



Challenges in Medicare Part B World

by Ray Sierpina, Senior Director of Government Programs, and
Mary Van de Kamp, Vice President of Clinical Services


In early December, Congress passed legislation extending the Therapy Cap Exception Process through 2007. This legislation is an interim solution. Many national professional organizations have been working closely with members of Congress to determine an alternative to the therapy cap. Peoplefirst has taken a leadership role with members of Congress and professional organizations in developing a solution that focuses on clinical outcomes as opposed to arbitrary spending limits. Congress looks at the national clinical leadership in rehab companies for an alternative process that supports appropriate payment based on clinical need. In addition to congressional activity, Peoplefirst will be participating in a national outcomes study with the National Association for the Support of Long Term Care to support this initiative.

While addressing the therapy cap issues, Congress also passed legislation that eliminated the 5.1% scheduled reduction in the Medicare Physician Fee Schedule. Unfortunately, this did not completely mitigate the reduction in payment. Some reduction occurred when CMS re-assessed the value of many commonly used therapy CPT codes. The reduction varies anywhere from 4-5% over last year.

In addition to the Medicare B cap issue, interest in payment for healthcare services delivered across the post acute setting is an ongoing conversation in Congress.

Common topics up for discussion with Congress are:

- standardized assessment criteria that follows the patient through numerous post-acute settings
- disjointed payment systems creating improper incentives
- safe and appropriate placement in the least costly setting
- cost reduction
- SNF market basket adjustments
- appropriate implementation of the 75% rule
- RUGs refinement

Clinicians and professional organizations must support research and data collection that quantifies the skilled nursing facility value proposition, helps refine post-acute quality outcomes measures, and supports a focus on quality. Using this data, clinical leadership must develop a proposal that is sustainable for comprehensive long-term care benefits. Rehabilitation providers must demonstrate a clinical and financial value proposition with regard to rehabilitation services provided to medically complex post-acute patients. Peoplefirst has already taken a leadership role in this process and will continue to work with our customers, professional organizations and Congress to support appropriate payment across all settings. 



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It's All About Putting People First.



Integrating New Technologies While Managing the Risks

by Glenda Mack, Rehab Clinical Consultant

On a daily basis, most geriatric healthcare facilities deal with an onslaught of new technology options and demands from all sides – from vendors, conferences, employees and physicians, to name a few. Very often, there is little or low quality research to support the implementation of new technology. Other times, the technology has a very strong research foundation to support its validity; however, the payment systems, specifically Medicare and Medicaid, have not caught up with technology. These are struggles that are very familiar to Peoplefirst. Much of the new technology appropriate for use in geriatric settings have rehab implications, and, therefore, require a rehab company that understands all the complexities of introducing technology advancements into the geriatric settings.


Some of the more recent challenges we have faced are electrical stimulation for dysphagia, light therapy for wound care and peripheral neuropathy, negative pressure wound therapy devices and low frequency ultrasound for wound care. All have different levels of research to support them, but each has multiple other considerations as well.

Specifically:

1. Has the research been accepted into peer-reviewed journals? If so, who funded the research? What is the type of research – randomized controlled trials versus case series?
2. Is there a National Coverage Determination from the CMS? If not, is there a Local Coverage Determination from your intermediary? Does Medicaid reimburse? If not, is this part of a per diem payment, or is it separately billable?

3. Which clinical role, physician, nursing, dietitian, physical therapist, occupational therapist, speech language pathologist or other has the appropriate clinical expertise to implement the technology safely and effectively?
4. Is this technology something that will improve outcomes, or are we already providing advanced technologies with great success?
5. What is the cost benefit of this new technology versus standard of care or other treatments we may be doing for that condition?
6. If this is not a Medicare-approved service, are you going to issue an NEMB form and bill the patient/family privately?

As you can see, there are many questions that must be answered before considering implementation of new technologies. At Peoplefirst we believe that new technology must be thoroughly reviewed. When there is evidence to support its use, it should be implemented strategically. We work very hard with our customers to provide support and resources. We want to ensure that implementation, sometimes very costly, achieves the best clinical and financial outcomes for our customers.

Providing excellent healthcare services is dependent upon a balance between knowing what works currently and knowing when it is time to introduce new clinical treatment opportunities into your setting. State-of-the-art care depends on providers who are willing to adopt new technologies early and work with vendors to maximize the overall value of that technology when there is evidence to support its validity. 

For more information, please contact:

Jerry Yarnish

Vice President, Business Development

888.836.8917 Office • 407-256-0461 Mobile

jerry.yarnish@peoplefirstrehab.com

Please visit us at:

www.peoplefirstrehab.com