OASIS Alert

Reimbursement: KEEP THERAPY DOLLARS FROM SLIPPING THROUGH YOUR FINGERS

The **Centers for Medicare & Medicaid Services** recently passed along some good news for home health agencies: Claims that the system automatically downcodes for patients who don't meet the 10-visit therapy threshold don't count as denials.

That means agencies can breathe a bit easier when answering "yes" to MO825 (therapy need), as long as their documentation shows they answered the question in good faith (see related story above), says the PPS Mailbox Q&A addressing questions from August 2001, recently posted to CMS' Web site.

Reasons Abound for Changes in Patients' Therapy Needs

There is a barrage of reasons why a patient who the agency sincerely thought would need 10 therapy visits could end up falling short of the mark, notes consultant **Pat Laff** with **Laff Associates** in Northbrook, IL. "Number one: The patient could expire, which is an automatic downcode," he says.

Another possibility is that the patient could transfer to a different agency during the course of the episode, Laff says. Even if the patient ends up receiving 10 therapy visits, you can't get credit for them if he receives the tenth from a different agency.

On a more positive note, the patient's condition could improve to the point that she doesn't need 10 therapy visits, Laff offers. That's great for the patient, and shows that you've been doing a great job caring for her but it also means the claims processing system automatically will down-code the claim and you'll miss out on the higher reimbursement.

Since none of these situations are the agency's fault, it makes sense that the downcode shouldn't count toward its denial rate. But claims that have HIPPS codes that medical reviewers manually downcode will count in an agency's denial rates, CMS explains.

Agencies definitely should not mark "yes" on MO825 as a matter of course, Laff urges. If the feds believe you're intentionally marking "yes" when you have reason to believe the patient won't meet that threshold, you might have to answer some pretty tough questions.

That's because you're effectively getting "sixty percent of a higher dollar amount" on the request for anticipated payment "and looking at it as an interest-free loan" you'll repay when you file the end of episode bill, he explains.

Keep in mind that while the system automatically will downcode patients who don't end up reaching the 10-visit threshold, it won't automatically upcode patients who do, notes consultant **Tuhin Sen** with **Sen & Associates** in Columbus, OH.

A clinician often will mark "no" on the original OASIS, but then due to a fall or some other reason the patient ultimately requires 10 or more therapy visits. In this case, the agency should file a significant change in condition (SCIC) adjustment, Sen instructs.

Another approach when faced with this situation is for agencies to cancel the initial RAP "and then refile with a corrected MO825 and get all their money," Laff says.

Editor's Note: The PPS Mailbox Q&A sets are at www.hcfa.gov/medlearn/refhha.htm.

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