# OASIS Alert

## Reimbursement: Here's Your Last Chance To Fix These Erroneous Claims

**Stop sending the feds a financial gift they don't deserve.**

Begin work now and end the year keeping at least $30,000 extra in your agency's pocket.

**Opportunity:** Home health agencies have until Dec. 31, 2006 to bill or correct claims for episodes ending from Oct. 1, 2004 through Sept. 30, 2005, billing experts tell **Eli.**

After Jan. 1, the Medicare timely billing limit will allow agencies to bill, adjust, correct, cancel or rebill only episodes ending after Oct. 1, 2005, says consultant **M. Aaron Little** with **BKD** in Springfield, MO.

**Expect At Least Some Errors**

Agencies have made progress in setting up better billing processes, but errors happen no matter what the size or level of sophistication of the agency, Little warns. In his experience, clients have never had less than $30,000 in claims errors and the maximum found was over $200,000, Little reports.

The most common mistakes are significant changes in condition billed in error and episodes billed with fewer than 10 therapy visits expected, but 10 or more therapy visits provided, Little says. Many times both these issues are involved in the same claim, he adds.
Other errors to look for are erroneously downcoded therapy claims and incorrect partial episode payment adjustments.

**Concentrate On High Risk Areas**

Avoid mistakes in the areas that plague most home health agencies:

**1. Incorrectly billed SCICs.** Billing claims as a significant change in condition when you don't have to will cost you money, advises consultant **Terry Cichon** with **FR&R Consulting** in Deerfield, IL. Check to see if you are following the correct SCIC billing process, she suggests (see OASIS Alert Vol. 6, No. 8). If you have not been following this process, audit charts and correct the claims to find your lost revenue.

**2. Underpayment for episodes with 10 or more therapy visits.** Most agencies know their fiscal intermediary will gladly downcode claims in which 10 or more therapy visits were expected but not provided. But they forget to consistently check for claims in which they provided 10 or more therapy visits, yet did not expect to when they answered M0825 on the start of care assessment.

**Warning:** Even if you provided 10 or more therapy visits, you will not get paid extra unless you answered "1" (yes) on M0825, explains **Karen Vance,** occupational therapist and consultant also with BKD. If you did not, you must cancel the original request for anticipated payment and submit a new one with the correct answer to M0825, she advises.

**Tip:** Have a system in place for correcting M0825, experts stress. Remember, M0825 is only a best guess, so it is perfectly acceptable to change it. Changing it does not mean the patient had a SCIC.

**3. Erroneously downcoded therapy claims.** Check therapy claims that were downcoded because of fewer than 10 visits, Cichon recommends. Make sure all the visits were listed on the claim and documented. Of course, your intermediary is working to disallow visits when possible, but be sure the downcode is valid before you accept it.

**4. Wrong discharge status code.** One simple -- but costly -- mistake is to incorrectly code a final claim with a "06" discharge status code, Little says. This causes the payment to include a partial episode payment adjustment. Reimbursement for a PEP is based on the number of days between the first billable service and the last billable visit. The total episode payment is divided by 60, and the resulting amount is paid for each of the covered days. So an unnecessary PEP can be an expensive error.

**Caution:** Once you have billed an episode erroneously, be very careful to make corrections only after thoroughly 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, he adds.