OASIS Alert

News You Can Use: PREPARE FOR FEDS TO PEEK AT YOUR THERAPY VISIT RECORDS

Wall Street Journal article kicks off congressional probe.

No matter how sharp you hone your patient-care strategy, telltale changes in your therapy visit patterns under prospective payment system revisions may land you in hot water, just like it has for four publicly held companies.

Senate Finance Committee Chair **Max Baucus** (D-Mont.) and Ranking Member **Charles Grassley** (R-Iowa) on May 12 requested documentation from four for-profit home health agency chains related to therapy provision and PPS payment incentives. The request letters went to **Amedisys Inc.**, **Gentiva HealthServices Inc.**, **LHC Group Inc.**, and **Almost Family Inc.**

The request came on the heels of a Wall Street Journal article that claimed that HHA therapy practice patterns had changed in response to PPS payment revisions that took place in 2008. Agencies manipulated visit numbers to increase profits, the article charged.

For example: The number of patients receiving 10 therapy visits from Baton Rouge, La.-based Amedisys dropped 50 percent after the new six-, 14-, and 20-visit therapy thresholds took effect in 2008, the Journal reported. At the same time, Amedisys patients receiving 14 visits rose 33 percent, and patients receiving 20 visits increased 41 percent, the newspaper said.

"So far, it appears that either the home health care reimbursement policy is flawed, some companies are gaming the system, or both," Grassley says. "As the Senate committee of jurisdiction, we're working to figure out what's going on."

All four companies, whose stock prices dipped after news of the inquiry, have promised to cooperate fully with the investigation. However, "as a company, therapy represents a much lower portion of our episodes than the national average," LHC pointed out in response to the probe.

Stats: "In 2007, 36.6 percent of our total Medicare episodes received therapy versus the national average of 49.8 percent, and only 38.2 percent of our total Medicare episodes in 2008 received therapy versus the national average of 50.2 percent," LHC shared in the response.

Further, the company noted that physicians write the orders for therapy; therapy visit numbers for 2007's top 20 diagnoses stayed the same in 2008 for the company; LHC therapy visit numbers increased due to total patient population growth; and LHC has a compliance program and third-party-manned compliance hotline.

Good news: Industry veterans hope the congressional probe helps put a stop to some abusive therapy practices they've seen lately. For example, in some therapist shortage areas, independent contractor therapists are running up visit numbers in order to secure higher reimbursement for themselves, one source charges.

Bottom line: This inquiry may be just the start of a big regulatory and compliance assault on the home care industry -- and it's been a long time coming. The **Medicare Payment Advisory Commission** has pointed out the large ratio of for-profits that have started up in the HHAand hospice industries in the last five years.

The government believes "there are too many agencies and too many [that are] doing things wrong or illegal," says **Tom Boyd** with Rohnert Park, Calif.-based **Boyd & Nicholas**.

But rather than potentially shutting down a slew of existing agencies, the feds should stop certifying new providers and

provide education and training to the agencies already in the program, Boyd recommends.

• One part of the regional home health intermediary-to-Medicare Administrative Contractor (MAC) transition is moving forward, but it won't require many changes.

As originally planned, the **Centers for Medicare & Medicaid Services** has awarded RHHI **Palmetto GBA** the home health and hospice MAC contract for Jurisdiction C.

That region is comprised of the 16 states Palmetto already serves as RHHI: AL, AR, FL, GA, IL, IN, KY, LA, MS, NM, NC, OH, OK, SC, TN, and TX.

HHAs and hospices in the 34 other states are supposed get new HH MACs. But two of the jurisdiction changes have been held up by contract protests that remain unresolved.

• CMS's take on the new 12-month deadline for submitting Medicare claims will make the time limit even shorter for home health agencies.

Medicare will use a claim's "from" date to start the 12-month submission clock, it says in new instructions about the requirement that was included in the Patient Protection and Affordable Care Act.

"Maintaining the start-of-care or 'from' date for an episode of care as the beginning of the one-year claim filing countdown will shorten the filing timeline for home health to 10 months in some cases," the **National Association for Home Care & Hospice** protests. "Because a home health claim may not be submitted prior to the end of an episode -- which could be 60 days - two months will already have ticked down in instances of a full 60-day episode."

NAHC has urged CMS to count the 12 months from the end of the home health episodeinstead, the trade group says.

Resource: Learn more about the dead line at www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf.

• Palmetto GBA's April 30 deadline tosend in licensure information may be past, but it's not too late to head off what would be a massive billing disruption.

"Palmetto GBA is not immediately revoking billing privileges associated with the recent HHA license update request," a Palmetto spokesperson tells **Eli**. The RHHI "will coordinate with state licensing agencies to verify licensure of agencies prior to any revocation actions."

That's good, because under new regulations that took effect Jan. 1, it takes a resurvey to reinstate revoked billing privileges.

HHAs may download the HHA License Verification Coversheet from Palmetto's website and send in their documentation, the representative explains.

But you don't have to worry about sending in information if you're in a no-licensure state, Palmetto says in newly updated frequently asked questions (FAQs). You don't even need to send in the cover letter saying you're in such a state unless you want to, Palmetto explains.

"No adverse actions will be taken by way of revocations for these providers," according to the newly updated FAQs.

• If you're confused about Medicare coverage for diabetic patients' blood glucose self-testing supplies and equipment, you may want to consult a new MLN Matters article.

Covered supplies include blood glucose monitors, blood glucose test strips, lancet devices, and lancets, and glucose control solutions for checking the accuracy of testing equipmentand test strips, the April 16 article notes.

Tip: "Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin," the article noted.

However, the amount of supplies that are covered varies. For instance, insulin-dependent patients qualify for coverage of up to 100 test strips and lancets per month, whereas Medicare covers 100 test strips and lancets only every three months for non-insulin-dependent patients.

Patients must have a valid prescription noting: the items that should be dispensed and the quantity of items, the frequency of testing,whether the patient is insulin-treated, the physician's signature, the signature date, and the start date of the order (if it's different than the signature date).

The article is online at www.cms.gov/MLNMattersArticles/downloads/SE1008.pdf.

• Having a hard time navigating the frequently asked questions (FAQs) on CMS' newly modified website? You aren't the only one.

CMS offers these steps to help agencies search for the information they need with minimal headaches:

1) Go directly to the FAQs by clicking 'Questions' from CMS' main site. Then click on 'Advanced Search' directly above the search field.

2) Type the subject in the 'Search terms' field, filter using the 'Limit by product' drop-down box, and select among different sorting options.

3) Click 'Search.'

This process should take you directly to the questions and answers you're seeking. Once there, note that ID numbers are located under the question rather than on the left at the beginning of the question.

Print the questions by clicking 'print answers found' at the bottom of the screen. When printed, the ID numbers will be to the left of the question.

• Get ready for more than 130 newICD-9 diagnosis codes debuting on Oct. 1. CMS has proposed the full listing of codes in a 1,000+ page Federal Register file.

More than one-third of the proposed codes are in the "V" code section, which describes "supplementary classification of factors influencing health status and contact with health services," according to the ICD-9 manual.

For a breakdown of how the new codes will influence home care coding, see a future issue of Eli's OASIS Alert.