January 2005

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HEALTHCARE COMPLIANCE
+ NETWORKING INC.

DENIALS DUE TO CORF/ORF PATIENTS WITH AN HHA EPISODE OF CARE

Background:

You might have experienced some post-payment denials due to patients having an HHA (Home Health Agency) episode of care during the time you treated them. Medicare will deny the service to the CORF/ORF in order to pay the HHA, causing a recovery (overpayment) of the funds you already received for those treatments.

Although Medicare provides an online mechanism to check for eligibility, the information may not be up-to-date. When you go online, the patient may not show an HHA episode, giving you the false impression that you can treat the patient and bill for services. Ask your billing agent about the Medicare online service.

Conclusion:

To minimize these types of denials, do not rely exclusively on the online check. We suggest that you question the patient about receiving services from HHA, especially if you are providing therapy services away from your main facility. Some patients may tell you that they are not receiving rehabilitation services at all, but you must be certain that they are not receiving other HHA services (e.g. tech cleaning the house, nursing, etc.). You may want to remind the patient that they are ultimately responsible for their bill, and if you discover that they were under HHA care, you will invoice them if Medicare denies payment.

Perhaps the referring physician can assist you with this process. He or she may know if the patient has been referred for HHA. If you combine online checking with patient interviews, the number of denials should decrease.

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OIG 2005 WORKPLAN

The following topics are some of the CORF/ORF issues to be targeted by the Office of Inspector General (OIG) for the 2005 fiscal year. Here are some that may affect your provider:

- **Physical and Occupational Therapy Services**

The OIG will review Medicare claims for therapy services provided by physical and occupational therapists in order to determine whether the services were reasonable, medically necessary, adequately documented, and certified. HC+N can provide you with a comprehensive review of the clinical documents supporting the need of the service.

- **Therapy Services Provided by CORF**

The OIG will determine whether (CORF) physical therapy, speech language pathology, and occupational therapy services that were provided and billed for meet Medicare eligibility and reimbursement requirements. Prior OIG reviews revealed that Medicare paid significant amounts for unallowable, or highly questionable, therapy services in outpatient rehabilitation facilities and nursing homes. The majority of these services lacked sufficient documentation or they were deemed unreasonable and unnecessary for the beneficiary's health condition. HC+N can provide you with a comprehensive review of the clinical documents supporting the need of the service.

- **Rehabilitation Services for Persons with Mental Illnesses**

There is a significant increase in the costs and number of providers of rehabilitation services. At the request of CMS, the OIG will review the State's claims for Medicaid rehabilitation services for persons with mental illnesses. The OIG will check to assure these claims are allowable. The State Medicaid agency that is under review also reports payments for rehabilitation services made by three other agencies of the State. According to the OIG, scrutiny of claims from sister state agencies by the State Medicaid agency may be inadequate and increase the Federal financial risk.

- **Billing Service Companies**

The OIG will identify and review relationships among billing companies and the Medicare providers who use their services. They will also look at the various types of arrangements Medicare providers have with billing services, and determine the impact of these arrangements on the providers' billing practices.

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HOW OFTEN CAN YOU BILL?

— Transmittal 270, Dated 8/3/04
Implementation date 1/3/05

Frequency of Billing for Outpatient Services to FIs

Are you ready? Providers billing FIs, including CORF/ORF, shall bill monthly (or at the conclusion of treatment) for all repetitive Part B services. This also applies to hospice services billed under Part A. Monthly billing reduces CMS processing costs for relatively small claims and instances where bills are held for monthly review. Some examples of repetitive CORF/ROF services with applicable revenue codes include:

- Respiratory Therapy 0410 - 0419
- Physical Therapy 0420 - 0429
- Occupational Therapy 0430 - 0439
- Speech Pathology 0440 - 0449
- Cardiac Rehabilitation Services 0482, 0943
- Psychological Services 0900, 0901, 0911 - 0919 (in a psychiatric facility)

REMEMBER THIS QUARTER!

Your Medicare Credit Balance Report is due 30 days after the end of each quarter. Failure to file this report will result in 100% withholding of your Medicare payments! File with the assistance of your billing agent. For a copy of this report, as well as detailed instructions, go online to **http://www.hcan.net/documents.asp**
Look for the document titled, *Credit Balance Report*.

LOOK INSIDE FOR:

- 2005 OIG workplan affecting CORF/ORF
- Denials due to CORF/ORF patients with an HHA episode of care

want more information?

Visit **www.hcan.net** or call **904.398.0506**

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