Eli's Rehab Report

Industry Notes: MAC Denies 40% of Claims in Home Health Therapy Reviews

More than 70% of denied claims were due to F2F in a recent probe. Whether Medicare will make elimination of the physician narrative for face-to-face retroactive is a vital issue for many home health agencies, including those with claims reviewed in a recent therapy-focused probe.

Home Health & Hospice Medicare Administrative Contractor **Palmetto GBA** announced the latest results from its probes targeting claims with HIPPS codes of 1BGP*, 5BHK*, and 5CHK*. Of the 1,773 claims with these HIPPS codes that it reviewed from the May-to-July time period, Palmetto partially or fully denied 708 40 percent.

Background: 1BGP* indicates 11 to 13 therapy visits, a mid-clinical score (2) and mid-functional score (2). 5BHK* indicates 20-plus therapy visits, a mid-clinical score (2) and the highest functional score (3). 5CHK* indicates 20-plus therapy visits, the highest clinical score (3) and highest functional score (3).

F2F continues to be a dominant denial reason in the 1BGP* probe. Twenty-eight percent of the 1,703 claims reviewed were denied due to F2F. That makes F2F the reason for 71 percent of the probe's denials.

Palmetto says it will continue all three probes in most of the areas for another quarter. Medical necessity was another significant reason for denials, the results show. Failure to respond to the additional development request with records, missing OASIS data, documentation contradicting OASIS M items, and missing plans of care or other physician documentation were more reasons Palmetto cited for denials.

Pitfall: Missing dates for physician signatures accounted for 10 percent of the reimbursement denied in the 5CHK results for Texas.

Home Health MAC Targets More Therapy Claims for Review

A quick way to lose an entire home health episode's reimbursement is to fail to have a matching OASIS data set in the system.

That's one of the many things Medicare Administrative Contractor **Palmetto GBA** will be looking for when it launches a new review of claims with a 2BGL* HIPPS code. That code represents an early episode with 16 to 17 therapy visits and moderate clinical and functional domain scores.

Other items on Palmetto's hit list include an itemized supply and/or DME list; a copy of the psych nurse approval letter from Palmetto when applicable; face-to-face encounter documentation; for management and evaluation of the care plan, a physician's brief narrative documentation describing the clinical justification for the services; therapy documentation including measurements; and much more, according to a new post on Palmetto's website.

Telemedicine: Don't Forget About HIPAA Compliance

Policymakers are examining all aspects of telemedicine lately from promoting improved care coordination to ensuring proper reimbursement. But a recent telemedicine policy hasn't left out patient privacy either.

On June 11, the **American Medical Association** (AMA) released a list of "guiding principles" for telemedicine services. The list comes on the heels of a policy report from the AMA's Council on Medical Services addressing coverage and payment for telemedicine.

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And although the AMA's guiding principles include a wide range of issues, including telemedicine payment rules and ways to improve health outcomes, they also address the unique challenges of maintaining patient privacy and HIPAA compliance while providing telemedicine services.

Links: To read the policy report, go to download.ama-assn.org/resources/doc/hod/x-pub/a14-cms-report-7.pdf. The AMA's June 11 announcement is available at www.ama-assn.org/ama/pub/news/news/2014/2014-06-11-policy-coverage-reimbursement-for-telemedicine.page .

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