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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - A-03
(June 2003)

Subject: Consolidated Home Care Payments by Medicare
(Resolution 119, A-02)

Presented by: Cyril "Kim" Hetsko, MD, Chair

Referred to: Reference Committee A
(Kevin T. Flaherty, MD, Chair)

1 At the 2002 Annual Meeting, the House of Delegates referred Resolution 119 to the Board of
2 Trustees. Introduced by the New York Delegation, the resolution calls for the AMA, "in
3 cooperation with national medical specialties, to urge the Centers for Medicare and Medicaid
4 Services to modify its policy of making consolidated payments for services following a hospital
5 discharge, when these services are rendered in the office by the physician or his/her staff"; and
6 further, to "exclude from the Consolidated Billing protocol and the 'Episode of Care' physician
7 services performed in a physician's office for a Medicare beneficiary receiving home health care."
8 The Board of Trustees referred the resolution to the Council on Medical Service for a report back
9 to the House at the 2003 Annual Meeting.

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11 In detailed written and oral correspondence to the Council, staff from both the Medical Society of
12 the State of New York (MSSNY) and the American Academy of Physical and Rehabilitative
13 Medicine (AAPRM) specified that the primary concern of the resolution was that private
14 physicians have no timely way of determining to which of their patients the Medicare consolidated
15 home health services billing protocol applies. This potentially leads to the provision of services for
16 which payment to the treating physician is ultimately denied by Medicare and by the home health
17 agency that receives the lump-sum, "episode of care" payment from Medicare.

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19 MEDICARE'S HOME HEALTH SERVICES PROSPECTIVE PAYMENT SYSTEM

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21 Effective October 1, 2000, the Centers for Medicare and Medicaid Services (CMS) replaced its
22 retrospective reasonable-cost-based system for payment of home health services under Medicare's
23 Part A and Part B programs with a new Home Health Prospective Payment System (HHPPS),
24 consistent with the requirements of Section 4603 of the Balanced Budget Act of 1997, as amended
25 by Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act
26 for Fiscal year 1999, and by Sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP
27 Balanced Budget Refinement Act of 1999. The HHPPS was designed by Medicare to improve
28 control of costs for home health services by shifting the incentive to control costs away from
29 Medicare and toward the home health agencies that provide those services. This is accomplished
30 by shifting the following:

- 31
32
- the liability for the cost of therapeutic and rehabilitative services;

- 1 • the discretionary authority for providing these services; and
- 2
- 3 • the global payment for these services.
- 4

5 The home health agencies are then responsible for paying the providers of those services, if and
6 only if those providers are under contract to and authorized by the home health agency to provide
7 those services. The services that are subject to the consolidated billing protocol are normally
8 provided by non-physician providers (i.e., therapy technicians). While the vast majority of services
9 provided by physicians are exempt from the consolidated billing protocol, and are billable and
10 payable according to the customary requirements of the Part B program, problems have arisen
11 when the provider of these therapeutic services, which are subject to the consolidated billing
12 protocol, was a physician.

13
14 Follow-up discussion with representatives of MSSNY and AAPRM revealed extremely limited
15 number of cases, in the two years since the inception of the HHPPS, to which the circumstances
16 described within Resolution 119 (A-02) applied.

17 18 DISCUSSION

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20 The underlying issue of Resolution 119 (A-02) is payment for a narrow set of therapy services
21 (e.g., physical therapy, speech-language pathology, and occupational therapy), when those services
22 have been provided to a Medicare home health agency patient, and when those services have been
23 provided by a therapist who is neither in the employment of, nor under contract to, the Medicare
24 home health agency that is caring for the home health patient. For example, a physical therapist
25 who provides physical therapy to a Medicare home health patient, and bills Medicare using one of
26 the specific Health Care Common Procedure Code System (HCPCS) codes used to identify therapy
27 services included in the home health agency fixed “episode of care” payment, will not be paid by
28 Medicare, since Medicare assumes all services under HHPPS have been previously paid.

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30 Similarly, unless the physical therapist provided those services pursuant to a preexisting contract
31 with the patient’s home health agency, the physical therapist will not be paid by the home health
32 agency, either. The same rules and restrictions were applied to physicians who provided the same
33 services represented by the specified codes. However, a physician who treats a Medicare home
34 health services patient for any of the vast majority of Medicare-covered services, other than those
35 specifically included in the fixed episode of care payment to the home health agency, will be paid
36 by Medicare according to all the usual and applicable conditions of the Part B program.

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38 According to CMS staff, the circumstances that gave rise to the problems described by the
39 resolution were, apparently, rare. Specifically, a physician must have:

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- 41 • provided therapy services (or have allied health professional employees do so) to patients to
42 whom Medicare’s home health consolidated billing protocol applied;
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- 44 • billed for those services using codes typically used by non-physician providers to bill for
45 certain specific therapy services;

- 1 • been unable to identify such patients in advance as being designated by Medicare as home
2 health episode of care patients and, therefore, not covered for therapy services provided by
3 physicians not under contract to their patients' home health agencies; and
4
- 5 • been denied payment for those therapy services by both Medicare and by the patient's home
6 health agency.
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8 CMS acknowledged in program memoranda and in discussion with Council staff that the HHPPS
9 regulations created a burden for health care providers who provided specified therapies to home
10 health patients on a fee for service basis, as they frequently could not identify these patients as
11 being beneficiaries of Medicare home health services. However, in its Program Memorandum
12 (Transmittal B-03-037) dated May 2, 2003, CMS clarified its policy, instructing all carriers to
13 "exclude from home health consolidated billing methodology claims for therapy services rendered
14 by physicians." Follow-up communication with CMS staff confirmed this policy shift. CMS staff
15 also indicated that the carrier advice is mandatory and effective immediately, and furthermore, that
16 carriers must implement the necessary changes to reflect this policy in their automated claims
17 processes by no later than October 1, 2003.
18

19 Given the shift in CMS policy as it pertains to the payment of physicians who provide therapy
20 services to Medicare home health patients, the intent of Resolution 119 (A-02) appears to have
21 been fully and satisfactorily addressed. The Council believes that relevant national medical
22 specialty societies and state medical associations should be advised of this policy shift so that their
23 members will be aware of their rights to payment for the services described above.
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25 RECOMMENDATION

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27 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
28 119 (A-02), and the remainder of this report be filed:
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- 30 1. That the AMA alert relevant national medical specialty societies and state medical associations
31 to Medicare policy instructing carriers to pay physicians for therapy services they render to
32 home health patients and to exclude such payments from the Medicare consolidated home
33 health billing protocol. (Directive to Take Action)