Three groups of codes for speech language pathologists

As a belated holiday gift, speech language pathologists will be receiving a gaggle of new codes for 2003. Set for implementation on January 1, these codes will better describe the procedures and services that pathologists provide their patients.

“We are very happy that the speech evaluation and therapy codes are in the book,” says R. Wayne Holland, EdD, CCC-SLP, of the American Speech-Language-Hearing Association (ASHA).

In the past, speech, language, and hearing therapy codes were listed under radiology and laryngology. Now the American Medical Association (AMA) has given pathologists their own section.

Over the next three pages BRRR will take a closer look at changes in cochlear implants, speech generating devices, and dysphagia.

Cochlear implants

Cochlear implants are one way to help patients who have trouble hearing. The AMA based the following codes for this

A Stark reality

Tips for handling the Stark regulations

The Stark law’s self-referral regulations have been around for a little more than a decade, and while they don’t have the same teeth as Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, therapists should be aware of the implications these rules may have on their practice.

The effects of Stark

The American Physical Therapy Association (APTA) is currently lobbying Washington lawmakers for specific billing codes so these same lawmakers can compare “apples to apples.” The APTA lobby is upset about unfair overbilling accusations that stem from a 1995 Office of Inspector (OIG) survey in Florida. In that survey (see box on p. 4 for more details), the OIG found that four out of five therapy services were unnecessary in 1994. Congress’ concerns about Medicare overbillings were the genesis of the original Stark legislation.

“Because of these overbillings, it was tougher to get reimbursement for therapy services,” says Michael P. Johnson, PT, MS, OCS, assistant professor of PT at the
Three groups of codes

surgical procedure on age:

- **92601.** Diagnostic analysis of cochlear implant for patients younger than seven years.

- **92602.** This code works in concert with 92601. It applies to the programming and subsequent re-programming of the device.

- **92603.** Diagnostic analysis of cochlear implant for patients over seven years of age.

- **92604.** Use this code the same as 92602, but in conjunction with code 92603, for the programming and reprogramming of the device.

The implant device mimics the mechanisms that a healthy ear uses to gather and provide information to the brain, Holland said recently at an AMA conference in Chicago. Through surgery, an ortholaryngologist implants this device in the patient.

Audiologist and faculty member at the University of Miami pediatrics department, Robert Fifer, PhD, said, “A patient’s hearing is not completely replicated, but the implant provides sufficient quantity and quality of information. The brain eventually learns to make use of [the information] to make communication much more efficient.”

With a device so delicate, it often takes a long time for the pathologist to find the correct setting.

“Part of the cochlear implant is a magnet, and that has to be specifically tuned so the patient can recognize certain sounds, whether it is the difference between an ‘f’ and an ‘s’ or how to recognize a whisper,” Holland said. “It can take as many as 25 visits to make these adjustments.”

Originally, the device’s programming and therapy were combined because the science had not progressed far enough, says Fifer. Now, the codes specifically separate programming the implant from providing a diagnostic analysis of the patient.

“Once the system is programmed, the therapy is done by audiologists primarily for adults,” Fifer says. A combination of audiologists and speech pathologists work on children. “Fundamentally, it’s teaching patients how to hear with the device and how to use it so that they can communicate and not be overwhelmed by environmental stimulation.”

While some speech pathologists see adults, Fifer says children account for the bulk of their patients because they represent a “clean slate.” In other words, they have zero language foundation. A speech pathologist must teach this patient literally how to hear by using activities that show the patient the differences between sound and no sound, high and low pitches, and rhythm. “The goal of the exercise is that the patient should be able to make distinctions of speech without looking at the speaker,” Fifer explains. “Use code 92507 for the rehab services.”

**Speech-generating devices**

There are more than 200 different speech-generating devices on the market today, said Holland. Some machines prompt a patient to use a touch screen to trigger a computerized voice to get their point across. Others use keypads attached to voice generators.

Use the following codes when billing for these devices:

- **92605.** This code shows that you’ve evaluated the non-speech-generating augmentative or alternative communication device the patient requires

- **92606.** This codes indicates that you’ve programmed and modified the device

Much like patients with cochlear implants, modifying the programming of these devices can take time. “It is not uncommon for the visits a patient makes to your office to be in the double digit range,” Holland explains.

To bill for face-to-face meetings, use
• **92607.** This is for the first hour of evaluation.

• **92608.** Use this code for each additional half-hour.

