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Eli's Rehab Report

Industry Notes

Claims System Fix For LUPA Glitch Leads To Errors

A new home health claims system edit may be kicking out claims in error. On the other hand, it may be kicking out claims because you're billing unallowable occupational therapy visits.

"The July 2015 system release included the addition of reason code (RC) 37249 to ensure appropriate payment is made on low utilization payment adjustment (LUPA) claims," Home Health & Hospice Medicare Administrative Contractor **CGS** says in a message to providers. "RC 37249 was implemented to ensure that LUPA claims (4 or fewer visits), that are for the first episode in a sequence of adjacent episodes, or is the only episode of care, include a skilled service skilled nursing (SN), physical therapy (PT), or speech-language pathology (SLP) on the claim. Occupational therapy (043X) visits are only covered when preceded by an intermittent SN (055X), PT (042X), or SLP (044X) visit."

The problem: "Claims that receive RC37249 will be sent to Return to Provider (RTP) (status/location T B9997). However, CGS has determined that some claims are being sent to RTP with RC 37249 in error. This issue has been reported to the system maintainer."

The solution: "At this time, if you feel your claim is in RTP with RC 37249 in error, please contact the home health and hospice Provider Contact Center (PCC)," CGS advises. "The Customer Service Representative will make a referral to the Claims department. If the Claims department determines that it went to RTP in error, the claim will be released to continue processing."

SNFs: Keep An Eye On Your Therapy Contractors, Or Pay For Their Mistakes

If your skilled nursing facility (SNF) contracts out for rehabilitation therapy services, don't let your contractor drag you down in an overbilling scheme.

That's exactly what happened to **Ross Manor** in Bangor, ME, owned by **First Atlantic Corporation** and **Rosscare Nursing Homes, Inc.** Ross Manor contracted with **RehabCare Group East, Inc.** (part of **Kindred Healthcare, Inc.**) to provide rehabilitation therapy services to its residents.

RehabCare allegedly submitted claims through Ross Manor to Medicare for inflated amounts of reimbursement based on providing unnecessary or unreasonable rehab therapy, according to a recent announcement by the **Massachusetts District's U.S. Attorney's Office.** Ross Manor has now agreed to pay $1.2 million to resolve these allegations. The U.S Attorney's Office stated:

"Prior to Oct. 1, 2011, Ross Manor failed to take sufficient steps to prevent RehabCare from engaging in a pattern and practice of providing high levels of therapy that were not reasonable or necessary during so-called 'assessment reference periods,' thereby causing Ross Manor to bill for its Medicare patients' care at the highest reimbursement level, even though RehabCare was providing less therapy to those same patients outside the assessment reference periods, when Ross Manor was not required to report to Medicare the amount of therapy its Medicare patients were receiving."

Even after Oct. 1, 2011, the U.S. Attorney's Office alleged that Ross Manor failed to prevent other RehabCare practices designed to inflate Medicare reimbursement, including:

1. Presumptively placing patients in the highest reimbursement level, rather than using individualized evaluations to determine the level of care most suitable for each resident's needs;

2. Planning the minimum number of therapy minutes required to bill at the highest reimbursement level while

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discouraging the provision of therapy in amounts beyond that minimum threshold, despite the Medicare requirement that patients' clinical needs determine the amount of care provided; and

3. Providing significantly higher amounts of therapy on the final day of a period that determines reimbursement to reach the next highest threshold level.

And this isn't the first time RehabCare has dragged an SNF into an overbilling case. In March, the **Catholic Health Care System,** also known as **ArchCare**, in New York City agreed to pay a staggering $3.5 million settlement to resolve allegations of inflated Medicare claims for rehab therapy. ArchCare contracted with RehabCare for therapy services.

Now Ross Manor is the latest SNF to pay for RehabCare's misdeeds. "This settlement is the latest in a series of resolutions involving Medicare billing for rehabilitation therapy at [SNFs]," **U.S. Attorney Carmen Ortiz** said in a recent statement. "We will continue our work to ensure that the provision of care in [SNFs] is based on patients' clinical needs and not tied to the financial targets of the companies providing their care."

Don't Forget The Legible Signature Rule

If your claims are lacking a legible signature, you'll also find a lack of income. That's because CMS requires a legible signature on your documentation, said Part B MAC **NGS Medicare** in a recent reminder.

"Unsigned documentation or lack of attestation will result in the denial of services," the payer says. "The MD signature is required on orders for laboratory services, diagnostic and therapeutic procedures, therapy treatment plans and physician progress notes," NGS adds.

What about chicken scratch? If your doctor's signature is present but unreadable, you've got options, NGS says. "If you notice the signature is illegible when asked to supply medical records, please include a signature key, signature page or a document from the provider/physician or compliance officer that affirms the signature is indeed the provider's/physician's."

Resource: To read more about how to comply with Medicare's signature requirements, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf .

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