Blue Cross Reviewers Clarify Statements in Medicare Article

As occupational therapy consultants and medical reviewers to Blue Cross of California in its role as a fiscal intermediary for the Medicare program, we are concerned about the adversarial tone and the incorrect portions of the article by Lori T. Anderson entitled "Appealing Medicare Denials," which appeared in the June 1988 issue of the American Journal of Occupational Therapy.

At a time when occupational therapists have achieved increased recognition as a Part B provider of service (including independent practice) and the Health Care Financing Administration (HCFA) has approached AOTA to develop guidelines for outpatient occupational therapy services, we feel it would have been more beneficial to present information on Medicare and appeals in a factual and collaborative manner.

As Medicare reviewers, we have not received information or felt pressure from HCFA to increase our denial rate. On the contrary, we receive a great deal of information reinforcing the mandate that we follow the existing guidelines, and we are audited in our Contractor Performance Review on those guidelines. No Medicare policy or factual evidence is presented in this article that justifies the inflammatory statement on the "alarming increase in arbitrary denials" (p. 358). The article presented a single case which does not specify the type of treatment given or the amount of assistance that was required by the patient. A patient performing at a high level of function (i.e., activities of daily living [ADL] performed with minimum assistance or supervision) may not always require occupational therapy intervention.

As highly functioning patients improve their mobility skills through increased activity and postsurgical healing, spontaneous ADL recovery often occurs. Occupational therapy is usually indicated when the patient is not expected to improve spontaneously.

The Government Accounting Office Report "Medicare Rehabilitation Service Claims Paid Without Adequate Information" issued in July 1987 pointed out that medical review, at the intermediary level, was often performed with incomplete records. After the release of that report services questioned by the fiscal intermediary have not received the careful review necessary to ensure that the medical record contains adequate information to substantiate the payment of the bill.

We would like to correct the following inaccurate and misleading statements:

1. "Initially, to give health care providers an incentive to participate in the Medicare system even if some of their claims should be retroactively denied, the government established the Medicare waiver of liability provision" (p. 353).

2. "The waiver of liability provision was repealed in March 1986 but reinstated a few months later because of complaints by providers. This provision gives relief to providers who act in good faith in providing Medicare beneficiaries with services that an intermediary may later find to be unreasonable or unnecessary and for which, therefore, it retroactively denies reimbursement" (p. 354).

3. "Once the 5% denial rate is exceeded for any one quarter, the provider will not be paid for any claims denied in that quarter." (p. 354).

4. "If the intermediary declares that the beneficiary is liable, the beneficiary may have to pay for the services. If the provider is covered under the waiver of liability provision, the intermediary may still pay the claim. If the provider is not covered under the waiver of liability provision, the beneficiary may have to take the financial loss" (p. 355).

The beneficiary would only be liable if he or she knew or had reason to know that the services to be provided were not a benefit of the program. The intermediary denial letter establishes liability. If the liability rests with the provider of service, it would violate its contract with the Medicare program if it asks the beneficiary to pay.

5. The case example presented implies that the decision of an administrative law judge in overturning a single case can be extrapolated to the entire program. We would like to caution occupational therapists that each case stands alone and does not set precedent for review of other cases.

As medical reviewers our greatest concern is that the section on the Documentation of Occupational Therapy Services (pp. 354-355) contains misinterpretations of documentation. We look for significant practical improvement in the patient to be described in the documentation. Often very little information is given that indicates a significant and practical improvement in the patient has occurred in response to the treatment given. Did the treatment really help? If so, how? The clinician has to do more...
than just document the type of therapy given and the degree to which the patient is able to use the skill gained to function at a higher level of independence. We wish to reinforce the idea that a clear concise picture of the patient's clinical status is the most effective way for an occupational therapist to ensure payment of a case.

In our experience as reviewers, the most frequent cause for an erroneous denial on the part of the fiscal intermediary (a patient in need of skilled services which are denied) occurs when the documentation is incomplete, inadequate, or erroneous. The responsibility lies with the clinician to present his or her clinical documentation in an accurate manner so that a reviewer is not forced to interpret or read between the lines but has a clear understanding of the clinical picture, the expected rehabilitation, and the patient's potential to attain the stated goals.