“These new codes for Augmentative and Alternative Communication [AAC] give speech-language pathologists a way to bill for AAC services,” said Dr. Carolyn Wiles Higdon, CCC-SLP, F-ASHA, interim department chair of the Department of Communicative Disorders at The University of Mississippi in Oxford and the chief executive officer of Dr. Carolyn Wiles Watkins, PC, a national practice that specializes in assistive technology, case management, and forensic rehabilitation.

“The codes better describe what exactly occurs in an AAC assessment or treatment.”

These codes are still awaiting assigned values. In the meantime, you must establish a learning curve with payers to see what they may deny.

Accurate documentation in both assessment and treatment remains the key to getting paid, said Higdon. AAC has been part and parcel of a speech pathologist’s toolbox for many years, and these codes are a tremendous boon to the speech industry for telling payers exactly what services a pathologist provided.

**Dysphagia**

For patients who experience problems swallowing, Holland said to use new fluoroscope and a fiberoptic endoscope inpatient and outpatient evaluation codes.

A fluoroscopy is an x-ray procedure done by a radiologist. It requires in-person observation by a speech language pathologist.

During the procedure, the patient swallows a variety of substances that contain barium-sulfate. This eases recognition when the pathologist watches for swallowing problems. If patients have swallowing problems, the speech pathologist instructs them to change their posture to assess the cause.

Use the following when performing this evaluation:

• **92611.** Evaluation code of a swallowing function, for use with a fluoroscope.

Radiologists make separate charges for their services.

Unlike the fluoroscope, the flexible fiberoptic endoscope is portable and uses real food instead of barium sulfate–laced items. The endoscope passes through the patient’s nasal passage and hangs down in the back of the throat so that the therapist can see inside, according to Nancy Swigert, MA, CCC, president of Swigert and Associates Inc., a Lexington, KY, private practice affiliated with the Central Baptist Hospital.

Because of the thick consistency and the way they show up on the readouts, food items such as milk or pureed peaches should be used to determine whether there is a blockage in the throat.

Use these codes when using an endoscope:

• **92612** or **92613.** Evaluation of swallowing using a flexible fiberoptic endoscope

• **92614** or **92615.** Laryngeal testing provided by a flexible fiberoptic endoscope

• **92616** or **92617.** Evaluation of swallowing and laryngeal sensory testing using a flexible fiberoptic endoscope

Some procedures may need a physician interpretation or report. However, according to Swigert, these interpretations and reports are a rare occurrence in which the doctor would want to jointly perform this evaluation with the speech pathologist.

“It can mean one of two things,” she explained. “Either the physician was physically there with the pathologist performing the evaluation or the physician reviewed a videotape of the study later.”

Speech pathologists would code their part with the first code in the above sets. If the physician either watched or participated in the evaluation, use the second code.
Stark

University of Sciences in Philadelphia and clinical specialist in the PT department at the Sister Marie Lenahan Wellness Center at Mercy-Fitzgerald Hospital in Darby, PA.

“But this wasn’t necessarily the fault of our profession. The billing codes aren’t specific in naming who has provided the services. PTs, athletic trainers, [and] doctors all can use the same codes.”

In addition to your coding and reimbursement practices being under tighter scrutiny, Johnson says the lax enforcement rules can also hurt practices.

“If you own your practice and there is a doctor-owned therapy practice down the street, you may not see any patients,” he reports. “Your biggest hope is that the city or town you practice in is large enough that other physicians can send business your way.”

Tell your congressional representatives why direct access is so important to therapists. “If direct access was ever granted nationally, we wouldn’t have to rely on doctors anymore for patients,” he says. “This would completely level the playing field.”

Currently, 35 states have direct access laws where patients can go directly to the therapist with a problem instead of first seeing a physician. In 2001 the APTA

The dawn of the Stark era

Lawmakers created the Stark self-referral laws to combat fears of Medicare fraud and abuse, says Michael P. Johnson, PT, MS, OCS, assistant professor of PT at the University of Sciences in Philadelphia. Physicians, he says, were investing in clinical laboratories and abusing the Medicare reimbursement system by ordering too many tests from the labs they owned. The more tests they ordered, the more money from federal reimbursements they received.

After investigating the matter, the courts wouldn’t define the physicians’ conduct as representing clear-cut fraud and abuse because the physicians had indirect ownership interests in these labs. However, Congress still wasn’t thrilled with doctors having a license to print money. The drafting of Stark regulations prohibited doctors from referring patients to themselves, to businesses where they have a monetary interest, or to practices run by family members.

