Antagonistic, towards a system that can scores the need for occupational therapists to be advocates of the aging. A denial is one effective (and appropriate) approach to improving access to rehabilitation services through the Medicare program.

The article was critical, but not antagonistic, toward a system that can and often does limit access to the aging to needed rehabilitation services provided through the Medicare program.

Ms. Andersen is not the only one to recognize this problem. The Center for Medicare Advocacy, Inc., for example, has published packets of materials designed to help Medicare beneficiaries, and those assisting them, appeal unfair denials for Acute Hospital Rehabilitation, Skilled Nursing Facility (SNF), Home Health, and other Part A and Part B services.

A letter from the Commissioner of the Connecticut Department on Aging to Medicare beneficiaries introducing the Center's "Medicare Skilled Nursing Facility Appeal Self Help Packet" states: "All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so."

The letter writers state that, "No Medicare policy or factual evidence is presented in this article that justifies the inflammatory statement on the 'alarming increase in arbitrary denials' (p. 125). I don't understand what is inflammatory about stating that one is (or should be) alarmed by an increase in arbitrary denials. When there is only a hint of unnecessary or arbitrary denials of legitimate Medicare benefits, occupational therapists should become alarmed and should investigate the situation and act appropriately to assure beneficiaries' access to covered occupational therapy services.

The fact that Ms. Andersen's article did not include factual evidence of arbitrary denials does not mean intermediaries do not arbitrarily deny services. The case of Fox v. Bowen (mentioned in Ms. Andersen's reply letter) is ample evidence of historical if not current use of arbitrary presumptions to deny Medicare coverage of services. The ruling held that the Medicare administration's practice of arbitrarily denying Medicare SNF coverage to beneficiaries needing daily physical therapy violated the Medicare statute and regulations. The ruling further stated that beneficiaries must receive an individualized assessment of entitlement to skilled nursing benefits.

According to a Health Care Financing Administration report on Part B carriers, in 1986 there were some 4.7 million requests for a review of denied charges. About 59% (2.8 million) of those requests resulted in an increase in benefits. In the same year there were about 42,115 requests for a fair hearing and over 42% (17,890) of those requests were upheld. Although it is not known how many of these appeals involved occupational therapy or other skilled rehabilitation services, these high percentages of upheld appeals support Ms. Andersen's contention that denials for payment of services can be erroneous and can deprive patients of essential health care services.

A new class action suit, entitled Rizzi et al. v. Bowen, filed by the Center for Medicare Advocacy, Inc., July 1, 1988, asserts that for many years Medicare intermediaries have arbitrarily denied Medicare home health coverage to patients considered to be chronically ill or in stable condition despite the fact there are no such limitations in the regulations. A ruling in favor of Rizzi et al. v. Bowen would be another proven example of arbitrary denials of services.

The letter writers intimate uniformity among intermediaries. There are scores of intermediaries and carriers in the United States, and although there is only one Medicare Law and only one set of guidelines (the Medicare Skilled Nursing Facility Manual, HCFA-Pub. 12, for example, which offers guidelines for covered services in SNFs), each intermediary interprets those guidelines somewhat differently. Some have denied services because an amendment was below the knee while others have covered similar services. Some have arbitrarily limited occupational therapy services to patients with total hip replacements while other fiscal intermediaries have not. It is common knowledge among occupational therapists, physical therapists, nurses, and speech pathologists working in the SNF arena that intermediaries differ in their view of what is and is not a covered service.

If we occupational therapists are to become advocates of rehabilitation for the aging, as Ms. Andersen's article asserts (and I feel we must), let us accept the possibility of occasional adverse opinions among peers, disagreement with Medicare and other insurance guidelines, and conflict
with the system itself. After all, vigorous and constructive disagreement can lead to needed changes.

As advocates of rehabilitation for the aging, we need a clear understanding of all reimbursement systems, including the Medicare program, so that we can work effectively within the existing structure, as the letter writers suggest.

Even more so, we need the clarity of vision to see where changes in the system are needed, the courage to criticize what is wrong with the system, and the will to change the system when doing so will improve access of the aging to needed occupational therapy services in a responsible and cost-effective manner.

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Reimbursement Restrictions in Home Health

I was intrigued by Daisy Kunstaetter's article "Occupational Therapy Treatment in Home Health Care" (Aug. 1988 AJOT pp. 513-519) quantifying the discrepancy that exists between home health therapists' perception of treatment and documentation entries as reviewed by the author. The article is a bold step in verifying providers' fears about the practical and psychological impact of reimbursement restrictions on the provision of health care.

It is highly unfortunate that the Reagan era has dictated this condition. Many providers live in doubt as to whether their treatments will be reimbursed by fiscal intermediaries and government regulators. This concern has been growing over recent years as the rate of home health denials has increased or fluctuated greatly and the interpretations of reviewers have varied due to lack of standards.

The article did not explore the possibility that home health agency administration or supervisory personnel might contribute to this discrepancy by encouraging therapists to document only reimbursable care rather than all kinds of treatment rendered.

Although I have some concerns about the credibility of any profession when such discrepancies are uncovered, I remain convinced we as therapists must demonstrate our unique contribution to patient care in addition to documenting the reimbursable aspects of our treatments. Only in this way can we educate colleagues, expand the reviewers' knowledge of occupational therapy, and justify the provision of our services (rather than having them substituted by other professionals) in any setting.

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Editor's Note

Material for In Focus is culled from a variety of resources, including press releases, newspapers, news services, and association newsletters. Some of these sources do not provide the kind of documentation requested above. Also, these sources do not usually indicate that their research or information is controversial. However, we will try to include the documentation in future In Focus columns.