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OASIS Alert

Compliance: 5 KEYS HELP YOU AVOID THERAPY DENIALS

Heed: OIG therapy audits results to make your claims tough to deny.

You can't do anything about therapy claims for fiscal year 2003--currently being audited--but you can use the audit reports to improve your chances of keeping what you earn going forward.

Problem: Medical review of home health claims showing 10 to 12 therapy visits is likely to continue, experts agree. Your fiscal intermediary has a huge financial incentive to deny your high-therapy-use claims--but that doesn't mean you have to make it easy.

What to do: Don't panic when the number of visits is in this 10 to12 range. Instead, focus on meeting the patient's needs and developing systems to ensure regulatory compliance for the claims, says **Cindy Krafft**, director of rehabilitation services for **OSF Home Care** based in Peoria, IL. While "medical necessity" is not very specific and may be hard to pin down, the denials in the most recent **HHS Office of Inspector General** audit could have been prevented, she adds.

Lessons learned: Putting all three OIG audit reports together gives agencies some good guidance on the critical parts of a successful high-therapy-use claim, Krafft suggests. She recommends that agencies:

1. Be able to justify every therapy visit. Avoid "cookie cutter" visit patterns. Focus on the patient's needs, not on some arbitrary or familiar pattern of visits. If your plan of care always has the same number of visits per week, regardless of the individual patient's needs, it's harder to justify medical necessity.

Tip: "On each visit ask 'why are you there?' If you don't have a reason--you're done with visits for that patient," Krafft says.

2. Use multiple therapies when needed. Most of the denied claims seemed to involve PT only, Krafft observes. It may be easier to defend the medical necessity of four to six visits each for PT and OT than 10 to 12 visits for just PT--and your outcomes may also improve, she notes.

3. Focus on documentation. When a claim has 10 to 12 therapy visits, it's especially critical that every visit note is complete and can stand alone. Each therapist must document the skilled services provided and the progress the patient is making on every visit.

Warning: Just having a visit note is not enough. Be especially careful not to leave out essential information when transitioning to computer documentation, Krafft advises. "Very good documenters on paper are not necessarily very good documenters on point of care," Krafft finds, "because the triggers are gone."

For example, paper charting can include a space for the PT to note the critical documentation of gait and level of assistance required. If that part of the documentation is missing, the blank spot makes that obvious to the clinician and the person reviewing the chart. In the electronic environment, though, the note prints just as written and that missing piece is not as obvious, she says. But that missing documentation may leave you open to denial based on the visit not being reasonable and necessary, Krafft says.

4. Include therapy use in clinical audits. By noting at the top of the clinical record review sheet the number of visits each discipline made, the auditor can then remember to check for the critical documentation and visit orders during the audit, Krafft recommends. Ideally, someone with a therapy background would review visit notes to be sure the documentation is not just present but is complete.

5. Tighten up pre-billing audits. With high-therapy claims, there's a direct reimbursement effect from missing dates or signatures on orders, visit frequencies that conflict with orders or orders signed after claims are filed. Focus your resources on checking these items before the claim is submitted.