Therapy Reassessment Training

What You Need to Know NOW!

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OASIS M2200

• "In the plan of care for the Medicare payment episode for which this assessment will define a case-mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-pathology visits combined)?"

• The HHA would provide the total number of projected therapy visits, unless NA.

Changing Visit Patterns

10 Visit Threshold

10 visit threshold:
50% of high therapy ended between 10 and 13 visits

Tiered model:
26% increase in episodes with 14 or more
MedPAC Report

MedPAC wrote in its March 2010 report that “payment incentives continue to influence treatment patterns, and that payment policy is such a significant factor in treatment patterns because the criteria for receipt of the HH benefit are ill-defined.”


Who Decides?

• “We believe that rehabilitation professionals, by virtue of their education and experience, are typically able to determine when a functional impairment could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.”

• “We expect rehabilitation professionals to be able to recognize when their skills are appropriate to promote recovery.”

Qualified Therapist

“We believe that when a unique condition of an individual patient requires more therapy than a typical Medicare HH rehabilitation patient, such a patient should be more closely monitored by a qualified therapist to ensure high-quality, effective services are being provided and/or acceptable progress towards goals is being achieved.”
Coverage Issue

“Therapy would not be covered to effect improvement or restoration of function when a patient suffered a transient and easily reversible loss or reduction of function.”

Therapy Assessments

- Create the foundation of the entire therapy plan of care.
- Begins to answer the question – “Why is therapy indispensible to this patient?”

Therapy Reassessments

- Reassessment focuses on the plan of care using relevant patient information.
- Purpose is to speak to the efficiency of therapy and the need to continue.
Every 30 Days

“Minimally”:
• Starts with the first visit from therapy
• Continues until discharge
• May cross certification periods
• DON’T wait until the last minute

Counting Visits

13 (before 14)

Single Therapy:
• On literal 13th
• Rural exception (11-13)
• Completion resets 30 days
• Specific to each cert period

Multiple Therapy:
• Range of 11 - 13
• “Closest to” exception
• Completion resets 30 days
• Specific to each cert period

19 (before 20)

Single Therapy:
• On literal 19th
• Rural exception (17-19)
• Completion resets 30 days
• Specific to each cert period

Multiple Therapy:
• Range of 17 - 19
• “Closest to” exception
• Completion resets 30 days
• Specific to each cert period

Reassessment Documentation

• “Clinically supported statement of expectation that the patient can continue to progress” or resume progress after plateau or regression.

• Speak to the “effectiveness” of therapy in relation to the goals.

• Plans to continue or discontinue:
  • Refer to clinical findings (objective assessments) and treatment plan revisions
Tests and Measures

- **Standardized:**
  - Must follow the directions

- **Validated:**
  - Assess research behind the tool

- **Value in repeating over course of care:**
  - Support ongoing need and impact of care

Objective Data?

- AROM/PROM?
- Manual Muscle Testing?
- Components of a Transfer?
- Gait Cycle?
- Time Based Activities?
- Pain Assessments?
- Pressure Ulcer Risk?
- OASIS?

Do We Withhold?

- In order to hold any therapy service, a physician order would be required.

- Reason for hold would have to be clinically or patient driven.

- If skilled services are necessary and orders are in place, withholding opens agency to legal action for not providing care.
Take a Deep Breath…

- How many patients have therapy for more than 30 days?
- How many of your patients actually end up with 14+ visits?
- Of those, how many are multiple therapy?

Patient Driven Exceptions

- Missed Visits?
  - Single Therapy
  - Multiple Therapy
- Interruptions in Care?
  - Hospitalization
  - SNF
- Who “caused” the missed reassessment??

Sematics

Is a missed therapy reassessment....

- Non-Billable
- Non-Covered
- Doesn’t Matter
Non-Billable

- Speaks to skill level seen on the visit
- Used to account for time spent with a patient that cannot be billed for:
  - Second therapist in the home for purposes of helping to lift a patient
  - Therapist AND Assistant out in the home at the same time
  - Patient not home or refused visit upon arrival

Non-Covered

According to CMS: “No visits should be omitted. The visits that are not payable should be reported with non-covered charges and will be assigned provider liability. Reporting non-covered charges is required per the Claims Processing Manual, Chapter 10, Section 40.2.”

“...never been great...”

CMS pointed out that non-covered charge information submitted by home health agencies “has never been great.” Their intent has been for home health agencies to include all non-covered visits and charges on claims to ensure a better representation of all home health costs. Furthermore, reporting non-covered charges shouldn’t be limited to missed therapy reassessments. Home health agencies should include all non-covered visits and charges on their claims, such as nursing assessments, aide supervisory visits, etc.
How to Bill

According to the National Uniform Billing Committee, coding guidance, form locator 48, Non-Covered Charges is a required data element for Medicare. The Medicare Claims Processing Manual, Chapter 10, Section 40.2 instruction can be found at:


Billing Systems

Need to confirm that the missed assessment information is correct BEFORE the claim goes out the door.

Error Rate Trending

Missing reassessments should be drilled down to determine patterns and decrease errors:

• Process
• System
• Discipline
• Clinician
Counting Visits

“Not Covered = Not Counted”

When Coverage Resumes

- Currently
  - AFTER the Reassessment is completed
  - 11, 12, 13, 14, 15 (RA done), 16, 17 (DC)
  - Total covered visits = 15

- Final 2013
  - ON the Reassessment visit
  - 11, 12, 13, 14, 15 (RA done), 16, 17 (DC)
  - Total covered visits = 15

Multiple Therapies

- Currently
  - Missed Reassessment impacts ALL therapy visits

- Final PPS 2013
  - Only the therapy the missed the Reassessment is impacted

- Implications for counting??
Example 1

- Multiple Therapy (PT and OT) - 17 visits
- Range of 11 - 13, OT is compliant BUT PT is not
- ... 10, 11, 12, 13, 14, 15, 16, 17, 18
- ... 10, 11, 13, 14, 15, 16, 17, 18
- Paid for 16 visits

Don’t Panic!!

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