

# Eli's REHAB REPORT™

The Practical Advisor on Reimbursement, Regulations & Business Strategies for Rehab Facilities

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## AUDITS

### Get Ready for CMS to Launch Its Full-Blown RAC Program

▶ *What every rehab provider should know about RAC audits in advance.*

CMS is counting on its recovery audit contractor (RAC) program to rake in masses of overpayments — and your practice's or facility's claims could soon be under scrutiny. Inpatient rehab was on RACs' radar from the start in California, Florida, and New York during the demonstration project. Now RACs are looking to go live, and their scrutiny will soon hit rehab providers in *all* settings across the United States.

#### Know Who's on the Docket to Scrutinize Your Claims

CMS just awarded contracts to four permanent RACs, the agency announced in an Oct. 6 press release. The contractors who made the cut are as follows:

- Diversified Collection Services, Inc. of Livermore, Calif., overseeing RAC Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York.
- CGI Technologies and Solutions, Inc. of Fairfax, Va., over Region B, initially working in Michigan, Indiana, and Minnesota.

*continued on next page*

## PRACTICE POINTERS

### 4 Things Every Rehab Manager Can Do to Prepare for RACs

▶ *It's never too late to improve your billing and documentation.*

Providers who think there's nothing they can do to prepare for CMS' recovery audit contractors (RACs) — since one can't go back and change claims — are mistaken. Take these steps to manage RAC audits efficiently so that if you do owe big bucks to Medicare, you're not also stuck with other surprise expenses.

**1. Determine your risk with a self-audit.** You can't change the past, but you can begin self-auditing claims samples to see where your risk is, says

*continued on page 91*

## AUDITS, continued

- Connolly Consulting Associates, Inc. of Wilton, Conn., over Region C, initially working in South Carolina, Florida, Colorado, and New Mexico.

- HealthDataInsights, Inc. of Las Vegas, over Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona.

**Take note:** The RACs, selected through a competitive process, get paid on a contingency fee basis on both the overpayments and underpayments they find. The Region A contingency fee is 12.45 percent, Region B is 12.5 percent, Region C is 9 percent, and Region D is 9.49 percent, points out **Rick Gawenda, PT**, director of PM&R for Detroit Receiving Hospital and owner of Gawenda Seminars and Consulting.

The “incentive model” created quite a bit of controversy in the demonstration period, but CMS assured it has selected the new contractors taking into account their technical strength, conflict of interest possibilities, and the competitive contingency fee.

But “how these folks get paid is not relevant,” says **Tim Johnson, MBA**, executive director of Castle Rock Medical Group, a Denver-based consulting firm specializing in RAC audits. “What matters is that they’re paid to do a job, and they’re going to do it.”

**Time frame:** CMS planned on adding more states to each RAC region in 2009, and Congress set a target date of Jan. 1, 2010, in the Tax Relief and Health Care Act of 2006 for a permanent RAC program to be in place. However, CMS released a notice on Nov. 4 that unsuccessful RAC bidders Viant Inc. and PRG Schultz, USA, Inc. have issued a protest of RAC awards to the General Accountability Office (GAO). Now CMS is required to impose an “automatic stay” on the originally selected contractors until the GAO makes a final determination. That means that the current RACs will have to pause any claims requests or provider education for now, Gawenda says.

The GAO has 100 days to issue its decision, so keep your ear to the ground in early February for more updates. “The four RAC contracts and any work under those contracts are on hold pending the outcomes of the protests,” CMS clarified.

### Know How RAC Audits Really Work

If you think that a RAC audit involves a team of people who make a one-stop visit to your clinic, and you pay a bill, think again. “RAC auditors don’t need to be physically there,” confirms **Richard Gundling, FHFMA**,

**CMA**, VP of thought leadership for the Healthcare Financial Management Association. And it’s not a one-shot deal, either.

RACs data-mine claims information from their own offices, based on industry weaknesses that CMS Quality Improvement Organizations and Comprehensive Error Rate Testing programs have flagged in the past, Johnson explains. “So in theory, you could get requests from a RAC in the mail to review certain claims every single day.”

**The good news:** CMS will be issuing limits on the number of claims RACs can request from each provider, Gawenda points out. CMS announced these limits on Oct. 29, and you can access them at [www.cms.hhs.gov/RAC/03\\_RecentUpdates.asp#TopOfPage](http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage).