The provider may challenge a denial if the services were not paid under waiver of liability. The beneficiary may initiate an appeal under any circumstances. The appeals process is initiated by a letter containing additional information about the case, and the content of that information must be substantiated by information already contained in the medical record. Reconsideration of the claim (bill) is then reviewed by another reviewer.

If we as occupational therapists have a clear understanding of the Medicare program and the procedures effectively used in the appeal process, it will be easier for us to work together within the guidelines of the program.

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Author's Response

My thanks to the letter writers for the clarifications. In addition, one statement in my article on page 355 should have read "If the provider is not covered under the waiver of liability provision, the provider may have to take the financial loss."

The purpose of my article was to outline the Medicare appeals process and encourage occupational therapists to appeal denials if they believe the services should have been covered under the Medicare program. There have been several instances in which providers have been inappropriately denied reimbursement for services. In my own experience, several providers in south Florida suddenly began receiving retroactive denials for reimbursement of occupational therapy services provided to patients with lower extremity diagnoses. The reason given was that "the treatment was not consistent with the symptoms and diagnosis and could have been provided by physical therapy and/or nursing personnel." The intermediary determined that the denials would not be covered under the waiver of liability provision because the providers should have known from the Medicare coverage guidelines for occupational therapy that they were not covered services. Attemps were made to obtain more specific reasons for the denials. Through conversations with the intermediary it became apparent that the reviewers (who were not occupational therapists) had a limited understanding of occupational therapy. We attempted to work with the intermediary to come to a common understanding of occupational therapy services covered under the Medicare guidelines. The intermediary assured us that these denials were appropriate and would continue. Although the intermediary maintained that each case was reviewed individually, the providers believed that the denials were being made arbitrarily on the basis of diagnosis and decided to appeal the cases.

Two avenues were pursued. First, the facility followed the appeals process established by the Social Security Act. Second, we attempted to work with the Health Care Financing Administration (HCFA) to clarify coverage of occupational therapy. To do this we enlisted the assistance of the Florida Occupational Therapy Association, the American Occupational Therapy Association, and our U.S. Congressman, Claude Pepper. Through the efforts of Claude Pepper we were able to obtain, in writing, HCFA's policy on reimbursement of occupational therapy services. A letter from C. McClain Haddow, acting administrator of HCFA at that time, stated, "occupational therapy generally is used to restore lost function in the upper extremities; it would not, therefore, ordinarily be provided to patients with hip replacements or hip fractures."

With this letter the Government and Legal Affairs Division of AOTA was able to work with HCFA and obtain a transmittal clarifying coverage of occupational therapy services. Although we stopped receiving retroactive denials, it took nearly 7 more months to complete the appeals process for the denied cases as each case had to be appealed individually. In my facility, over 100 cases were successfully appealed by people using the process outlined by the Social Security Act and described in the article.

I do agree that documentation is very important for reimbursement. Having been newly hired by the facility when it began receiving retroactive denials, I was put in a position of having to defend the services and documentation of several therapists who no longer worked at the facility. Several cases were not appealed because of poor documentation.

There have been other documented cases of arbitrary denials. In a decision rendered on a case filed in the U.S. District Court, District of Connecticut—Fox vs Bowen, April 23, 1986—the district judge found that the intermediary had used informal presumptions or "rules of thumb" (rather than reviewing each case on its individual merits) to deny reimbursement for physical therapy services provided to several patients in skilled nursing facilities in Connecticut. Most recently, HCFA has been under fire for denying home health services to certain Medicare beneficiaries on the basis of HCFA's interpretation of parttime or intermittent care (OT Week, August 25, 1988).

Occupational therapists should work with their intermediaries to resolve any problems with denials of reimbursement for services. However, if the problems cannot be resolved and there is good reason to believe that the denial is inappropriate, occupational therapists should be encouraged to use the appeals process.

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