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OASIS Alert

Therapy: Pin Down Reimbursement Numbers For Therapy -- Here's How

Use this chart to predict M0826 impact on cash flow.

If you're ready for the financial impact of therapy changes, you can focus more on preparing clinicians to match visit numbers to patient needs.

How your clinicians answer M0826 under the 2008 prospective payment system will be very different from answering M0825 -- and your bottom line will reflect that.

M0825 just asks whether the projected number of visits will meet the high therapy threshold, which is 10 or more visits.

M0826 requires clinicians to be much more detailed. It asks, "In the plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-pathology visits combined)?" The clinician must write in a specific number of visits.

Old way: If the clinician indicated a high-therapy episode in M0825, the **Centers for Medicare & Medicaid Services** paid about $2,000 extra, part of that upfront with the request for anticipated payment (RAP).

New way: Under the final rule, extra payment for therapy will begin with six visits. The other payment thresholds are 14 and 20 visits, but there are smoothing payments for visit numbers in between (see chart, p. 97).

"Managing profits by M0825 is over," says reimbursement consultant **Pat Laff** with **Laff Associates** in Hilton Head, SC. But therapy still matters under the PPS update. "The therapy piece still has a significant bearing on revenue," even if an agency furnishes only six or seven visits, notes consultant **Lynda Laff**, also with Laff Associates.

Fit Therapy Use Into The Equations

Under the new PPS rule, therapy by itself does not provide a specific reimbursement amount. CMS determines the amount depending on whether the patient is in an early or later Medicare home health episode, explains therapist **Cindy Krafft**, consultant with **Fazzi Associates** in Northampton, MA. An early episode is a first or second adjacent episode and a later episode is a third or more adjacent episode (see Eli's OASIS Alert, Vol. 8, No. 8, p. 74 for more detailed information about the four equation model).

CMS doesn't spell out what the pay differences are for the number of therapy visits per episode, but you can deduce that information from studying Tables 4 and 5 in the final rule, says consultant **Mark Sharp** with **BKD** in Springfield, MO. The number of therapy visits is the only M0 item that adds service points under the new PPS. So the only other piece of information you need to calculate the service piece of the home health resource group is whether the episode is early or late, he says (see chart, p. 96).

Example: An early episode with six visits is an S2 level (HHRG = CxFxS2) and Table 4 in the final rule shows S2 adding $608.54 to the PPS base rate for the episode.

Compare Current Episodes To Prepare For Financial Changes

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The complexities of the new therapy payment rules mean it's hard to predict the financial impact M0825 will have on your agency. Some agencies may see reimbursement drop overall. But therapy use is important to improving outcomes, and for many agencies the multiple threshold system will reimburse them better than the old system, Krafft says.

Determine the financial impact on your agency by comparing the reimbursement systems using current episodes -- which are still reimbursed under the old system -- experts suggest. (See chart below for a how much each list of therapy visit adds to the base rate after Jan. 1).

Don't Accentuate Finance

You may have to worry about how the new M0826 answers will affect your bottom line, but don't ask your clinicians to. Use the change to emphasize how therapy will be reimbursed at different levels to allow agencies to better match therapy with the patients' needs, experts say.

Concentrate your efforts on improving communication between nurses and therapists to allow them to better predict therapy needs, Krafft suggests. The focus should be on the number of visits the patient need.

And wait for the therapy evaluation before answering M0826, says consultant **Melinda Gaboury** with **Healthcare Provider Solutions** in Nashville, TN.

Warning: The financial incentive to provide more therapy visits means CMS will be watching agencies like a hawk to detect abuse of the new therapy-related reimbursement, experts predict.

Expect medical necessity edits from your intermediary and possible scrutiny from Program Safeguard Contractors, Sharp advises. Claims with six to eight therapy visits will be most likely to wind up in review, because the associated dollar amounts recouped if the visits

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