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IN THIS ISSUE

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Therapy Changes, Face-to-Face Encounter Provisions and Enrollment Changes are Highlights of CY 2011 Home Health PPS Final Rule

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Home Health Agencies (HHAs) have many challenges ahead as they deal with the requirements of the CY 2011 Final Rule for the Home Health Prospective Payment System (PPS) [PDF]. Among other things, this Rule implements the requirement of the health reform legislation that certifying physicians have face-to-face encounters with patients in order to certify the need for home health services. It also revises assessment and documentation requirements for therapy services, and enrollment requirements for HHAs.

The Final Rule includes the following changes, among others:

- Finalizes statutory requirement for physician face-to-face encounter with patient before physician certifies that patient is homebound and needs skilled care.
- Changes timetable for face-to-face encounter from proposed rule. Encounter must be performed no more than 90 days prior to start of home health care if the encounter is related to the reason for home health care; or within 30 days after start of care if there has been no prior encounter within 90 days, or if prior encounter is not related to reason for home health care. (Guidance on issue of "related to the reason for home health care" will be in manuals).
- Indicates encounter can be by a non-physician practitioner (NPP), who must document findings and report them to the certifying physician. These NPPs are subject to the same Stark limitations as are physicians.

- Provides physician (not NPP) must document who performed encounter, date of encounter, and describe how clinical findings support patient's eligibility for HH, as part of certification document or as addendum to certification.

- Codifies in regulation prior manual guidance that physician certifications must be dated by the physician, in addition to signature by physician.

- Deletes proposed requirement that encounter also must be documented in physician's medical record for patient (on theory that HHAs are not responsible for physician's own documentation).

- Provides encounter can be by telehealth.

- Clarifies that a hospitalist ("hospital physician") can be the physician that initiates orders and performs face-to-face encounter.

Ober|Kaler's Comments

This major change in coverage requirements for home health services will be a substantial compliance challenge for HHAs. Physician education will be difficult. The ability of hospitalists to provide the initial orders and the face-to-face encounter will facilitate discharge of patients from the hospital to home health.

Therapy Coverage Requirements (42 CFR § 409.44(c))

Changes the regulation on coverage of skilled therapy services to emphasize assessment and reassessment using objective measures, as follows:

- Patient's plan of care must describe course of therapy and therapy goals that are consistent with patient's functional assessment. Patient's clinical record must document how the therapy meets accepted standards of clinical practice.

- Plan of care must include therapy treatment goals, established by qualified therapist in conjunction with physician, that are related to the injury or illness and that can be measured, and progress toward those goals is objectively measured.

- Patient's clinical record must demonstrate that the method used to assess functionality included objective measurement in accordance with professional standards of clinical practice, enabling comparison of successive measurements.

- Qualified therapist (not therapist assistant) must initially assess and periodically reassess and measure the patient's functionality, using objective measurements.

- Qualified therapist (not assistant) is required to perform therapy visit, reassess and measure progress toward goals at least once every 30 days.

- Patients needing 13 or 19 therapy visits would be reassessed on the 13th and 19th visits, except as follows:

    - In response to concerns about scheduling, final rule provides flexibility for beneficiaries in rural areas and in non-rural areas where documented circumstances outside control of therapist preclude visits at 13th and 19th visit. In these circumstances, the qualified therapist may perform the visit to reassess and measure any time after 10th visit but not later than 13th visit, and after 16th visit but no later than 19th visit.

    - Also provides that where patient is receiving more than one therapy discipline, therapist from each discipline must provide service and do reassessment and measurement at visit that is closest to, but no later than, 13th or 19th visit for that discipline.

- No subsequent therapy visit would be covered until reassessment is completed, progress objectively measured, goals reevaluated, and measurement results, reassessment and progress are documented.

- Retention of requirement that for therapy to be covered, there must be an expectation that patient's condition will materially improve in a reasonable (and generally predictable) period of time.

  - Final rule clarifies that maintenance therapy is not subject to the requirement for documenting improvement

- Therapy is not covered, because not reasonable and necessary, where patient suffered "transient and easily reversible loss or reduction of function that could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities" (e.g., temporary weakness after surgery improved with bed rest).

- Amount, frequency and duration must be reasonable as determined by a qualified therapist and/or physician using accepted standards of clinical practice, factors influencing amount, frequency and duration must be documented in plan of care or functional assessment.

- Clinical record would document objective measurements that show progress. Not covered if no progress, unless (1) therapy regressed or plateaued but justification supports expectation of progress with continued therapy or (2) therapy is maintenance therapy.

  - Final rule delays implementation of assessment documentation changes until April 1, 2011.

Ober|Kaler's Comments

HHAs should carefully review the preamble to the regulation for the nuances on therapy coverage criteria and documentation requirements, and schedule staff training to review them. Some may require changes in current agency practice (e.g., have HHAs been providing services and submitting claims for patients where there is a "transient and easily reversible loss or reduction of function that could be expected to improve spontaneously as patient gradually resumes normal activities.")

Enrollment Provisions for HHAs

- HHA Capitalization Requirements (42 C.F.R. § 489.28)
  - Revises HH capitalization requirements to provide that prospective HHA must submit verification that it complies with initial reserve operating funds requirements of § 489.28 at three points: (1) at time of application submission, (2) during period in which state survey agency or accrediting body is determining whether provider meets conditions of participation, and (3) during 3-month period immediately following issuance of Medicare billing privileges. Documentation must be submitted within 30 days of MAC's request.
  - Provides that capitalization requirement is to be determined by comparing prospective HHA with similarly situations HHAs.
- Change of Ownership (changes to 36-month rule) (42 C.F.R. § 424.550)
  - Does not finalize the proposed exception for publicly traded companies.
  - Finalizes exceptions for:
    - an existing HHA that has submitted 2 consecutive years of full cost reports;
    - HHA parent undergoing internal corporate restructuring, (eliminates proposed requirement for submitting cost reports for 5 years);
    - change of existing HHA business structure (e.g., partnership to LLC) where owners remains the same; and
    - death of individual owner of HHA (eliminates proposed requirement that this individual have 49% or less ownership).
  - Clarifies that definition of "majority ownership" only applies to changes in direct ownership, not to indirect ownership changes

- Provides that any change in majority control and/or ownership during first 36 months of initial billing privileges or within 36 months of last CHOW would trigger rule.

Ober|Kaler's Comments

CMS's changes to the exceptions to the 36-month rule will mean fewer HHAs are subject to it.