“Initially, this only affected physicians as it related to their ownership of clinical laboratory services,” explains Johnson. “But then lawmakers began to think that self-referral problems could affect therapy services as well. Especially after doctor groups began to open therapy practices.”

A 1995 study of Florida therapy practices, run by the enforcement arm of the Centers for Medicare & Medicaid Services—the Office of Inspector General—compared the amount of physical services therapy being offered by therapy practices owned by PTs to therapy practices owned by physicians.

What the report found shocked federal lawmakers: Physician-owned therapy practices had 43% more per-patient visits, accounting for 31% more revenue than practices owned by therapists.

The report also found that four out of five therapy services were not even needed, accounting for $47 million in unnecessary therapy services in 1994.

Something had to change. And that’s when Stark II, named for Representative Pete Stark (D-CA) was born. It included 11 designated health services to which physicians could not self-refer, including PT, OT, and speech therapy.
sponsored H.R. 3363, which would allow all Medicare patients direct access to PTs. Contact your federal lawmaker to reiterate how important this rule is.

In the meantime, if you suspect that any doctors are referring patients to the therapy practices they partly own, letting the OIG know is like whistling in the wind—no one will hear you, Johnson opines.

“If a patient goes into a doctor’s office and tells [the physician] that his knee hurts, the doctor can provide therapy and call it an ‘incident-to’ service,” says Johnson. “The one thing you can do is to tell fellow therapists not to work for doctor-owned practices, especially if they don’t have the autonomy to make their own decisions.”

**APTA comes out against physician self-referrals**

According to Gayle Lee, the APTA’s associate director of federal regulatory affairs, watch out for these potentially abusive situations:

- When PTs or PT assistants are employed by referring physicians
- When the referring physician receives compensation either directly or indirectly as a result of a referral for prescribing or recommending physical therapy.

Consider these suggestions to avoid fraud citations:

- **Become a member of the ownership team.**
  Johnson poses this question: “If you work for a doctor-owned practice and are a valuable member of the team, why do you work for the doctors and not with them?” If you have the financial backing, approach the doctors and ask them whether you can become a member of the ownership team.

  This way, you will be on equal footing with the doctors and less concerned to say no if a boss asks you to bend your ethics.

- **Make sure you stick to your guns when discharging patients.** “Don’t continue to see patients if you think they no longer require skilled therapy services, even when the practice-owning physician is pressuring you to keep them for a little while longer,” Johnson says. “Not only is it a form of fraud, but it goes against all medical ethics.”

If this predicament arises, explain to the physicians why you think the patient would not benefit from more therapy. The doctor may have a different rationale for keeping the patient an extra week or so, and it may be something you overlooked.

Working with a physician is beneficial to you in this case. However, you may want to find a new practice if the physician’s reasons seem suspect.

“I’ve had plenty of friends who have worked for doctors and it has worked out well for them. But the physicians respected their opinions, which was key.”

**Getting ready for Stark**
The beauty of the Stark regulation is that you will not have to do much to get ready for it. This rule limits practices owned by doctors.

Be sure that your practice is run ethically, because you can get in trouble for fraud even if a doctor tells you to go along with unnecessary therapy. “Both the doctor and the therapist would be at risk for not meeting Medicare requirements,” says Lee.

“As a therapist, you have ethical obligations. If the doctor was doing the billing, chances are he or she would get into the most trouble, but Medicare would trace the services back to the therapist. These charges could seriously affect a therapist’s licensure.”

Another good thing about the Stark regulations is what you see is what you get. “From the people I’ve talked to, the Stark legislation is dead,” says Johnson.

“The rules have already been promulgated and there is nothing to tighten up.”

**Editor’s note:** The Centers for Medicare & Medicaid Services (CMS) pushed back the implementation date for Stark’s first phase to July 7, 2003. CMS wants time to reconsider the definition of advance compensation so it does not interfere with contracts already existing between physicians.
If you’re the trendy Hollywood type, chances are you know what Botox can do for your lips—namely, enlarge them for that chic, pouty look. But if therapy is your style, consider Botox injections to help speed up the rehabilitation process for your patients.

Botulinum toxin, Botox for short, isn’t for every patient, explains Kathy Graham, director of corporate communications at the Drake Center in Cincinnati. “We only use it for patients who have suffered a traumatic injury,” she says. “But this procedure has been around for a long time. At Drake we’ve been using it for over a decade.”

