PUBLICATION

Rehabilitation Agencies - What Changes Will Be Required by New CMS Guidance? [Ober|Kaler]

2013: Issue 8

Through Transmittal 83, dated March 15, 2013, CMS published additional guidance in the State Operations Manual (SOM) interpreting the Medicare regulations for Medicare-certified OPT/OST providers, commonly referred to as rehabilitation agencies. In its explanation for the changes, CMS noted that the additional guidance is to assist state surveyors in determining if the provider is in compliance with the regulations. The changes, however, are not limited to mere clarifications. Rather, the changes will significantly affect the operation of many rehabilitation agencies.

The survey process will be more comprehensive, focusing on services provided and compliance with all conditions of participation, leaving agencies vulnerable to survey sanctions including termination. Additionally, focus on enrollment data reported via the CMS 855A could place a rehabilitation agency at risk for a Medicare billing privilege deactivation or revocation.

Most of the changes appear in Appendix E of the SOM; however, the guidance in Chapter 2 related to services at extension locations was significantly revised as well. Rehabilitation agencies, particularly those in an expansion mode or operating in larger geographic areas, need to pay close attention to this new guidance. Failure to comply with the rules could have significant consequences.

Conditions of Participation

Enrollment Data

Surveyors are asked to review the CMS 855A form prior to the survey to verify the names of the owner(s) and corporate officers and to determine if the organization is part of a chain or not. Providers should review previously filed enrollment forms to ensure all enrollment data is current. If enrollment data is not current, a CMS 855A change of information or a voluntary revalidation application should be filed to provide any needed updates.

Administration

Both the administrator and the alternate administrator are expected to have knowledge of the “equipment and the modalities required by the organization to ensure adequate therapy programs.” In addition to a bachelor's degree, CMS now requires evidence that the administrator and alternate administrator have had specific education related to managing patients with rehabilitation needs. The alternate administrator needs to be readily available on the premises of the primary practice location if the administrator is not physically present.

Policies

The revised CMS guidance sets forth requirements for specific rehabilitation agency policies, including among others: (1) human resource policies for verifying professional licensure status, assessing competency, describing direct supervision frequency, performing staff evaluations; (2) patient care policies that describe admission and discharge criteria in addition to scope of services; and (3) medical records policies that address record retention, access to records (including electronic medical records), and confidentiality.

Care Planning and Patient Care

Many of the changes to the SOM simply reinforce prior CMS guidance related to outpatient therapy services generally, which appears in Chapter 15 of the Medicare Benefits Policy Manual, or professional standards of care. However, the new SOM guidance outlines how state surveyors should evaluate the services being provided, the content of the medical records, and the equipment and modalities available to meet patient care needs. In particular, the surveyors are required to sample a *minimum of 25 medical records*, which must include current patients and patients discharged within the last six months, and patients treated both by W-2 employees and by contract staff if applicable.

Staffing

Surveyors are instructed to evaluate the sufficiency of staffing and the staffing mix, such as by reviewing how closely the patient schedule and treatment plan is followed and evaluating waiting times. To determine if the requirement to have two staff at all locations during patient treatment is satisfied, CMS instructs surveyors to review staff time cards and patient sign-in sheets. CMS reinforced the regulatory requirements for a written contract, with certain defined terms, when therapy services are not provided by W-2 employees.

Emergency Care

The SOM was updated to reflect prior changes in the regulations which eliminated the requirement to have an on-call physician to furnish emergency care. There is, however, new guidance regarding emergency care policies and the content of what is to be documented following an incident requiring emergency care.

Equipment Maintenance

CMS outlines expectations regarding procedures for equipment calibration and periodic preventive maintenance checks. Surveyors are asked to review maintenance checklists, repair statements, and equipment maintenance procedures.

Infection Control

When a rehabilitation agency provides services at more than one location per day, CMS requires infection control policies to address procedures to avoid cross-contamination. As an example, CMS cited to a therapist who provides services at a nursing facility and then at an assisted living facility on the same campus in the same day.

Extension Locations and Relocations

As noted above, CMS expanded its guidance related to extension locations, including establishing a specific geographic restriction for the location of an extension site. There was no discussion regarding the effect that this new guidance would have on existing extension locations that are outside of the defined geographic area. There is also new guidance for relocating an existing rehabilitation agency. And the role of the Regional Office (RO) has been expanded from issuing final approval of an extension location addition or relocation to having more active involvement earlier and throughout the process.

Extension and Other Offsite Locations

- Although advance notice of the addition of an extension location was previously required, the notice was given by filing the CMS 855A change of information application. Now, in addition to filing the CMS 855A form, *advance notice of an intent to add an extension site must be provided to the RO* "within 90 days of the expected move" to allow sufficient time to obtain the advanced approval.
- CMS established "criteria" for an extension location approval, which includes a requirement that the extension location be "situated within a *30 mile radius of where 90 percent of the agency's primary*

site's population lives." CMS did indicate that consideration would be given for longer or shorter distances if unusual geographic features exist.

- The *RO will determine if a survey needs to be conducted* prior to approval of the extension location. CMS highlighted its existing policy with regard to obtaining prior approval of the extension location addition prior to providing and billing for services. The effective date of the extension location approval will be the date the RO determines the extension location meets the federal requirements.
- CMS also highlighted its existing policy with regard to exclusive use of the primary site, any extension location site, or another offsite location during the hours of agency operation. CMS provided examples of when exclusive use is required to protect the privacy of the patients being treated, such as when services are provided in a "general use" area of an assisted living facility or the provider contracts with a community pool to provide aquatic therapy.

Relocation of an Existing Practice Location

- Similar to the notice requirement discussed above, a 90-day advance notice of an intent to relocate the primary or any extension site must be provided to the RO.
- Simultaneous with notice to the RO, the provider is to file the CMS 855A change of information application to report the anticipated relocation.
- *The relocation of the primary site will require a survey* in order to obtain RO approval. Additionally, if a rehabilitation agency wants to change its primary practice location, CMS has placed restrictions on when the current administrator can serve as the administrator or alternate administrator for the new primary practice location.

Rehabilitation agencies should carefully review the guidance in Transmittal 83 and implement any necessary changes to ensure compliance with the new and expended guidance. This may require updates to policies, changes in how certain procedures are documented to ensure compliance with the requirements, revisions to existing contracts with therapy personnel, and other similar actions. Most importantly, any decision to relocate or expand to a new location will require sufficient advanced planning to obtain approval with an effective date prior to being able to provide and bill for services. Furthermore, if the planned location is outside of the geographic radius, another rehabilitation agency enrollment would likely be required. Depending upon the state survey agency and its federal budget, opening a new rehabilitation agency may need to be accomplished by seeking deemed accreditation status.