OASIS Alert

Prospective Payment System: Therapy Use Goes Hand In Hand With Profitability

But beware: Not all high therapy use episodes are profitable.

The correlation between high therapy use and high reimbursement hasn't escaped the notice of your friendly local intermediary.

About 10 percent of the patients clinicians had expected to need 10 or more therapy visits at start of care needed 10, while only 4 percent needed nine visits in that episode, reported **Amanda Twiss**, president of Seattle-based **Outcome Concept Systems** at the recent **National Association For Homecare & Hospice's** National Policy Conference in Washington.

Caution: That 6 percent jump between nine and 10 visits -- which drops back to almost 4 percent again by 15 visits -- coincides with another interesting OCS statistic. Ten therapy visits also is the point at which reimbursement begins to significantly exceed the agency's cost (excluding supplies) for an episode that includes therapy, Twiss reported.

Another concern: OCS data on Home Health Resource Groups usually indicated a positive correlation between high therapy use and profitability as well.

The five most profitable HHRGs -- C3F1S3, C1F0S3, C3F3S3, C1F1S3 and C2F1S3 -- averaged between 9.5 and 19.1 therapy visits per episode, OCS data showed. These HHRGs resulted in average profits of $1,264 to $1,427 per episode.

And of the five least profitable HHRGs -- C2F0S1, C3F0S2, C1F0S1, C1F0S0 and C0F3S1 -- only C3F0S2 had more than 10 therapy visits. These five HHRGs lost agencies from $223 to $687 per episode, OCS calculated.

HHAs Aren't The Only Ones Looking At Data

Red flag: First, the **HHS Office of Inspector General's** 2004 work plan announced a focus on high therapy use episodes (see Eli's OASIS Alert, Vol. 5, No. 3). Now discrepancies between functional domain scores and therapy use are attracting regional home health intermediary attention.

RHHI **Cahaba GBA's** medical review department has initiated an edit of claims with a low functional domain -- represented by an "E" in the HIPPS code -- and a high service domain ("M"), due to "possible aberrant billing practices and vulnerabilities," the RHHI says in an article in its April bulletin to providers.

The functional domain of the HHRG comes from the activities of daily living scores in OASIS questions M0650, M0660, M0670, M0680, M0690 and M0700 (see Eli's OASIS Alert, Vol. 4, No. 11). So a low functional domain indicates little or no problem with ADLs -- which are one of the main reasons for therapy.

Cahaba denied nearly a third of the claims the edit selected. More than three-fourths of these were denied for one of four reasons: lack of homebound status (23 percent); the patient having a hospital stay within 14 days of admission (20 percent); the therapy visits not being medically necessary (18 percent) and no orders for the therapy (16 percent).

How To Protect Yourself

A consistent documentation system is especially important in the face of increased focus on therapy visits. Here's how to make yours bulletproof:

1. Document eligibility. If you don't document homebound status -- a qualifying factor -- the RHHI can deny the entire episode, warns consultant **Linda Rutman** with the Charlotte, NC-based **LarsonAllen Health Care Group**. Besides documenting the reasons for eligibility at start of care, continue to reinforce these reasons with on-going evidence, especially as the patient makes progress in therapy, she adds. Throughout the episode, include specific information, such as how far the patient can walk, and be sure the documentation is consistent from one clinician to another, Cahaba advises.

2. Document often. "The homebound status is to be documented in the medical record frequently enough to reflect the beneficiary's current functional status, and at a minimum, at least once per certification/billing period," Cahaba says.

3. Document basis for OASIS answers. The clinical record must support your OASIS answers throughout the episode, not just at start of care. This is especially important for the answers that support your reimbursement -- such as activities of daily living -- says consultant **Pat Sevast** with **American Express Tax and Business Services** in Timonium, MD.

4. Document therapy. Include the skills the therapist is working on and the patient's progress from one visit to the next, suggests Chapel Hill, NC-based clinical consultant **Judy Adams**, also with LarsonAllen. Be as specific as possible and include examples, she adds.

5. Document verbal orders. Writing down verbal orders in the record seems to be an area of difficulty for agencies, Cahaba notes. The clinician receiving the verbal order after the plan of care is established should document that it was received, the date and the order, the RHHI instructed. The physician also must sign and date the verbal order before the HHA submits the claim, Cahaba warns.

Editor's Note: For detailed instructions on what the RHHI looks for, go to www.iamedicare.com/Provider/newsroom/newslines/040104.pdf and scroll down to page 48.