You should also know how RACs make their decisions. “It’s not a discussion of medical necessity; it’s about payment criteria,” Johnson tells Eli. The RAC basically checks boxes to see if your documentation meets all the criteria for reimbursement, he says. “And it’s not a preponderance of the evidence — if your claim meets only seven of eight payment criteria, it doesn’t matter; you have to meet all eight of them.”

### Experts Predict Initial Targets

No surprise here, in the inpatient rehab facilities, RACs have been and will continue to be looking at joint cases, says **Fran Fowler, FAAHC**, president and CEO of Fowler Healthcare, an Atlanta-based partner of Health Dimensions Group.

And for outpatient rehab settings, claims with more than 8-12 visits are at risk. “RACs don’t differentiate between therapy for neurological problems where a patient could justifiably use 14 visits, versus musculoskeletal cases that use around eight visits,” says Fowler.

“The [top] thing we’re finding in inpatient rehab is that people simply are not knowledgeable with the requirements in the Medicare Benefits Policy Manual [Chapter 1, section 110] and their LCDs [local coverage determinations],” Johnson says. And “based on our proactive evaluations of hospitals, we believe that documentation of time and of short-term therapy goals will be targets in outpatient rehab.” RACs may even begin tracking hospital acute care stays and the percentage of patients appropriately admitted to rehab — and automate the denial process if they note a pattern, Johnson predicts.

**Note:** You can purchase an Eli-sponsored audioconference CD, on RACs with speaker, Rick Gawenda at [www.audioeducator.com/industry\\_conference.php?id=1297](http://www.audioeducator.com/industry_conference.php?id=1297). ■

## PRACTICE POINTERS, continued

**Fran Fowler, FAAHC**, president and CEO of Fowler Healthcare, an Atlanta-based partner of Health Dimensions Group. “You have to figure out where the money is going to come from to pay back the Medicare program.”

**Take note:** RACs have a three-year look back period beginning with Oct. 1, 2007, says **Rick Gawenda, PT**, director of PM&R for Detroit Receiving Hospital and owner of Gawenda Seminars and Consulting. So revisit claims from that time period.

You might also review your particular RAC’s Web site to see the patterns of improper payments they’ve uncovered, CMS advised providers.

**2. Gear up your staff for extra work:** Begin setting aside time to deal with RAC audits on a daily basis. “The amount of requests and activity that these auditors require is quite onerous, so you really need to have dedicated staff to oversee the process,” says **Richard Gundling, FHFMA, CMA**, VP of thought leadership for the Healthcare Financial Management Association.

Daily activities may include anything from addressing RAC notifications to reviewing their decisions to appealing, if necessary.

**3. Review your reimbursement criteria.** Experts stress that so many rehab providers still don’t know how to properly document and bill for their services. Make sure you’re not one of these providers. And even if your claims are squeaky clean, continuing education will not only bulletproof your claims going forward, but also help you choose wisely whether to appeal a RAC decision.

**4. Start planning for appeals.** Realize that appeals could be well worth your while — but that you could also “spend virtually another half-million appealing and still not have any of the overpayments overturned,” Fowler says. So decide a cutoff point of dollars in overpayments where it would be in your best interest to appeal.

**Important:** File an appeal before the 120-day deadline if you’re unhappy with an RAC determination, CMS reminded providers.

And if and when you find yourself fighting for deserved reimbursement, remember to reference the rules from the time period of the claims in question. “Some of the RACs in California were applying current payment rules to old claims,” Fowler warns.

Don’t let that be the case for you. ■

## CODING 101

# Say Hello to a New CPT for CRM Procedures

► *Learn important information on Medicare’s reimbursement decision.*

New CPT codes just came out, and therapists who work in vestibular rehab have something to be excited about. There’s now a procedural code to describe canalith repositioning, 95992 (*Canalith repositioning procedure[s] [e.g., Epley maneuver, Semont maneuver], per day*).

**What it is:** Canalith repositioning, or “CRM,” consists of specialized techniques to help relieve patients from Benign Paroxysmal Positional Vertigo (BPPV).

