# Eli's Rehab Report

## Medical Review: Whittle Down Claim Errors With Meticulous Therapy Documentation

**Comprehensive Error Rate Testing report gives therapy pride of place.**

Get and retain reimbursement that is rightfully yours by ensuring that documentation of your agency, physicians and therapists are squeaky clean. Prevent technical denials with a review process before you submit claims suggest experts.

Therapy-related problems with home health claims topped the list in the latest Comprehensive Error Rate Testing results, notes Home Health & Hospice Medicare Administrative Contractor CGS in its June newsletter for providers. Many of the denials were technical -- the claims lacked a plan of care signed by the physician or the visits weren't documented in the record.

Bottom line: \"The plan of care must be signed and dated by a physician ... before the claim for each episode for services is submitted for the final percentage payment,\" the Centers for Medicare & Medicaid Services says in its Medicare Benefit Policy Manual. \"Any changes in the plan of care must be signed and dated by a physician.\"

Mistakes like these are due to sheer sloppiness, says Chicago-based regulatory consultant **Rebecca Friedman Zuber.** \"Most agencies understand that they can't file a final claim until they get all of the physician's orders signed, including the plan of care, and that they have to have all visit notes in the chart in order to include a visit on the final claim.\" Many agencies haven't been motivated to clean up their haphazard ways because so few claims are reviewed, Zuber believes.

Tip: \"The way to prevent the technical denials is to ... have a review process prior to submitting claims,\" advises consultant **Betty Gordon** with Simione Consultants in Westborough, Mass. The process would \"make sure that all visits have orders, [are] signed and dated, and [are] appropriate to bill.\"

The burden is on you to make sure all the pieces are in place to back up your claims. \"Implement a process to ensure that all physician orders affecting the care plan (visit utilization) are signed and in the record prior to billing,\" instructs consultant **Lynda Laff** with Laff Associates in Hilton Head Island, S.C.

Monitoring documentation and claims prior to submission to ensure that requirements are met may be tedious, Zuber allows. But it is necessary \"to ensure that you are only billing Medicare for what is allowed,\" she stresses.

**Beef Up Documentation To Head Off Medical Necessity Denials**

CERT reviewers also denied home health claims for lack of medical necessity for therapy services, CGS notes. \"The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist,\" CMS says in the Manual. \"To be covered, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury.\"

The problem: Documenting medical necessity for therapy is \"one of the current frontiers in the battle for good home health agency documentation,\" Zuber tells **Eli**. \"Therapists will document what the patient does (e.g., patient ambulated 200 yards x 2).\"

The solution: Instead, \"in order to qualify as a skilled visit, the therapist needs to describe what she did,\" Zuber explains. For example, \"patient ambulated 200 yards x 2 with verbal cuing to shorten stride and insure proper heel

strike.\"

Note: CGS's article on CERT errors is at http://cgsmedicare.com/hhh/pubs/mb_hhh/2012/06_2012/index.html#004.