

The New Dimensions Quarterly Quarterly

“Your partner in today’s changing healthcare environment”

Looks Like Medicare Part B Therapy Cap Feels Like Part B Therapy Cap—Here We Go Again!

Special points of interest:

- Physician fee schedule is frozen, so no cut in 06, but no 1% addition.
- Therapy caps go in effect January 1, 2006 under current law, but an exception process is identified. If justification warranted a physician order can be given if the patient has met the cap and still needs Secretary approval.
- The capped rental for DME is limited to 13 months (identical to Senate), and then the beneficiary may purchase certain DME products.
- A three year demonstration project is authorized for all post acute settings to analyze costs and outcomes after hospitalization.

As of Sunday January 1, Medicare will cap outpatient rehabilitation coverage at \$1,740 for physical and speech-language pathology services and \$1,740 imposed on occupational therapy services, but will be with a caveat. Under the new provision, Medicare beneficiaries would not automatically be entitled to exceed the \$1,740. Instead for 2006, a beneficiary would have to apply to the Secretary to exceed the cap and would have to show that exceeding the cap is medically necessary. If the Secretary fails to decide within 10 business days of receipt of the request to exceed the cap, then the services are deemed to be medically necessary and the cap may be exceeded.

arises under the rule is whether a beneficiary would have to wait for the Secretary’s favorable determination before exceeding the cap or the “BIG” question may the beneficiary exceed the cap and simultaneously apply for relief from the cap? The language, while ambiguous, favors an interpretation that would permit a beneficiary to accept the therapy while simultaneously seeking relief from the cap. Specifically, the phrase, “if the provision of such services is determined...” appears to contemplate both services that have been performed and services to be performed. There is not tense marker that restricts the scope of exception. Secondly, we understand that here might be a question as to whether a beneficiary suffering from a chronic condition could petition for relief from the cap at the start of receipt of ser-

vices rather than forcing the patient to wait until the cap looms near. Again, there is nothing in the language that would preclude a patient from requesting relief from the cap at the onset of treatment. The language merely states that the Secretary’s duty to act on a request is triggered “upon request of the individual...from the uniform dollar limitation...if the provision of such services is determined to be medically necessary.”

There are still many unanswered questions and a lot of gray matter. We need to proceed into 2006 as if we are tracking cap dollars utilized. Hopefully in January we will receive clarity or a moratorium until we can implement a appropriate system to deal with Part B therapy services. Stay tuned!

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There are implementation issues that obviously need to be worked through. One issue that

Other January Regulatory Provisions That Are In Effect For SNFs

Other January 1, 2006 provisions that will be in effect are that claims for the Physician Fee Schedule services will be paid with a 4.4% reduction from the 2005 levels. Also, capped rental items for DME and oxygen will remain unchanged. Under current law, certain cap

rental items of DME are paid for on a rental basis for up to 15 months, but the beneficiary has the option of electing continued rental or purchase at month 10. The bill would eliminate the rental option and require suppliers to transfer the title after 13 months. Additionally, oxygen

which is currently rented indefinitely would be capped at a rental period for thirty-six (36) months had the legislation gone into effect.



Challenging Medicare A & B Denials



What to do???

“If you disagree with a decision, it is possible to submit a request to the next level”.

If you disagree with a decision, it is possible to submit a request for the next level of appeal, which is a hearing. Part A requests can be forwarded to the (ALJ) Administrative Law Judge of the Social Security Administration. Part B claims should be forwarded to the hearing officer with the carrier the claim is being processed through.

When submitting an appeal to the hearing officer for Medicare Part B claims, you must submit either a signed “Request for Part B Medicare Claim Form” or you can forward a signed letter requesting a hearing and the reason you’re dissatisfied with the appeal determination. You can choose from three types of hearings. They are:

- 1.) On-the-record. A decision is made using the facts contained in the hearing file. This includes all the information from the time the claim was completed to the time the hearing was requested.
- 2.) Telephone. Oral testimony is presented over the telephone. The testimony is taped so there’s no question about what was said during this hearing.
- 3.) Personal Appearance. The claimant and/or his representative gives testimony in a face-to-face meeting with the hearing officer. These hearing are also

taped.

Most providers choose telephone hearings for several reasons. The first is always cost and you also lose valuable work time. With a telephone hearing, you can speak with the hearing officer and justify the services rendered. The hearing officer can likewise ask questions about the claim. The officer must then render a decision within 30 days of the phone hearing. This then speeds up the process for potential payment.

With on—the-record hearings, you’ll have to wait at least 120 days for a decision. In person decisions are always 30 days after the date of the hearing.

If an appeal for a Part A and Part B claim is denied, you may then request and in-person hearing before an ALJ who’s employed by the Social Security Administration Office of Hearing and Appeals Division of Medicare. To do so, submit a request before the ALJ within 60 days from the date of the hearing officer’s decision or the reconsideration denial date. The hearing officer’s determination letter or reconsideration letter will include instructions on how to request an ALJ hearing and where to mail the request.