When a person has BPPV, small crystals, or otoconia, from the inner ear become dislodged and float into the canal system, inadvertently hitting sensory organs that, in response, send signals triggering eye movement to adjust for repositioning, explains **Christopher T. Morrow, PT, NCS**, with Pacific Balance & Rehabilitation Clinic in Seattle.

The result is vertigo and dizziness for a person lying down and then sitting up, or lying down and rolling over.

**The solution:** CRM is one of several techniques the therapist performs while watching the patient’s eye move-

ments for cues, using gravity to direct the otoconia out of the canals and into an area where the body can re-absorb them, Morrow says.

“This new CPT code is desperately needed for many reasons,” says **Deanna Dye, PT, PhD**, assistant professor and co-director of the Dizziness and Balance Clinic at Idaho State University. “First, the procedure is unique and has a clearly defined skill set. Second, the skill set for performing the procedure correctly should be valued greater than therapeutic exercise.”

Not to mention, there’s considerable evidence that these techniques are both cost-effective and effective at relieving BPPV symptoms, Dye adds.

### Choose Wisely What CPT You’ll Report

Most therapists have reported CRM as therapeutic exercise (97110) or therapeutic activities (97530), to describe what they did, says **Melissa Horton, PT**, owner and director of Carolina Balance and Rehabilitation Center

## CODING 101, continued

in Raleigh, N.C. Some have even coded CRM as manual therapy (97140) or neuromuscular reeducation (97112).

**Critical:** But that will have to change come Jan. 1, since 95992 more accurately describes CRM, and it would be fraudulent to code it otherwise. Unfortunately, CMS just released its preliminary version of the 2009 Medicare Physician Fee Schedule, and it considers the new code for CRM bundled into E/M services, thus it's not reimbursable for therapists for 2009.

That's too bad because the RUC committee recommended that CRM have a work relative value unit (RVU) of 0.75 — that's about .30 points higher than the current commonly used CPT codes for this procedure. *The good news:* "CMS will consider comments for 95992," the Final Rule says. So don't give up yet.

**Tip:** For what it's worth, if the code eventually does become reimbursable, note that you should not report it in conjunction with 92531 or 92532, which are evaluation codes for vertigo. Therapists don't even report these codes, but if you're a physician, a non-physician practitioner, or audiologist who can report these codes, keep alert. In addition, note that 95992 is not a timed code. The descriptor states "per day," which means you can only bill one unit per day per discipline.

**Don't miss:** On a slightly separate note, CMS also mentioned in the Final Rule that it has added the Category III CPT code 0183T (*Low-frequency, non-contact, non-thermal ultrasound, including topical application[s], when performed, wound assessment, and instruction[s] for ongoing care, per day*) to its code list of PT, OT, and SLP services.

### Beware of Potential ICD-9 Issues

Regardless of which CPT you report for CRM, make sure your therapy diagnosis is solid. "There is an ICD-9 code for BPPV (386.11), but therapists can't report that because it's a medical diagnosis," Horton points out. Unfortunately, there's no great functional ICD-9 code for therapists to use, so many providers will simply report 781.2 (*Abnormality of gait*).

But that's not even a great choice because although the patient may have initial dizziness when standing up, if he just has a straightforward case of BPPV, he doesn't really have a functional gait disorder, Horton explains.

**Another option:** There is also 780.4 (*Dizziness and giddiness*). Or, you can code the 386.11 if a physician performs the CRM and it's payable by the insurance payer. ■

## HOME HEALTH

### Watch Out: Home Health Therapy Makes OIG's Hit List

► *Use these 2 tips to avoid hot spot pitfalls.*

Your therapy visits could land you in hot water with the OIG as the watchdog agency increases scrutiny in this area.

The HHS OIG (Office of Inspector General) lists "Part B Therapy Payments to Home Health Agencies" as one of the five home health agency topics it plans to investigate in 2009, according to the new Work Plan for the year. "We will determine whether payments made to HHAs are correct and supported for the service level claimed," the Work Plan says.

"The fact that newly established therapy thresholds were applied to home health agencies in 2008 should not make it too much of a stretch to see that therapy services in general would be scrutinized," observes attorney **Marie Berliner** with Lambeth & Berliner in Austin, Texas.

The OIG may be concerned that therapy visits provided under arrangement are excessive, predicts **Lucien Bernard** with Pearson & Bernard in Covington, Ky.