Consider this example for using Botox: A car accident causes a woman to slip into a long-term coma. When awoken, people find that the woman cannot bend her limbs.

When a person’s limbs stay in one position for a long stretch of time, it becomes difficult to maneuver them for the needed therapy. That is where the shot comes in.

“The injection releases the limb,” Graham says, explaining that the brain sends signals to the limbs when movement is needed. If movement stops for a length of time, the signals stop. Botox helps people regain that movement by sending signals to the brain. This is not a one-time shot, as each Botox injection lasts only three months. An injury’s severity will dictate how many shots a patient receives.

Who provides the shots? Physicians, not therapists, administer Botox shots. To find doctors who use Botox, Graham advises simple research.

“Contact your local medical associations to see who in your community gives Botox shots,” she says. “Also, you can use the Internet to gather information.”

Reimbursement
While you can’t bill for the shot administration, you can bill for the patient’s PT evaluation visit and weeks of therapy, says Ellen Harrington-Kane, MS, HSM, OTR-L, senior director of Medical Rehabilitation Services department of Easter Seals in Chicago.

“What usually happens is that the patients will have a medical evaluation from a physician who would determine that they need a Botox injection,” she says.

“In this process, the PT provides the patient with the therapy evaluation and any ongoing treatment. Right after the injection, the patient receives intensive therapy.”

At Harrington-Kane’s clinic, the PT and the physician see the patient in separate evaluations on the same day. This saves the patient from going to the therapist’s office one day, and the physician’s office the next. Following insurance authorization, patients return to the physician’s office to receive their Botox shot. Therapy starts immediately following the injection.

Botox isn’t just for the vain
Botox injections can help your patients recover quicker

Botox-eligible patients

Not everyone is a candidate for Botox injections. The Drake Center’s Medical Director of Neuro Rehabilitation, Dr. Thomas Watanabe, says patients who experience the following symptoms are ideal candidates for Botox therapy:

• Patients with focal spasticity—an increase of the normal tone of muscles with heightened deep tendon reflexes—who can only move a few muscles
• Increased function
• Improvement in positions

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These patients also experience spasticity, a chronic movement disorder that can interfere with functional activities, positioning, and bracing. This disorder causes pain and impedes normal movement. With Botox-therapy combination, patients have seen their levels of mobility and independence increase.

The other positive effects include the following:

- Improved walking speed and balance
- Reduction in pain
- Better sleep quality
- Increased range of motion
- Ability to position the affected limb more comfortably

“You are going to be stretching the muscles that have the spasticity and were injected with the Botox to increase range of motion,” says Harrington-Kane. “Then you will be working on strengthening the antagonistic muscle groups, the muscles opposite the spastic muscles.”

By the time the Botox injection wears off, your patient should have a better functioning muscle.

**Documentation**

Harrington-Kane says when documenting the therapy, make sure to note the Botox injection and, therefore, the need for intense therapy to optimize the effects.

“For an insurance [company] that requires an authorization or verification process, our clinic usually calls [the carriers] so they have an understanding of why we are providing intense therapy three times a week,” she explains.

**Tip:** Be sure that your patient’s insurance covers Botox therapy. Although many carriers are now on board with Botox for therapy, some still perceive it as an unproven injury treatment method.

**Patient benefits**

“Often, the results of Botox and therapy are very dramatic,” Graham says. “We have a jazz musician that comes to our facility and he couldn’t walk onto the stage. Now that he receives Botox injections, he is able to walk without his limp being so obvious.”

Botox works in conjunction with the other therapy the patient receives. Many patients who experience strokes, spinal cord or brain injuries, multiple sclerosis, and Parkinson’s disease, marry Botox with their PT.

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**Government updates electrical stimulation policy**

Reiterating a July decision memorandum, the Centers for Medicare & Medicaid Services (CMS) in November officially released the policy for electrical stimulation (e-stim) of wounds in Transmittal 161.

The new rule takes effect for e-stim services rendered after April 1, 2003. CMS says the e-stim coverage decision will apply to chronic ulcers in Stage III and Stage IV only. The following wounds are included in the coverage:

- Pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

The policy does not cover initial treatment modalities or any form of electromagnetic therapy for the treatment of chronic wounds. Medicare will only cover e-stim after you have tried standard wound therapy for at least 30 days without seeing any signs of healing.

