Let’s Talk Appeals

Effective May 1, 2019, CMS has expanded the appeals demonstration activities to the Part A East (PAE) Qualified Independent Contractor (QIC) jurisdiction. Under the demonstration, selected provider/suppliers have the opportunity to participate in a recorded telephone discussion that will be included and considered as part of the appeals case file, prior to the QIC’s (C2C Innovative Solutions, Inc.) reconsideration decision.

The Telephone Discussion Demonstration will yield the following benefits:

- Provides an opportunity for the provider community to verbally discuss the case with a decision maker before a QIC decision is made;
- Informs the provider what documents are present in the QIC case file and what documents are needed and are critical to the outcome of a case;
- Provides the opportunity to fax or transmit through other secured media additional documentation that supports a favorable appeals decision to the QIC decision maker prior to the reconsideration decision being made; and
- Assists and educates providers on CMS policies and requirements

Tips on Avoiding Unfavorable Appeal

- Ensure provider signature is recorded on the order(s)
- Include complete and signed Advanced Beneficiary Notice (ABN), when applicable
- Obtain all records to support medical necessity
- Report complete and valid diagnosis codes
- Submit diagnostic reports
C2C Innovative Solutions, Inc. reports monthly data illustrating the outcome and decision rationale of reconsiderations for providers who participate in the telephone discussion. These are the error trends observed for the month of June that resulted in unfavorable appeal decisions.

**Inpatient Rehabilitation Facility (IRF) Services**

**Coverage Requirements**

- IRFs provide intensive rehabilitation services using an interdisciplinary team approach in a hospital environment
- Patient must require intensive rehabilitation
- Admission to an IRF is appropriate for patients with complex nursing, medical management, and rehabilitative needs
- Reasonable expectation that the patient will benefit from an inpatient admission
- Patient must be able to fully participate in and benefit from the intensive rehabilitation therapy program

**Documentation Requirements**

- Preadmission screening (PAS)
- Post-Admission physician evaluation (PAPE)
- Individualized overall plan of care (POC)
- IRF-Patient Assessment Instrument (PAI) included in the IRF medical record
- Interdisciplinary team notes
- Physician supervision:
  - Documentation of three face-to-face visits per week

**Identified Errors from QIC Telephone Discussion**

- Beneficiary was medically stable, alert and oriented, and not in acute distress:
  - Documentation does not support beneficiary lacked knowledge regarding how to transfer, ambulate, and perform ADL for which intensive, multi-disciplinary therapy services would have been required or demonstrated significant impairment of upper and lower extremity strength and range of motion
- Documentation does not support that the beneficiary was suffering from acute or ongoing medical comorbidities that would require close supervision and complex medical management by a rehabilitation physician or was demonstrating functional deficits that would require an intensive, multi-disciplinary, IRF-level rehabilitation program
- Plan of care does not include the expected intensity, frequency and duration of the anticipated therapy services
- Insufficient evidence to support that the IRF admission was medically reasonable and necessary
- Documentation indicates that at the time of the pre-admission screening, this beneficiary was able to bear weight as tolerated, required minimal assistance for transfers and moderate assistance for self-care activities
- Review of the patient’s functional status, showed no indication to support an expectation that the rehabilitation needs in this case would be complex to require the intensive rehabilitation program, the interdisciplinary team approach, and the direction by a rehabilitation physician as provided in an inpatient rehabilitation facility
Speech Language Pathology (SLP) Services

- Speech-language pathology services are designed to improve or restore speech and language functioning (communication) following disease, injury or loss of a body part. Clinicians use the clinical history, systems review, physical examination, and a variety of evaluations to characterize individuals with impairments, functional limitations and disabilities.

- Medicare pays for medically necessary therapy services when a plan of care (POC) for furnishing such services has been established by a physician, non-physician practitioner (NPP), or the therapist providing such services, and is periodically reviewed by a physician or NPP.

- POC must include:
  - Diagnosis
  - Long-term treatment goals
  - Type, amount, duration, and frequency of therapy services required

- Therapy services that do not require the professional skills of a therapist to perform or supervise are not medically necessary. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service.

Identified Errors from QIC Telephone Discussion

- Claim was billed with diagnosis code unspecified dementia without behavioral disturbance:
  - Secondary diagnosis code(s) is required in addition to primary diagnosis code to clarify the reason/diagnosis for SLP services.
  - Reconsideration indicates that the appellant is wanting to add diagnosis code to the claim:
    - Did not submit a revised Uniform Billing Form (UB-04) listing diagnosis code to support the SLP services.

- Documentation indicated the service was performed for dysphagia, which is not a covered diagnosis for group speech therapy, according to the LCD L35070.

- Documentation shows that the claim was billed with diagnosis codes that do not support medial necessity for SLP services:
  - Dysphagia, oropharyngeal phase
  - Altered mental status, unspecified
  - Personal history of TIAs
Resources

Inpatient Rehabilitation Facilities

- Provider Specialty: Inpatient Rehabilitation Facility (IRF) (JH) (JL)

Speech Language Pathology Services

- Local Coverage Determination (LCD): Speech - Language Pathology (SLP) Services: Communication Disorders (L35070)
- Local Coverage Article: Billing and Coding: Speech Language Pathology (SLP) Services: Communication Disorders (A54111)

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- Interactive Voice Response (IVR)

Our self-service tools page is just a click away by accessing the following links:

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