The contracted therapist has an incentive to increase visits because he is usually paid per visit, and the HHA has an incentive to increase visits because under the

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✓ **Dec. 11:** Fran Fowler, FAAHC., presents **ENCORE: New Opportunities for Making Your Rehab Business Grow**

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## HOME HEALTH, continued

PPS revisions, many visit increases warrant a reimbursement increase.

**Tip #1:** “If your average number of therapy visits per episode has changed, you’d better be able to defend and justify the variance, especially now that the therapy thresholds have changed,” Bernard counsels.

**Tip #2:** “Review this information with the provider of their under-arrangement therapy services,” Bernard suggests. “Remind them that it’s in both of [your] best interests to provide appropriate and medically necessary thera-

py services.” If not, both the agency and the therapist are at risk.

The OIG also will look at Part B therapy services mistakenly paid for while a patient is under a home health plan of care.

**Note:** The Work Plan is online at <http://oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf>. Also, check out the news story on page 95 for a list of other rehab industry OIG targets. ■

## CODING CORNER

### Get a Sneak Peek Into the ICD-10 Format

#### ► ... and know what to expect for staff training.

You read about the controversial ICD-10 implementation planned for 2011 in the last issue of *Eli’s Rehab Report*. And rehab advocates are worried just as much as physician advocates. The American Physical Therapy Association (APTA) has asked CMS to delay implementation of ICD-10 until at least 2013, according to the Oct. 24 edition of *PT Bulletin Online*, APTA’s weekly newswire.

While there’s still more groundwork to lay, it’s not too early to start implementation planning, and preparation — and to take advantage of the lead time, says **Sue Bowman, RHIA, CCS**, director of coding policy and compliance with American Health Information Management Association (AHIMA).

#### Know Key Differences Between ICD-9 and ICD-10

- **More specificity.** Level of detail and specifics are greatly expanded in ICD-10-CM. But don’t let that scare you. While ICD-10 can provide greater specificity, it won’t require more detailed documentation. Other initiatives such as pay-for-performance and quality measures will require more detailed documentation, Bowman says. ICD-10 will simply provide the means for reporting it.

- **Newer terminology.** ICD-10-CM updates medical terminology and classification of disease to be consistent with medical practice.

- **More details.** With ICD-10, you can provide more detail with a single code than you can in ICD-9. Added detail makes ICD-10-CM more applicable to non-hospital healthcare encounters — a plus for coders in other specialty areas such as rehab. ICD-10-CM also adds the ability to

describe laterality (affected side of the body), particularly in the injury chapter.

- **More characters.** Codes in ICD-10-CM are all alphanumeric and can be up to seven characters in length. The seventh character, referred to as an extension, is used in some chapters to capture episode of care, such as initial encounter, subsequent encounter (or sequelae), and other additional information.

- **More combination codes.** ICD-10 combination codes provide detail that requires more than one code in ICD-9 format.

#### Plan Your Training Wisely

Once you’ve become familiar with ICD-10-CM and the way it works and looks, you’ll want to get some official training. But don’t get your staff trained too far in advance, warned **Joanne Byron, LPN, BSNH, CHA, CMC, CPC, CPC-I, MCMC, PCS**, CEO of the American Institute of Healthcare Compliance Inc, in an e-mail to members. If they can’t apply what they’ve learned, the “use it or lose it” factor will kick in.

**Best bet:** Wait until three to six months before the final implementation date, Bowman suggests. Two to three days of training should be adequate for trained ICD-9 coders to learn what they need to know to make the transition, and for coders who need to learn both ICD-10-CM and ICD-10-PCS, “we estimate five days of training,” she says.

Training could become quite expensive, but you can avoid unnecessary retraining cost by training one or two

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## CLINICAL REHAB ROUNDUP

### Try Activity Strategy Training With Osteoarthritis Patients

*“Effects of activity strategy training on pain and physical activity in older adults with knee or hip osteoarthritis: A pilot study.”* Murphy SL, Strasburg DM, Lyden AK, Smith DM, Koliba JF, Dadabhoy DP, Wallis SM. *Arthritis Rheum.* 2008 Oct 15;59(10):1480-7. Researchers at the University of Michigan Health Care System sought to examine effects of activity strategy training (AST), a structured rehab program occupational therapists use that teaches adaptive strategies for symptom control and engagement in physical activity (PA). Researchers conducted a randomized controlled pilot trial at three senior housing facilities and one senior center, studying 54 older adults with hip or knee osteoarthritis. Researchers randomly assigned participants to one of two programs: exercise plus AST (Ex + AST) or exercise plus health education (Ex + Ed). The programs involved eight sessions over four weeks with two follow-up sessions over a six-month period. Researchers assessed pain, total PA and PA intensity, arthritis self-efficacy, and physical function at baseline and post-test.