Insert the new policy language on e-stim in your coverage issues manual. Go to [www.cms.gov/manuals/pm_trans/R161CIM.pdf](http://www.cms.gov/manuals/pm_trans/R161CIM.pdf) to see the memo.
HIPAA tip: Make sure to consult with patients before leaving phone messages

It’s not always easy to get in touch with patients, and practice staff often must resort to leaving messages on answering machines or with friends or family. But you don’t usually know who has access to those messages or whether patients want you to share information with others.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) doesn’t specifically address what information to leave in messages, but the minimum necessary standard requires you to release only the essential information to get the job done, says Jill Callahan Dennis, JD, RHIA, principal of Health Risk Advantage in Denver. “You don’t want to do anything to hurt the patient’s care.”

Staff should leave generic, innocuous information, she says. “You don’t want to give away the store.” Go over the policies and procedures for leaving messages with all employees who may do so as part of their job.

Dennis recommends the following:

1. Find out the patient’s preference.
Ask patients whether you should leave messages and how to do so, says Dennis. “Getting an up-front agreement is the best possible situation. Check with patients during their first visit to see what’s appropriate.”

Consider developing a form to indicate the patient’s instructions and periodically updating it.

Ask patients whether you should call a particular number or leave specific details, says Dennis. “Some patients might say ‘It’s just me at home. Go ahead and leave a message,’ or ‘It’s family. I don’t care if they hear anything.’ ”

2. Leave very little information.
In many cases, you can’t get an up-front agreement, says Dennis. “It may be the first time that you’ve worked with the patient or you’ve only talked to them over the phone.” In those situations, consider leaving the following message:

“This is therapist Smith’s office with a message for Ms. Dow. Please call us at 800/123-4567.”

“That’s about the best you can do,” says Dennis. “Don’t mention any appointment, because that starts to get you on a slippery slope, where you are giving away more and more information.”

3. Consider omitting the therapist’s name.
If you leave only a number, and don’t give any information about who is calling, you’re unlikely to get a call back, says Dennis. Patients may think the call is from a telemarketer. If you are concerned that leaving the therapist’s name provides too much information, try simply saying, “This is the PT’s [or OT or speech pathologist] office with a message for Ms. Dow. Please call us at 800/123-4567,” she says.

“It’s a little less information, but at least the patient has an idea that it might be a call he or she should return.”

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Using an internal or outside auditor—which is best?

When performing an audit of your practice, you have two options: Choose someone from your office to do the job or hire an outside consultant. Each choice carries pros and cons, says Emily Hill PA-C, president of Hill and Associates of Wilmington, NC.

Consider the following before you decide:

**Outside consultants**

1. Their opinions may weigh more with office staff. Your office workers are more likely to have greater confidence in private consultants, says Hill, because they have “been around the block more times.”

2. Consultants have more time to stay on top of their game. “Outside consultants have to stay abreast of changing rules. This is their job,” Hill says.

“They also have access to more newsletters on this subject and have more time to monitor government Web sites for new nuggets of information.”

3. Just an annual thing. If you belong to a smaller practice, you need to do only one audit per year. For this, bring in an outside consultant to look at the following:

   - A sample of medical records from the previous year. Include problem areas that your practice has not had the time to catch up with, or other mistakes.

   - Review charts that internal auditors have already looked at. The sampling of these charts should be small, says Hill, because external auditors ought to find the same mistakes that the internal ones find.

**Internal auditors**

1. A better understanding of your practice. “Internal reviewers works better with their own systems,” Hill says.

“They know how to access claims from the billing system, can research what actually happened to the billing, and know the contact people.”

2. Relationships. Pick someone whom your staff trusts. Sure, the experiences of an outside auditor are a benefit, but your workers may be more inclined to trust the motives of a colleague than an unknown does.

3. Size matters—especially when it comes to cost. Large practices should conduct multiple audits each year.

“If you are a large practice with a lot of auditing to do, it’s probably more cost-effective to have an internal auditor,” Hill says. “The average cost of an outside auditor is between $20 and $40 per encounter.”

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Get a life raft!
How to save yourself from drowning in a sea of documentation

Q We are overwhelmed in our clinic by documentation. The therapists constantly complain about the volume of patients we see, which is the cause of the mountains of documentation they have to write out. I have tried to streamline the process, but can’t seem to get anywhere with the hospital forms committee. We are a hospital outpatient rehab clinic. Do you have any recommendations as to how we can tackle this problem?

