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Eli's Rehab Report

Industry Notes: F2F, POC Problems Plague High-Therapy Claims

Face-to-face, plan of care and OASIS requirements continue to torpedo high-therapy claims in one **Palmetto GBA** edit.

Palmetto reviewed 10 claims with HIPPS code 5BHK* in Illinois, Louisiana and Mississippi in its latest edit targeting the HIPPS code that represents 20-plus therapy visits, a mid-clinical score (2) and the highest functional score (3). The Medicare Administrative Contractor either fully or partially denied four of the 10 claims. Of the total dollars reviewed ($8,541.11), Palmetto denied $4,463.50, resulting in a charge denial rate of 52.3 percent.

The top reason for denials, based on dollars, was plan of care/certification problems, Palmetto says. The number-two reason was face-to-face.

More issues: Palmetto also cites four instances of changing a HIPPS code because documentation didn't support OASIS M0 items. Undocumented visits, homebound status problems, and single nurse visits also caused denials.

ASHA Appeals For Stoppage Of Hearing Aid Law

The Veterans Access to Healthy Hearing Act, H.R. 353 which was introduced on January 13, 2015, proposes to recognize hearing aid specialists for appointments to the VA. However, the **American Speech-Language-Hearing Association** (ASHA) has appealed to the public at large to campaign against this new law.

ASHA feels that implementing this law could lead to fragmented care rather than serve the intended purpose of allowing greater access to hearing health care services. "The VA Deputy under Secretary for Health Policy and Services stated (in a hearing held on legislation in March 2014) that the lack of standardized educational and professional health licensure requirements of hearing aid specialists could fragment hearing health care services and limit delivery of comprehensive hearing health care services," ASHA said in a Jan. 21 press release.

Are You Among These Providers?

The **Centers for Medicare & Medicaid Services**' (CMS') new Comprehensive Error Rate Testing (CERT) results, which were released on Dec. 15, show that practices and facilities made more errors in 2014 (with a national average error rate of 12.1 percent) than in the previous year (2013's error rate was 10.1 percent). The biggest offenders in CMS's eyes were chiropractors, social workers, independent labs, intensivists, private practice physical and occupational therapists, allergists, psychologists, psychiatrists and neurologists, all of whom logged error rates above 18 percent.

Look for Upcoming ICD-10 End-to-End Testing Options

If you already applied for the January ICD-10 testing session, CMS will automatically re-register you for the subsequent rounds. But if you didn't put your name in for the January testing, you can apply with your MAC for the future periods.

In addition to acknowledgement testing, CMS's upcoming end-to-end testing will offer the provider community an opportunity to submit claims during January, April and July. "Approximately 850 providers will have the opportunity to participate during each of the testing periods for a total of 2,550 individual testers," said CMS's **Suzie Chagniss** during a Jan. 7 Open Door Forum call. "The goals of this testing are to demonstrate the providers and submitters are able to submit test claims successfully, that those claims will be adjudicated properly, and that accurate remittance advices are provided."

Each MAC will select 50 participants per testing round. To be eligible to test, you must be ready for ICD-10, including ensuring that your vendor software is ready to use. In addition, you must be a direct submitter to Medicare and be able to receive electronic remittance advice.

MACs have already selected participants for the Jan. 26 to 30 period, and CMS will publicly release the in-depth results of the first round by the end of February. Registration for the April testing is now open. The deadline to volunteer has been extended to Jan. 21. You can register on your MAC's website.

To read the MLN Matters article on this topic, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1435.pdf.

Here's Your Therapy Cap Value For 2015

On Nov. 14, the **Centers for Medicare & Medicaid Services** (CMS) announced the new therapy cap values for calendar year (CY) 2015, which are effective on Jan. 1. Under Medicare Part B, therapy caps for CY 2015 will be $1,940.

This means that the allowed dollar amount for CY 2015 outpatient therapy is limited to $1,940 for physical therapy and speech-language pathology combined, and $1,940 for occupational therapy. Section 103 of the Protecting Access to Medicare Act of 2014 extended the exceptions process to the therapy caps for reasonable and medically necessary services through March 31, 2015.

To read the CMS transmittal announcing the CY 2015 therapy caps, go to www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3120CP.pdf.