The Peoplefirst Press

Peoplefirst Rehabilitation

A Quarterly Newsletter Provided by Peoplefirst Rehab

2nd Quarter, 2005

Changes in Medicare Claims Appeals Process

On March 8, 2005, the Centers for Medicare and Medicaid Services (CMS) published in the Federal Register an interim final rule to change the Medicare Claims Appeals Procedure. Medicare beneficiaries and, in some circumstances, providers of healthcare services have been able to appeal adverse determinations regarding claims for Medicare benefits. This new rule changes the current procedures and sets down the timetable for implementing these changes. It is extremely important that all providers of healthcare services understand these changes, as failure to properly appeal an adverse determination will result in the provider not being paid for legitimate services delivered.

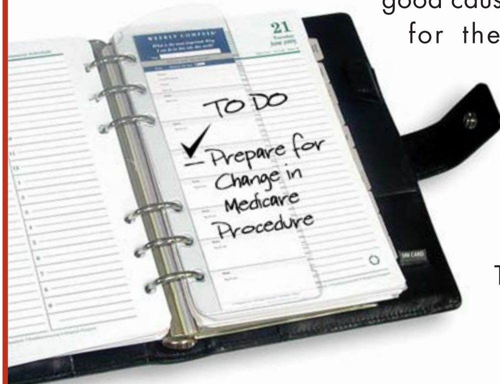
These new rules also establish a uniform appeals procedure for both Medicare Part A and Part B, including a new appeals level for Part A.

Quality Independent Contractors (QICs)

CMS has established new entities, QICs, to conduct the second level of administrative review of claims denials made by fiscal intermediaries and carriers. This second level is referred to as Reconsideration. Previously, there was no second level for Part A. Part A appeals went straight to the third level, the Administrative Law Judge (ALJ) level. The first level is now referred to as Redetermination.

Early Introduction of Evidence

Providers and beneficiaries represented by providers must now present by the QIC (second) level all of the evidence they believe should be considered in the appeal. Unless good cause can be established for the failure to timely introduce evidence, no new evidence can be introduced at higher appeals levels.



The purpose of this change is to expedite the process by making a case at the earliest possible appeals level.

Reduced Decision-Making Time Frames

CMS is requiring that the decision-making time frame be significantly reduced at all levels of review and appeal. Fiscal intermediary and carrier reviews must now be completed within 30 days of the receipt of requested additional documentation. Redeterminations and QIC Reconsiderations must be processed within 60 days. This will give providers a set timeframe in which to expect the results of an appeal.

Transfer of ALJ Functions to the Department of Health and Human Services (HHS)

The functions of ALJs will be transferred from the Social Security Administration to HHS. ALJs are required to be organizationally and functionally independent from CMS. However, this is seen as a means to make the ALJs more responsive to Medicare and less responsive to beneficiaries and providers.

Implementation of Changes

Implementation of these changes will occur in several stages. Effective May 1, 2005, all Redeterminations made by fiscal intermediaries will be subject to QIC Reconsideration. The transfer of ALJ responsibilities will occur sometime between July 1 and October 1, 2005.

People*first* and Medicare Appeals

The People*first* Client and Clinical Services staff has significant experience in handling Medicare appeals and in assisting our clients in responding to them. If we can be of assistance to you, please contact our National Director of Client Services, John Eanes, at 678-393-3916 or email him at john.eanes@kindredhealthcare.com.

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Talking Points for an SLP Discussion

1) DYSPHAGIA INSTRUMENTATION

(Modified Barium Swallows and Fiberoptic Endoscopic Eval of Swallowing)

***The Question:* What is our facility's percentage of patients with pharyngeal phase dysphagia who have instrumental assessment completed?**

Background: Following CMS Guidelines, instrumentation should be completed for all patients presenting with a pharyngeal dysphagia. Reasons for recommending dysphagia instrumentation should be documented.

If instrumentation is not completed or recommended, the clinical rationale should be reasoned through and documented.

If there is a wait time for instrumentation, determine what treatments are appropriate to implement while waiting. If there are none appropriate, the patient should be placed on Medical Hold following PF policy until instrumentation can be completed.

Options to consider for completion of dysphagia instrumental assessments include nearby acute care facilities, potential use of mobile modified barium swallow studies, portable fiberoptic endoscopic eval of swallowing, and Kindred Hospitals as a referral for dysphagia instrumentation.

Refer to Peoplefirst Clinical Service Bulletin Criteria for Dysphagia Instrumentation Assessment.

2) DOCUMENTATION REQUIREMENTS

***The Question:* Given that prior level of function and treatment history are important points for rehab documentation, do you believe our facility receives adequate information on these points? If not, how shall we seek to obtain it?**

Background: Prior level of function should include discipline-specific status descriptions for communication, cognition and swallowing. Previous treatment history should include the type of treatment received, the timeframe and the outcomes/results of that treatment. Networking and effective communication between referring facilities (nursing and SLP staffs) and patients/families will ensure an accurate picture of the patient's prior level of function and details of previous treatment.

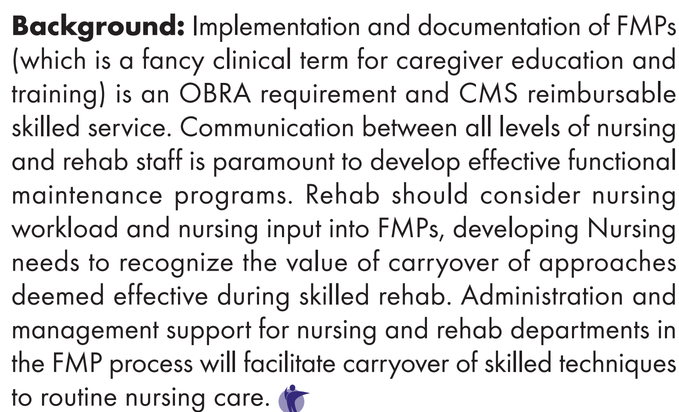
3) NUTRITION, HYDRATION DYSPHAGIA AND COGNITION

***The Question:* Do you believe weight loss is a reason for skilled intervention of the SLP?**

Background: Weight loss is a consequence of impaired nutrition and hydration. For skilled SLPs, poor nutrition and hydration are due to either an underlying dysphagia or impaired cognition or both. It is the SLP's job to discover the impact (if any) of dysphagia and/or cognition on nutrition and hydration and, subsequently, weight loss. Therefore, SLPs do not pick up residents for weight loss, but for the swallowing and/or cognitive difficulties a resident may endure that leads to weight loss.

4) FUNCTIONAL MAINTENANCE PROGRAMS

***The Question:* How can our facility step up our functional maintenance programs (caregiver education and training)?**



Background: Implementation and documentation of FMPs (which is a fancy clinical term for caregiver education and training) is an OBRA requirement and CMS reimbursable skilled service. Communication between all levels of nursing and rehab staff is paramount to develop effective functional maintenance programs. Rehab should consider nursing workload and nursing input into FMPs, developing Nursing needs to recognize the value of carryover of approaches deemed effective during skilled rehab. Administration and management support for nursing and rehab departments in the FMP process will facilitate carryover of skilled techniques to routine nursing care.

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