Eli's Rehab Report

Industry Notes

Therapists Must Now Issue ABNs For Therapy Services That Exceed Caps

What's the difference between a "recommended" advance beneficiary notice (ABN) and a "required" ABN? That difference could be thousands of dollars in lost revenue if you don't keep up with CMS requirements.

Background: Earlier this year, if you provided outpatient therapy services to a patient who had exceeded the therapy cap, the beneficiary was automatically responsible for the non-covered services, and CMS had encouraged therapists to issue a voluntary ABN as a courtesy, even though it wasn't required.

Fast forward to Sept. 6, when CMS issued MLN Matters article MM8404, which states that this rule has changed. "Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable," the article advises. "ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges."

Of course, as in the past, if you are providing therapy services that aren't reasonable and necessary, you must get the patient to sign an ABN, regardless of the patient's status with the therapy cap.

To read the complete article, which includes examples of phrases you can use in a therapy cap-related ABN, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8404.pdf.

Watch Out For These Therapy Denials

For home health agencies furnishing Part B outpatient therapy services in the home, don't be surprised to see denials if you leave Functional Reporting G-codes off your claims.

Background: "The Functional Reporting data collection system is effective for therapy services with a Date of Service (DOS) on or after January 1, 2013," the **Centers for Medicare & Medicaid Services** notes in MLN Matters article SE1307.

"However, a testing period was in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements without penalty while they assured that their systems worked. During this period, claims were processed with or without the required G-codes and modifiers."

Now the claims system is requiring the reporting, under which providers must use 42 G-codes and seven severity/complexity modifiers. If you fail to include the required codes, "Medicare will return a Claim Adjustment Reason Code 246 (This non-payable code is required for reporting only) and a Group Code of CO (Contractual Obligation) assigning financial liability to the provider," CMS explains. "In addition, beneficiaries will be informed via Medicare Summary Notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes."

More details about the requirement are in the article at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1307.pdf.

Miami Recruiter, Therapy Co. Owner Plead Guilty

A patient recruiter and a therapy staffing company owner have pled guilty in connection with a $7 million home care fraud scheme involving the now defunct Home Health Agency **Anna Nursing Services Corp.,** the **DOJ** says in a

release.

Ivan Alejo negotiated and paid kickbacks and bribes to patient recruiters in return for the recruiters providing patients to Anna Nursing for home health and therapy services that were medically unnecessary and/or not provided, prosecutors allege. Alejo also paid doctors and their office staff for signing plans of care, certifications and other documentation.

Hugo Morales, owner of **Professionals Therapy Staffing Services Inc.,** created fictitious progress notes and other patient files indicating that therapists from Professionals Therapy had provided physical or occupational therapy services for Anna, when those services had not been provided and/or were not medically necessary, the DOJ says.