OASIS Alert

Assessment: Shore Up Your Bottom Line By Dodging These M0825 Pitfalls

Warning: One of these errors could cost you $1,800 to $2,200 an episode.

Simple OASIS answers like "no," "yes" and "not applicable" can be a lot trickier than they seem - and one mistake can cost you thousands.

You may think M0825 simply asks if you are going to do 10 therapy visits, but the question is more complicated than that, advises occupational therapist and consultant **Karen Vance** with **BKD** in Springfield, MO.

For accuracy, focus on three parts of the question: "Medicare payment period," "need for therapy" and "meets the threshold," she told listeners in a March 10 teleconference, "Strategies to Boost Accuracy in the Service Utilization Domain," sponsored by **Eli Research** and **The Coding Institute**:

1. "Medicare payment period." M0825 is important if Medicare is a primary or secondary payor, but not for a Medicare HMO, because no case mix group or HHRG is assigned for HMO patients, Vance explains. So unless the patient is Medicare - primary or secondary - choose answer "NA" (not applicable), she says.

Watch for: Don't use "NA" to indicate the patient is not receiving therapy, Vance warns. And remember the payment period means a 60-day episode. If you do a resumption of care assessment after a patient was hospitalized, count the therapy visits before as well as after the ROC. Failure to do this has cost many agencies $1,800 to $2,200 per episode, experts report.

2. "Need for therapy." Many clinicians think therapy means only physical therapy, but you must also consider occupational and speech therapy visits for M0825, Vance stresses.

Watch for: Count only the therapy visits you expect to take place. Don't automatically answer "yes" knowing the intermediary will downcode the claim if you don't reach the threshold, warns PT **Cindy Krafft** with Peoria, IL-based **OSF Home Care.** Under the prospective payment system, regional home health intermediaries fork over a big part of the payment at the beginning of the episode. That means your intermediary will become suspicious of abuse if you consistently overestimate your therapy visits, she says.

3. "Meet the threshold." A Medicare high-therapy case mix group is currently defined as 10 visits, but that could change at any point, Vance says. The question is worded so your form won't need to change.

Watch for: The **Centers for Medicare & Medicaid Services** debated about whether to use 10 visits or eight hours as the high-therapy threshold, Krafft reports. So keep an eye on both the number of visits and the amount of time to be sure you are not shortening visits to increase the number, she warns. The **HHS Office of Inspector General's** 2005 Work Plan lists this pattern as a potential fraud area for the feds to scrutinize.

If you are significantly increasing the number of therapy visits you are providing for patients, be especially sure your documentation thoroughly supports your visits, Krafft cautions. And coordinate care to prevent overlapping treatment when more than one therapist treats the patient. An intermediary can deny a few visits and downcode your claim, experts advise.

Avoid These Other M0825 Pitfalls

Now that you understand the question, check your practices against these common problems to be sure you aren't throwing money away:

1. **Underestimation.** Even if you provide 10 or more therapy visits, you won't be paid for them unless you answered "1" (yes) on M0825. If you did not, you must go back and cancel the original request for anticipated payment (RAP) and submit a new one with M0825 answered correctly, Vance says.

   Agencies should have a system in place to check this field before filing a claim, experts say. Changing the answer doesn't need to involve a significant change in condition (SCIC), Vance notes, because estimating therapy for 60 days in the future is a "best guess" anyway.

2. **Miscount.** If you provided 10 or more therapy visits and answered M0825 correctly, but fail to show 10 visits on your final claim, your intermediary will automatically downcode the episode, Vance warns. Investigate every therapy downcode to verify its validity, advises consultant **Terry Cichon** with **FR&R Healthcare Consulting** in Deerfield, IL.

3. **Canned answers.** Focus on patient needs rather than on canned frequency and duration orders, Vance advises. Develop an individualized care plan and insist on documentation to back up your clinical judgment and each therapy visit. Descriptive notes are essential, experts say.

   Editor's Note: To order a tape of Vance's March 10 teleconference, go to http://codinginstitute.com/conference/tapes.cgi. To sign up for her upcoming sessions on strategies to boost outcomes in the functional and clinical do-mains, call 1-800-508-2582.