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OASIS Alert

Reimbursement: DON'T WAIT UNTIL CHRISTMAS TO CORRECT CLAIMS ERRORS

You could be forfeiting up to $10,000 to $60,000.

You probably wouldn't send the feds a Christmas gift of thousands of dollars, but that's what agencies do when they neglect to review claims for errors before the deadline for claims corrections.

Home health agencies have until Dec. 31, 2005 to bill or correct claims for episodes ending from Oct. 1, 2003 through Sept. 30, 2004, billing experts tell **Eli.** The two most common mistakes are significant changes in condition (SCICs) billed in error and episodes billed with fewer than 10 therapy visits expected (M0825), but 10 or more therapy visits provided, says consultant **M. Aaron Little** with **BKD** in Springfield, IL.

Some clients last year started the process too late and were not able to claim the money they were owed, reports **Karen Crosby** with **Abraham & Gaffney** in St. Johns, MI. But by starting earlier, one client reported recovering $230,000, though most recoveries were in the $10,000 to $60,000 range, she tells **Eli.**

Focus on the Most Likely Errors

Take time to go back through accounts receivable aging reports to look for claims that are either unpaid or need correcting, Little advises. But remember that a claim that was billed and paid with an error won't necessarily show up on a report, he adds. Look for these frequent errors, experts suggest:

1. Don't just accept therapy downcodes. Check therapy claims that were downcoded because of fewer than 10 visits, recommends **Terry Cichon** with **FR&R Healthcare Consulting** in Deerfield, IL. Make sure all the visits were listed and documented. Of course, your intermediary is working to disallow visits when possible, but be sure the downcode is valid before you accept it.

2. Correct M0825 when needed. Remember, your intermediary is happy to downcode claims with fewer than 10 therapy visits if you answered "yes" on M0825. But even if you made 20 therapy visits, you won't get paid for them if you answered "no" on M0825. It's up to you to find those claims, go back and correct the OASIS answer, and re-bill the claim, Crosby reminds providers.

3. Look closely at SCICs. "If an agency has billed more than 3 percent of its annual episodes or 30 or more episodes as SCICs," Littlesays he consistently finds billing errors. Some errors result from software systems that automatically bill claims as SCICs each time a resumption of care or other interim OASIS assessment is done, unless the user tells it not to, he warns.

Other SCIC errors result when agencies automatically bill a SCIC when a ROC assessment results in a lower HIPPS/HHRG score--without checking to see if all the SCIC criteria are met, Little explains. Or agencies misunderstand how to calculate payment with a SCIC and bill it thinking it is advantageous when it is not, he adds (see OASIS Alert, Vol. 6, No. 8.).

Caution: Once an episode has been billed erroneously, be very careful to make corrections only after carefully reviewing the documentation, Little warns. If you are unclear about SCIC or therapy issues, getting outside help not only corrects these errors but also prevents them in the future, he adds.

Opportunity: Asking for guidance about partial episode payments (PEPs) and low utilization payment adjustments (LUPAs) will also help your bottom line, Little and Crosby agree. And rather than repeating this process next year,

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implement internal audit processes and learn how to get the most out of your information system, Crosby recommends.

Note: If you use Direct Data Entry for claims and corrections, Palmetto GBA recently announced some changes in the system. Go to www.palmettogba.com or www.iamedicare.com/Provider/newsroom/whatsnew/20050907_rtp.htm.

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