A signed letter requesting a Part A or Part B ALJ

hearing . Be sure to resubmit the required documentation to support your appeal. For appeals before the ALJ (Part A & B claims) or before a hearing officer (Part B claims), the amount in questions must be at least \$100.00. This is minus deductibles and coinsurance amounts..

If you disagree with the decision of the ALJ, you can appeal to the next level—the Medicare Appeals Council at the Departmental Appeals Board. You will need to follow the directions on the decision letter mailed to you. If an MAC/DAB determination is unfavorable, an additional letter will be provided with directions for the next step of appeal.

The final level is going to the Federal District court. The timeframe to submit this appeal is 60 days from the MAC/DAB determination date. The amount in question must be at least \$1,000.00. All carriers and FIs should follow the time frames for the different levels of appeals.

Remember, you can avoid all of this by submitting the complete medical record to Medicare. Do so within the allotted time frame and provide documentation that supports skilled therapy services and functional improvement of the patient.



The key elements of the new RUG refinements are that they go into effect January 1, 2006. We get the full (3.1)% market basket update. There have also been no changes to the Look-back or Grace Days. Payments

from 10/1/05–12/31/05 are based on the existing RUG-44 system, including 3.1% market basket updates. There were nine (9) new categories added that would classify candidates into extensive services. Patients

to qualify for the new Rehab plus extensive services require skilled level of care, therapy services, qualify for extensive services category and have ADL count of 7 or above.

IN BRIEF—NEW RUG REFINEMENT UPDATES

The Five Pillars Of Organizational Excellence

In today's world of business good is no longer good enough. To survive in today's environment, your organization needs to excel. In order to do this, an organization needs focus on all parts optimizing the use and effectiveness of all of its resources.

Times have changed and our thinking about the way we manage our improvement activities has to change. Good is not good enough. **Only the very best will attract customers in today's competitive healthcare environment.** We have to excel in all parts of our healthcare organization. We must have an organization the "wow" the customer, not just satisfies them.

Customers will remember your company's name under two conditions and under two conditions only: 1.) When you produce an extremely poor product or service. 2.) When you produce an exceptional product or service.

If you just meet their requirements you do not build customer loyalty. Your customers can be attracted away from you if your competition undercuts you by a few cents. Boy, does the contract rehabilitation business know this. You have to have an organization that radi-

ates excellence in everything they do.

Organizational excellence is designed to permanently change the organization by focusing on managing the five key pillars of the organization. The pillars are:

1. Process management
2. Project management
3. Change Management
4. Knowledge management
5. Resource management

By effectively managing these five key pillars and leveraging their interdependencies and reactions an organization can bring an amazing transformation within itself.

"Today, more than ever, knowledge is the key to organizational success".

In following Issues of the "New Dimensions Quarterly" we will address each of these pillars of success in detail.

While we mentioned the five pillars that must be managed to achieve excellence, there are a number of things that run across all of them that need to be achieved in this process.

1. Communication
2. Teamwork

3. Empowerment
4. Respect for one another
5. Honesty
6. Leadership
7. Quality
8. Fairness
9. Technology

All the key factors are built into the word "**management**". It is all the things that turn an employee into an individual who owns their job, thereby bringing satisfaction and dignity to the individual for a job well done.

Customers are concerned about the products they purchase, but they are equally or more concerned about dealing with organizations who care, who care about a quick response, and a group who will listen and react to their unique needs. This is not "ROCKET SCIENCE"! This demands that, in order to succeed in today's market. You must have an organization that excels at what it is doing, and also is recognized for its excellence to win today's savvy customers. Please read further issues for more to come.

This shortened version of the article, which originally appeared in Handbook of Business Strategy, Volume 6 Number 1, 2005. The Handbook of Business Strategy is an annual publication that provides senior level management insight into their most critical issues.

"Only the very best will attract customers in today's competitive healthcare environment"



Appraisals in the Workplace

Each performance management appraisal system will be different, because each company is different. However, there are some key elements which appear in every well constructed system. The checklist below lists these factors. Check them against your own system to see if you are getting the very best for your staff.

1.) An appraisal system should have full support of senior man-

agement.

- 2.) The system should first be piloted and then reviewed.
- 3.) Intentions of the system should be clearly communicated to the staff.
- 4.) The system should have clearly established aims and objectives that are linked with the business strategy.
- 5.) The system should follow a cycle of defining the performance that is required, measuring

- and evaluating it, giving feedback and sharing information with other parts of the organization.
- 6.) The system should have simple and easily understood documentation supporting it.
- 7.) The appraisal system should not be part of the standard disciplinary procedures of the company.
- 8.) The system should be adapt-

-able and encompass all levels in the organization.

9.) The appraisal system must be subject to ongoing monitoring, review, evaluation and updating. Remember, that as your business evolves, so must your appraisal procedures. Bottom line, staff should feel at ease because they work for a company that helps them do their job.



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