Eli's Rehab Report

Industry Notes

Is ICD-10 Delayed for A Year?

When the **Centers for Medicare & Medicaid Services** (CMS) and the **American Medical Association** (AMA) jointly announced that they would wait a year before denying claims with incorrect ICD-10 codes, some facilities and physician practices shrugged and said "See you next year, ICD-10" — but unfortunately, that's not going to work.

"The CMS/AMA Guidance does not mean there is a delay in implementation of the ICD-10 code set requirement for Medicare or any other organization," CMS said in its clarification released on July 27. "Medicare claims with a date of service on or after Oct. 1, 2015 will be rejected if they do not contain a valid ICD-10 code."

Translation: You can't get away with just continuing to report ICD-9 codes once Oct. 1 hits. Claims systems won't be able to accept the current diagnosis coding system, so you must start using your ICD-10 codes in two short months.

Your Therapy Assessments Could Soon Change

Your skilled nursing facility's (SNF's) therapy assessments aren't yielding proper Medicare payments. So says a new report from the **HHS Office of Inspector General** (OIG) entitled, "Skilled Nursing Facility Billing for Changes in Therapy: Improvements are Needed."

In fiscal years 2011 and 2012, the **Centers for Medicare & Medicaid Services** (CMS) implemented three new types of assessments that capture changes in a beneficiary's therapy more quickly: start of therapy (SOT), end of therapy (EOT), and change of therapy (COT). The OIG analyzed SNF claims that billed for changes in therapy during this time and found that under the new policies, SNFs used assessments differently when decreasing therapy than when increasing it — costing Medicare $143 million over two years.

Problems: SNF billing for changes in therapy increased only slightly, but SNFs frequently used the new SOT assessment incorrectly, the OIG found. Also, SNFs often used a SOT assessment but billed for no therapy during the stay.

Brace yourself: CMS should speed up its efforts to implement a new method of paying for therapy, to ensure that beneficiaries are receiving the amount of therapy they need and that Medicare is paying appropriately, the OIG concluded. A new payment method should base payments on beneficiary characteristics rather than on the amount of therapy provided.

The OIG also recommended that CMS should mitigate the problems with the new therapy assessments by:

1. Reducing the financial incentive for SNFs to use assessments differently when decreasing and increasing therapy; and

2. Strengthening the oversight of SNF billing for changes in therapy.

CMS agreed with the OIG's recommendations. You can read the report at http://oig.hhs.gov/oei/reports/oei-02-13-00611.pdf.

Therapy-Based Denials Cost HHAs Millions In Latest Review

Do your therapy evals contain these 11 items? It's not only high-therapy claims that will cost you big if they don't pass reviewers' therapy-focused scrutiny.

Case in point: Home Health & Hospice Medicare Administrative Contractor **Palmetto GBA** reviewed nearly 2,500 claims with HIPPS code 1BGP* in the Feb. 1-April 30 time period in the Midwest and Southeast regions, the MAC says on its website. The 1BGP* code indicates 11 to 13 therapy visits, a mid-clinical score (2) and mid-functional score (2).

Palmetto denied 27 percent of the charges in the Midwest and 24 percent in the Southeast, totaling more than $2 million in denied reimbursement. "MR HIPPS Code Change Due to Partial Denial of Therapy" accounted for a big chunk of the denials 36 percent of charges in the Midwest and 30 percent in the Southeast, according to Palmetto.

"Based on medical review of the records submitted, some of the therapy visits were not allowed, thus, reimbursement was adjusted due to a partial denial and the original HIPPS code was changed," Palmetto explains.

The other big denial reason was "Absence of Short and/or Long Term Goals Within the Initial Therapy Evaluation Documentation" 30 percent in the Southeast and 19 percent in the Midwest.

"Short- and/or long-term goals were not included in the record submitted for review" in those cases, the MAC explains. Palmetto lists 11 items that should be in the therapy evaluation, and notes that the eval "must be completed prior to beginning therapy."

Palmetto also posted the results of medical review of claims from March 1 to May 31 with a variety of high-therapy HIPPS codes (those beginning with a "5"). The much smaller reviews saw denial rates ranging from 0 percent to 72 percent.

While the probes focused on high-therapy claims, the denials were usually caused by problems with the plan of care/certification (either missing or insufficient); supporting documentation; missing or wrong OASIS; or lack of a response to the medical record request.