**Findings:** At post-test, participants who received Ex + AST had significantly higher levels of objective peak PA compared with participants who received Ex + Ed. Although not statistically significant, participants in Ex + AST tended to have larger pain decreases, increased total objective and subjective PA, and increased physical function, researchers noted. No effects were found for arthritis self-efficacy. Researchers concluded that although participants were involved in identical exercise programs, participants who received AST tended to have larger increases in PA at post-test compared with participants who received health education. ■

## READER QUESTION

### Don't Confuse Group Therapy With 'Dovetailing'

**Question:** *I've heard that long-term care settings can concurrently treat two patients with different care plans. Is this considered group therapy, and can this type of treatment occur in a hospital inpatient rehab setting? If not, what kind of group treatment is allowed, if any?*

— Arkansas Subscriber

**Answer:** Concurrent treatment as you described above is not considered “group therapy,” and therapists are not allowed to do concurrent treatment in an inpatient rehab facility. Concurrent treatment, also known as “dovetailing,” is only allowed in the skilled nursing facility setting, reimbursed under Part A benefits.

According to chapter 3 of the RAI User's Manual for skilled nursing facilities, a therapist in the SNF Part A setting can begin working one-on-one with a patient. Once the resident can continue with supervision, the therapist can move on to a second resident to get her started on a different task, while continuing to supervise the first resident. To count as supervision, however, the therapist must be able to make eye contact with the patients and offer verbal cues.

**Important:** “Time supervising the resident is a part of total treatment time,” The RAI manual clarifies. For example, as his last treatment for the day, a resident gets rehab on an exercise bicycle. The therapist takes two minutes

one-on-one to set the resident up with the cycling apparatus, then supervises the resident for two five-minute cycling periods while starting therapy (perhaps of a different kind) on another patient. The first patient takes a two-minute rest between the exercise periods and takes one minute to get out of the apparatus. The therapist should count the total therapy time at 15 minutes. “The key is that the resident was receiving treatment the entire time and had the presence of a therapist in the room, supervising the entire treatment process,” the RAI manual says.

Inpatient rehab facilities can still do *group* therapy, just not dovetailing. Legitimate group therapy in the IRF setting means that a therapist or a therapist assistant works with two or more patients at the same time doing the same things — and does not spend any significant amount of one-on-one time with either patient.

**Keep in mind:** In the IRF setting for Medicare and many other payers, what matters is that the patients receive three hours of skilled therapy on at least five out of seven days. Many payers would not consider a significant amount of group therapy, if any, as skilled therapy in the IRF setting, as the patient is supposed to require an intensive rehab therapy program.

— Reader Questions were answered by **Rick Gawenda, PT**, director of PM&R at Detroit Receiving Hospital and owner of Gawenda Seminars and Consulting. ■

## NEWS BRIEFS

### ASHA Tackles Special Needs Personnel Shortages

For organizations that are short on school-based speech-language pathologists and audiologists, a new Web site is here to help.

The American Speech-Language Hearing Association (ASHA) and the National Coalition on Personnel Shortages in Special Education and Related Services launched the Web site [www.specialedpros.com](http://www.specialedpros.com), which addresses personnel shortages of special needs children educators, announced a Sept. 11 news release from ASHA. The site also helps educators recruit and retain qualified personnel.

Currently, less than 20 percent of the 17.5 million children and youth in need of mental health services receive care, while shortages continue to grow, ASHA pointed out. Information on the site is geared toward administrators, school officials, policymakers, and others interested in addressing staff shortages in special education and related student services.

Specialedpros.com provides ratio data concerning specialized instructional support services personnel.

The site also includes current data on supply and demand across the special education and student services professions, certification and licensure requirements, model job descriptions, advocacy materials, and related resources.