A Many providers have found that combining several forms into a master form helps considerably with documentation time. For example, combine the daily attendance log in the same form as the daily billing log and daily soap note.

But before you rush to do that, I would recommend a zero-based approach to determine the type of forms and records that you will need to document outpatient rehab.

A good place to start is with the Medicare documentation requirements. Medicare has basic outpatient rehab documentation requirements that are supplemented and interpreted by your Medicare payer—the fiscal intermediary (FI).

Your FI will probably have published a local medical review policy on physical medicine and rehabilitation, as well as occupational therapy and speech therapy.

Look to your FI’s Web site or on www.lmrp.net for rules and guidance on documentation requirements within these policies.

As a general guide, your medical charts should include patient medical and financial intake information, including a patient information release form.

From the time you begin treating the patient you should include the following:

• Evaluation forms
• Daily encounter notes and attendance records
• Progress notes
• A plan of care

Include a record of charges incurred daily, too.

The medical record should also include copies of exercise programs or home programs, and discharge notes.

As you develop these forms, always consider whether they will be efficient and useful, and whether they will comply with Medicare regulations.

Place special emphasis on your Medicare required plan of care form. While Medicare has published the 700 Form for this purpose, it is not required.

We strongly encourage providers to use the 700 Form format and include in it all of Medicare’s required plan of care elements. Most FIs highly recommend using this form, too. A well prepared plan of care can be your best ally if your charts are selected for medical review.

Medicare tends to have documentation requirements that exceed what other payers demand, but don’t automatically assume that your Medicare documentation will meet other payer guidelines such as workers’ compensation or various managed care plans. Check each payer’s requirements first.

Here are a few questions about incentives, including ones for our Medicare patients: Can we offer our patients transportation to our facility? What about other items, like a T-shirt with our logo on it as part of our wellness program?

A Offering incentives to Medicare beneficia-
On August 30, 2002, the Office of Inspector General (OIG) of the Department of Health and Human Services issued the following Special Advisory Bulletin, “Offering Gifts and Other Inducements to Beneficiaries:

“A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services, may be liable for civil money penalties up to $10,000 for each wrongful act. Remuneration, for the purposes of section 1128A(a)(5) of the Social Security Act, includes, without limitation, waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value.” [Congress enacted this section of the Social Security Act as part of HIPAA.]

Unless your T-shirt and free transportation incentive policies fit within the exception or are the subject of a favorable OIG advisory opinion covering a provider's own activity, any gifts or free services to beneficiaries should not exceed the $10-per-item and $50 annual limit rule.

The OIG is, however, considering a new exception for local transportation offered to beneficiaries in their local area. Until then, transportation remains a problematic issue and I recommend the opinion of a legal expert in the area of Medicare fraud and abuse.

Go to www.oig.hhs.gov/fraud/fraudalerts.html to download the bulletin in a PDF format.

These questions were answered by Nancy J. Beckley, MS, MBA, president of Bloomingdale Consulting Group in Brandon, FL. Submit questions to Byron Magrane, BRRR associate editor, at bmagrane@hcpro.com or complete the form below and fax it to 781/639-2982.
**HHS announces 2003 rates for SMI program**

The Department of Health and Human Services announced the 2003 monthly actuarial rates for aged and disabled enrollees of the Medicare Supplementary Medical Insurance (SMI, or “Part B”) program on October 21.

The rates are as follows:

- $118.70 for aged enrollees (patients over the age of 65)
- $141.00 for disabled enrollees (disabled patients under the age of 65)

Part B Medicare pays all or part of the costs to a number of providers, including comprehensive outpatient rehabilitation facilities, for certain medical and health services not covered by hospital insurance. These rates become effective January 1, 2003. Go to www.access.gpo.gov/su_docs/fedreg/a021021c.html and look under the Centers for Medicare & Medicaid Services heading to see the full memorandum.

**Hawaiian auditor wants to end state regulations for OTs**

To many, Hawaii is a tropical paradise, and if a state official has her way it may become a paradise for OTs, too. In early November, Hawaiian state auditor Marion Higa recommended that the Aloha State end any regulation of OTs. Higa told the Associated Press that there has not been one complaint about the state’s nearly 300 registered OTs.

Hawaii’s registration law, which requires OTs to register with the state, is classified as a sunset law that expires after a number of years. This law is set to end next year. If lawmakers disagree with Higa and decide to keep the registration law, she hopes changes will be made. The biggest change would be for officials not to equate state registration with state licensure.