Eli's Rehab Report

Home Health ~ Prepare for Major Therapy Threshold Changes -- or Face Serious Federal Scrutiny

Your episode calculations are about to get a lot more complicated

Home health agencies expecting a drastic change in how Medicare reimburses for home health therapy won't be disappointed by the prospective payment system refinements rule issued April 27.

As expected, the Centers for Medicare & Medicaid Services proposes changing the current 10-visit threshold to a staggered threshold at six, 14 and 20 visits. Further, CMS calls for "smoothing" payments for different visit levels within the three therapy categories, says consultant **Mark Sharp** with BKD in Springfield, Mo.

Case Mix Gets a Mix-up

CMS made sweeping changes to how it will determine and structure the payment categories, resulting in a proposed increase from the current 80 HHRGs (home health resource groups) to 153 categories.

A major reason for the drastic increase is taking long-stay patients into account. CMS will pay differently based on whether a beneficiary is in an "early" (first or second) episode or a "later" (third or later) episode.

Details: For these definitions, episodes don't have to directly follow one another but can be "adjacent" -- spaced apart up to 60 days, CMS says. And the definitions apply whether the subsequent or adjacent episodes take place at one home health agency or across multiple HHAs.

17 therapy categories: When combined with the other case mix change of paying differently for early and later visits, the result is a very complicated therapy reimbursement system. The new service domain will have five severity levels (S1-S5) based on visits that receive different payments over five episode and threshold increments, totaling 17 different payments for different therapy levels.

"On the surface, it is difficult to decipher how [the new thresholds] will contrast with the prior 10-visit therapy threshold as far as payment rates go," says Sharp, who presented a TCI-sponsored teleconference on the PPS changes May 17.

CMS Ponders Therapy Alternatives

CMS knew it needed to change the therapy threshold when it saw how much therapy utilization changed pre- and post-PPS, the agency says in the rule. It saw a "marked shift" in therapy delivery, from a concentration under 10 visits to a concentration over 10 visits. The current PPS clearly provides "undesirable incentives" with the single 10-visit trigger for a significant payment increase.

CMS looked at using items other than therapy visits to determine payments, including "pre-admission status on activities of daily living (ADL), more diagnoses with a focus on conditions such as stroke, and more OASIS variables," it says. But none of those proved successful in predicting the amount of therapy furnished.

The agency also rejected using straight therapy visit or time amounts because it didn't want to undermine the PPS's bundled nature.

Review target: Regulators settled on the six, 14, 20 stagger because they found six to 13 visits reasonable for most episodes, CMS says. Intermediary medical reviewers will find discerning medical necessity for 14 or more therapy visits

easier than discerning medical necessity for 10, while episodes requiring 20 or more visits will be quite rare and will receive significantly more payment.

"By avoiding a therapy threshold within [six to 13 visits] we hope to reduce the influence of payment incentives on treatment decisions," CMS says.

Note: The proposed rule is at www.cms.hhs.gov/HomeHealthPPS/downloads/CMS-1541-P.pdf.