### MAC Transition Proves Rocky for California Therapists

If your Medicare contractor hasn't yet transitioned to a Medicare Administrative Contractor, be aware of potential problems ahead.

Therapists in California experienced some major problems with the shift from National Heritage Insurance Corp to Palmetto GBA, according to the Sept. 26 edition of *PT Bulletin Online*, the American Physical Therapy Association's (APTA) weekly newswire.

To begin with, therapists had difficulties contacting the contractor's customer service department and experienced delays in processing enrollment applications.

Once enrolled, many providers were unaware of a new local coverage determination (LCD) they had to abide by and therefore received denials, APTA said. In addition, the new LCD had "an extensive crosswalk," in which ICD-9 codes were linked to CPT codes for reimbursement — and certain ICD-9 codes were excluded from coverage.

To top it off, providers and patients had difficulties determining dollars accrued toward the therapy cap, as

well as difficulties in resolving outstanding issues from the previous contractor, NHIC, according to APTA. Physical therapists in other parts of the country may experience similar problems as CMS implements contracting reforms, the *Bulletin* warned.

**The good news:** Palmetto GBA issued a revised LCD in response to APTA's and its California chapter's complaints, according to the Oct. 17 edition of the *Bulletin*. The revised LCD eliminated the existing ICD-9/CPT crosswalk and replaced it with a list of ICD-9-CM codes for reporting physical medicine and rehabilitation services.

Palmetto told APTA that if claims are denied due to the crosswalk and contain an ICD-9 code that is included on the new list of ICD-9 codes in the revised policy, it will reprocess those claims automatically and make the appropriate payment adjustment, the *Bulletin* said. ■

### OIG Has Its Eye on Rehab for 2009

The HHS Office of Inspector General (OIG) has once again released its annual laundry list of audit hot spots. This year, rehab providers in all settings should be on their toes. Items in the OIG's 2009 Work Plan included:

- **Inpatient hospital settings.** The OIG plans to review inpatient rehab facility payments, as well as coding and documentation for Medicare-Severity diagnostic related groups.

- **Home health agencies.** The Work Plan lists Part B therapy payments for home health beneficiaries as first on its list for HHAs. See the article on page 92 for industry expert tips on this area.

- **Nursing homes.** The OIG plans to review accurate RUG coding, and on the Medicaid side listed "plans of

*'Coding Corner' continued from page 93*

key people and having them train the rest of your staff, Byron suggested. Also, "secure a line of credit and financially plan in advance to cover expenses for the last quarter of the year of implementation of ICD-10."

**Good idea:** Change encounter forms as soon as your staff has completed their training, Byron said. "This will allow them to use what they have learned and reinforce their understanding of the new code sets."

Finally, "upload the new codes at least one month in advance, but use software security to prevent the codes from being assigned to dates of service prior to the effective date," Byron said.

**Note:** To view the ICD-10 codes, visit this site: [www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm). ■

## NEWS BRIEFS, continued

care: addressing minimum data set and resident assessment protocols through provided services.

- **Private practices.** The OIG promised to review outpatient physical therapy services provided by independent therapists.

Other items on the OIG’s list included reviewing Medicare payment for power wheelchairs, along with a slew of other kinds of durable medical equipment. The OIG will also review recovery audit contractors’ work.

**Note:** To view the entire 2009 OIG work plan, visit [www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf](http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf).

### Cahaba Gives Home Health Providers a DME Heads Up

If you’re a home health agency setting that’s frustrated by the documentation physicians submit to support your wheelchair claims, you may get some help soon — from the durable medical equipment (DME) Medicare administrative contractors.

“Power mobility devices ... continue to be a major medical review focus for the DME MACs,” intermediary Cahaba GBA pointed out in a message to providers. “Documentation by physicians of the statutorily required mobility assessment is often incomplete.”

Documentation forms recommended by “certain high-volume power wheelchair suppliers” often aren’t sufficient for claims, Cahaba warns. Instead, the intermediary recommends sharing with docs a three-page letter generated by the DMACs.

**Resource:** The letter reviews the eligibility and documentation requirements to support PMD claims. E-mail the editor, Lindsey Rushmore at [lindseyr@eliresearch.com](mailto:lindseyr@eliresearch.com) with “DMAC Physician Letter” in the subject line to receive a free copy of the letter. ■



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