Eli's Rehab Report

News You Can Use: Fight Fraud With This 8-Minute-Rule Refresher Course

Plus: Familiarize yourself with these vital licensing requirements

When the OIG put therapy services on their 2005 Work Plan, they weren't kidding.

Recent bouts of healthcare fraud indictments charge several rehab physicians and employees with billing excessive units and allowing nonlicensed employees to practice therapy. Here's how you can avoid sticking your neck out on the OIG chopping block.

Obey the 8-Minute Rule

The Office of Inspector General (OIG) will take little pity on you if you claim more units than your therapist actually performed. "There is no excuse to report more time than what he or she worked," says **Joanne Byron, LPN, BSNH, CPC, CHA**, president of Health Care Consulting Services Inc. in Hickory, N.C.

To properly report units of time-based codes, you have to know the 8-minute rule inside and out. Payoff: "You should easily be able to translate the actual time spent with each patient for therapy - or time-based charges - to the number of units you should claim," says **Fran Law, CPC**, a rehab coder in Richmond, Va.

Example: Your therapist documents spending 37 minutes performing **CPT 97113** (Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises). When you consult the 8-minute rule, you'll see that you should report two units for this service.

Mistake: Never round up. If you decided to round 37 minutes to 40 minutes, then you would report three units, according to the 8-minute rule. That extra unit is an overcharge. By the end of the day, if your practice continually rounds up, you could have coded hours more than the therapist actually worked.

Beware: "Some states like Texas have a law that allows insurance companies and the public to report a physician for overcharging to the medical board," Byron says. Overcharging relates directly to coding, so your own patients could catch you. "You've got to know what the rules are by payer," Byron says.

Note: Don't overlook constraining of units for Medicare. Learn how by rereading "3 Strategies for Constraining Time-Based Units" featured in the March 2005 Physical Medicine & Rehab Coding Alert.

Learn These Licensing Requirements

You must make sure that a licensed, qualified provider performs every medical service your practice gives. Understanding what qualifies a provider may be tricky because you've got state licensure and Medicare requirements to contend with.

Medicare may say, "It doesn't matter what your state licensure board told you - if you didn't meet CMS requirements, then you cannot report this service," Byron says.

Caution: Be sure the proper provider ID number is on the claim. "Not getting proper documentation with authentic signature will definitely come back to haunt you," Law says. A lot of practices use automation with "electronic signature on file," so the scheduled provider's signature might appear on the report - not the provider who actually saw the

patient.

Hot zone: With the new incident-to therapy rules issued by CMS, many practices have to restructure to make sure that a qualified provider performs therapy services.
Don't be caught disobeying the rules. What to do: "If you are unsure about whether an unlicensed professional can render treatment, you should check both state and federal laws," says **Chad Clark, MSPT, CSCS**, physical therapist and owner of Sports Performance & Rehab in Pueblo, Colo.

Note: Brush up on incident-to therapy coding by rereading "News You Can Use: Reporting Incident-To Therapy Services? Better Have a Therapist" featured in the July 2005 Physical Medicine & Rehab Coding Alert.