# OASIS Alert

## Therapy: THERAPY AUDITS PAY BIG FOR FEDS--ARE YOU READY?

**Look to three recent OIG audits for guidance.**

While you're concentrating on medical necessity for your high therapy patients, don't drop the ball on the basics--your intermediary is waiting to slam dunk an overpayment.

The **HHS Office of Inspector General** recently released the third in its series of audits of home health agency claims with 10 to 12 therapy visits. Through regional home health intermediary **Palmetto GBA**, the OIG determined that 22 of 100 such claims from a Florida agency were inappropriately paid, according to the report (A-04-05-02000).

**Total Patient Care Home Health in** Jacksonville, FL had 407 claims in fiscal year 2003 that included at least one therapy visit, and 200 of those claims contained between 10 and 12 therapy visits. When Palmetto examined a 100 claim sample at the OIG's request, reviewers denied visits for a variety of technical and regulatory reasons.

The 22 inappropriately paid claims total $43,088, the OIG says. Applied to Total Patient Care's universe of claims for FY 2003, the overpayment reached $63,425.

**Medical Necessity Not Enough**

After the first two OIG audits of high therapy use claims (see OASIS Alert, Vol. 6, No. 7), agencies expected medical necessity to be the reason for denial in similar audits in the future, says physical therapist **Cindy Krafft**, director of rehabilitation services for Peoria, IL-based **OSF Home Care**. But the newest audit presents a more complete picture, she tells **Eli.**

**Protect yourself:** In all the claims reviewed in this audit, the therapy visits were medically necessary, the OIG reports. Instead, the 22 claims downcoded had other fatal flaws--including problems with signing and dating doctor's orders, conflicts between visits ordered and those provided and incomplete or inaccurate records, the report shows.

• In six claims, the physician didn't date the orders or plans of care.

• In two claims, the claim was submitted before the orders were dated.

• In one claim, the physician didn't sign the orders.

• In one claim, the physician didn't specify frequency and duration or date the orders.

• In several claims, the agency provided services beyond the time specified in the orders or provided more visits than ordered. These visits were disallowed, dropping the number below the 10 visit threshold.

• Inaccurate home health resource group codes led reviewers to downcode three claims. And double counting a visit shot down another claim.

**Reviewers Push Hard To Cut Visits**

The OIG report clearly articulates why agencies should expect ongoing therapy audits.

For claims with 10 or more therapy visits, Medicare pays agencies about $2,300 morethan it would have paid them for

the same claim with nine or fewer therapy visits, the watchdog agency points out. "The money involved provides the government a strong incentive to knock the visits below the threshold," Krafft says.

In cases very close to the 10-visit mark, it's "easy pickings" for reviewers to deny a few visits for a variety of reasons, so agencies would be wise to audit these claims, advises Burtonsville, MD-based health care attorney **Elizabeth Hogue**.

**Example:** In one 11-visit claim, where occupational therapy made three visits in a week and only two were ordered, the reviewers denied all three visits for that week, not just the extra visit. This allowed them to reduce the number of visits below 10 and recoup $1,944 for that episode.

Note: The OIG report is at http://oig.hhs.gov/oas/reports/region4/40502000.pdf.