October 2005

HEALTHCARE COMPLIANCE + NETWORKING INC.

news + updates

SELF EVALUATION

At least once a year, every CORF and ORF should perform a self-evaluation to ensure the facility is meeting Medicare's (CMS's) conditions of participation. First, contact your State's agency to gather information about requirements such as fire inspection, OSHA, privacy & security requirements, etc. Then, perform a self-assessment based on either CMS 360 (CORF survey questionnaire) or the CMS 1893 (ORF survey questionnaire). These are the questionnaires used by the State/Federal agencies' surveyors to perform onsite inspections in CORF and ORF facilities. **Be proactive; do not be caught off-guard!** You can download both forms from our web site: http://www.hcan.net/documents.asp.

STATUS OF THERAPY CAP

So far, the current moratorium on the therapy cap ($1,750 for PT and $1,750 for OT) is set to expire December 31, 2005. However, various associations are lobbying to have Congress step in and change legislation that would implement these caps. Congress delayed the cap on three different occasions. Hopefully, they will, at least, extend the moratorium so patients needing therapy will not have to choose between paying out-of-pocket for necessary care and halting their therapy.

This cap is arbitrary and only affects the neediest of PT and OT patients. It is our hope that members of the U.S. Senate and House of Representatives will pass the Medicare Access to Rehabilitation Services Act of 2005, repealing the cap. We strongly recommend that you contact your State representative and ask him or her to approve the bill and block the therapy cap.

PROPERLY COUNTING THE MINUTES IN THE MODALITIES

In order for a modality to be billable under Medicare's rules, duration of treatment must be at least eight minutes. The Fiscal Intermediaries and the OIG have denied claims and assessed overpayments when the time is less. When your quality assurance team reviews the charts, it is extremely important to ensure that time is properly documented and the modalities properly billed according to the payers rules.

Medicare states that for any timed, single CPT code, providers should bill a single 15-minute unit for treatment greater than or equal to eight minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes and less than 38 minutes, then you should bill two 15-minute units. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim	Number Minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

REMEMBER THIS QUARTER!

Your Medicare Credit Balance Report is due 30 days after the end of each quarter. Failing to file this report will result in 100% withholding of your Medicare payments! You must file with the assistance of your billing agent. You can download instructions and a copy of this report from our web site: http://www.hcan.net/documents.asp. Look for the document titled, *Credit Balance Report*.

tel 904.398.0506
fax 904.398.0503
4940 Emerson Street, Suite 200
Jacksonville, Florida 32207
www.hcan.net

want more information?

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