Debunk This Myth

Common pitfall: Without concrete guidelines of what "close to" includes, many HHAs are making up their own visit ranges, Krafft has found. Often they mirror the 11-to-13 and 17-to-19 ranges that are the requirement for the exception for single discipline episodes.

CMS requires no such visits ranges for multi-discipline episodes, Krafft emphasizes. HHAs and their therapists must use their clinical judgment to decide what qualifies as "close to," she tells **Eli**.

For example, HHAs might have a case where physical therapy and occupational therapy are involved, then the OT gets put on hold at visit #8 while waiting for equipment and doesn't expect to resume before the PT's visit #13. In that case, the agency can stay in compliance by having the OT do her reassessment visit on #8, Krafft says. There's no reason to have the OT go back in for a non-billable reassessment visit with no clinical goals when the PT gets close to visit #13.

"Think of the language as saying 'closest to' instead of 'close to'" for multi-discipline cases and that may help, Krafft

suggests. Just be sure to document why the OT did her assessment at that time. "It always goes back to the 'D' word," Krafft reminds providers.

Resource: To download free 15- and 18-minute podcasts presented by Krafft explaining G codes & maintenance therapy and reassessment visits, respectively, go to the website for the American Physical Therapy Association's Home Health Section at www.homehealthsection.org.