Eli's Rehab Report

Home Health: Sharpen Your Therapy Prediction to Master New Service Domain

Every therapy visit could make a difference under revised PPS billing

You'll see big changes to how therapy affects your Medicare payments under the proposed prospective payment system -- and an incentive to kick your therapy evaluations into gear.

Out with the old: The industry met with glee the CMS plan to eliminate the OASIS item on prior inpatient stays (M0175) from PPS' service domain.

In with the new: That leaves the case mix question on therapy utilization as the only item in the service domain, says consultant and physical therapist **Cindy Krafft** with UHSA in Atlanta.

And CMS wants to change the question from M0825 (Therapy Need: Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy [physical, occupational, or speech therapy] that meets the threshold for a Medicare high-therapy case mix group?) to M0826 (Therapy Need: In the home health plan of care ... what is the indicated need for therapy visits [total of reasonable and necessary physical, occupational, and speech-language pathology visits combined]?).

Home health agencies will have to enter an exact number of predicted therapy visits in response to M0826, says **Betty Gordon** with Simione Consultants in Westborough, Mass. If no therapy visits are necessary, providers must submit "0" as the response.

CMS also plans drastic changes to how PPS reimburses for therapy. Instead of one 10-visit threshold that adds an extra $2,000 to the episode payment, CMS proposes a three-tier threshold with bumps in payment at six, 14 and 20 visits (see Physical Medicine & Rehab Coding Alert, Vol. 8, No. 7). And the new system will include "smoothing" payments for therapy visits between seven and 19, said consultant **Mark Sharp** in an TCI-sponsored audioconference on the PPS revisions.

Therapist Communication More Important Than Ever Before

Asking HHAs to exactly predict the number of therapy visits for a patient's episode is a tall order. Many factors can easily change the prediction, Krafft says. For example, the patient can progress more quickly or slowly than originally predicted, or the patient may refuse care.

To increase their accuracy in predicting therapy, agencies may have to adjust their therapy evaluation procedures, Gordon says. HHAs will have to strive to get their therapists in to evaluate the patient as soon as possible after admission, she says.

Bright side: Many agencies are already achieving very quick therapy evaluations, says therapist **David Perry, PT, MS,** with Perry Therapeutics in Grosse Pointe Woods, Mich. That's due to competitive pressures. But HHAs will have to be just

as quick to collect the evaluations after therapists complete them, Perry says. "The timeliness of getting the reports in following the assessment will be key to getting this projected visit number information accurately reflected on the OASIS," he says.

Agencies on computerized systems may be at an advantage on this issue, Perry says. But HHAs can also rely on phone, fax or drop-off points to relay the information quickly.

Remember, Every Visit Counts

Under the new smoothing payment methodology, every visit counted on the OASIS form will mean more money added to the episode payment, if the visit range is between seven and 19. That gives agencies even more incentive to capture all therapy visits at the outset.

Good news: But a welcome PPS refinement provision calls for Medicare automatically to correct the number of therapy visits included in the case mix category on the final claim. So if an agency predicts 12 visits but actually delivers 14, the claims processing system will automatically upgrade the Home Health Resource Group (HHRG) accordingly.

That's in contrast to the current system. It automatically downcodes final claims when agencies predict 10 or more therapy visits but deliver fewer than 10, but it doesn't upcode when the reverse occurs.

"That's unbelievably incredible," says reimbursement consultant **Melinda Gaboury** with Healthcare Provider Solutions in Nashville, Tenn. Under the new system, agencies will automatically receive the therapy money they are entitled to.

Added benefit: The automatic upcoding will take the pressure off agencies to predict therapy accurately at the outset, Perry says.

"Although we need to be as accurate as possible, we are not expected to be perfect in therapy prediction," Krafft reminds agencies. "With an automatic safety net in place, agencies do not need to be as concerned about getting paid correctly."

Don't Play Fast and Loose With Overestimates

Although the pressure's off, therapy accuracy will probably actually be better with the upcoding provision, says Abilene, Texas-based consultant **Bobby Dusek**. The current system gives providers an incentive to report 10 or more visits, even if they're not sure they'll hit that goal, because they don't want to forget to manually upcode themselves if they deliver at least 10 visits. Failing to make the manual change causes them to lose out on $2,000.

If the new system automatically upcodes, agencies will report visit numbers based more closely on their clinical predictions, Dusek says. That's because they won't have to err on the higher side to avoid lost reimbursement due to billing errors.

Red flag: With the auto-upcoding in place under the PPS refinements, authorities may crack down on providers that always report higher predicted therapy utilization, experts say. Agencies can get more money up-front from the request for anticipated payment (RAP) by claiming a higher-paying functional domain category than they will deliver.

"Systematic overestimates that generate a higher up-front payment may attract attention," Krafft says. "It can look like a way to enhance cash flow."

Note: Buy a CD of Cindy Krafft's TCI-sponsored audioconference on the PPS therapy changes at www.audioeducator.com/industry_conference.php?id=405 or by calling (800) 874-9180.