Session R22:

Prevention Of Medicare Denials: Create Proactive Compliance and Rehabilitation Systems

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Objectives:

• Learn how to implement a proactive approach to denial management in four reasonable steps including:
  1. Identification
  2. Reporting and Tracking
  3. Documentation
  4. Assessment
• Create streamlined facility processes and identify key players
• Develop accurate and accountable documentation for skilled necessity to reduce and prevent further denials
Who are the Auditors? Identification

CMS’ Center for Program Integrity (CPI)

• CMS’ Center for Program Integrity (CPI) mission is to protect the Medicare & Medicaid Trust funds against losses from fraud and abuse and other improper payments, and to improve the integrity of the health care system.
• To achieve this mission, CPI identifies 4 program areas:
  • Prevention,
  • Detection,
  • Recovery and
  • Transparency and accountability

Prevention activities include:
  – payment system operation,
  – medical review
  – provider and beneficiary education.
CPI plans to expand these activities with improved fraud identification, safeguards, payment system accuracy and coordination with law enforcement.

Detection activities include:
  – plans to implement analytical data mining to detect improper payment trends, including predictive modeling and geographic mapping based on hotline tips.

Recovery activities include:
  – collaboration with program integrity partners (e.g., OIG, DOJ, state survey and certification agencies, state Medicaid agencies, etc.) to increase overpayment recoveries through restitution, fines, penalties, damages, program suspensions and exclusions.

Transparency and Accountability activities include:
  – plans to develop performance measures used to evaluate outcomes and better track, report and disseminate program integrity information.
Progressive Corrective Action (PCA)

- PCA is an operational principle upon which all medical review activities are based.
- PCA involves data analysis, error detection, validation of errors, provider education, determination of review type, sampling claims and payment recovery.
- It serves as an approach to performing medical review and assists contractors in deciding how to deploy medical review resources and tools appropriately.
- The Medicare Contractor may use any relevant information they deem necessary to make a prepayment or postpayment claim review determination.

Program Integrity Contractor Initiatives

- Launched by Federal Government
  - Reduce Fraud and Abuse
  - Increase in Medical Record Audits
    - Strict response timelines
    - Complex appeal processes
    - Significant penalties
  - Goal is for MACs to prevent improper payments and create an Error Rate Reduction Plan (ERRP), which includes initiatives to help providers comply with the rules.

Complex and Non-Complex Reviews

- Complex reviews involve requesting, receiving, and medical review of additional documentation associated with a claim.
- Non-complex reviews occur when the MAC, CERT, Recovery Auditor, or ZPIC makes a claim determination without clinical review of medical documentation submitted by the provider.
  - are based on clear policy that serves as the basis for denial, or a medically unlikely edit (MUE); or occurs when no timely response is received to an ADR.

*NOTE: MAC does conduct Prepayment ADR when associated with the Recovery Audit Program Review Demonstration on historically high rates of improper payments (Manual Medical Review (MMR) in California, Florida, Illinois, Louisiana, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas- These may change to postpayment waiting information from CMS)*
The Purpose of a Medicare Review is:
- To ensure that payment is made only for covered services and services that are medically reasonable and necessary for the treatment of the beneficiary's illness and/or injury.
- The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources.

Identification

There are a variety of Medicare Medical Reviews including:

Prepayment:
- National Correct Coding Initiatives (NCCI) Edits
- Medical Unlikely Edits (MUEs)
- Medical Review (MR)

Postpayment:
- Comprehensive Error Rate Testing (CERT)
- Recovery Auditors or Recovery Audit Contractors (RAC)
- Zone Program Integrity Contractor (ZPIC) formerly the Program Safeguard Contractors (PSC)

Identification

Often referred to as EDITS (Performed by MACs and are automated prepayment reviews):
- National Correct Coding Initiative (NCCI Edits)
  - Created to promote national correct coding methods
  - Impacts Medicare Part B Claims
  - Edits occur when incorrect code combinations are billed
  - Updated quarterly on CMS website
- Medically Unlikely Edits (MUE's)
  - Relates to HCPCS/CPT codes- is the maximum units of service that a provider would report for a single beneficiary on a single date of service
  - While the majority of MUEs are publicly available on CMS website, not all are published
  - Services must still meet medical necessity definitions
Identification
• Provider Response: Most reviews, except NCIs and MUEs start with an ADR – Additional Development Request
  – Medical Records are requested by the Contractor (i.e. MAC, CERT, RA) when unable to make a coverage determination from the billing claim
  – All pertinent medical documentation must be submitted
  – ADRs Timelines:
    • MR to the MAC within 30 days
    • CERT-60 days.
    • RAC-45 days from letter unless a request for extension completed
  – Failure to meet the timeline will result in denial of the claim

Identification
• (CERT) Comprehensive Error Rate Testing Program (post payment reviews)
  – Sets a national annual improper payments rate for Medicare Fee For Service Program
    • Indicator of how claim errors in program impact Medicare Trust Fund
  – Measures the performance of the MACs to gain insight into the causes of errors
  – Identifies error categories of:
    • No and insufficient Documentation
    • Medical Necessity
    • Incorrect Coding and other (such as duplicate or non covered payments)
### Identification

- **Recovery Auditors** (formerly known as Recovery Audit Contractors or RACs)
  - Identify Medicare overpayments and underpayments
  - Paid a percentage of what they recoup from or return to the provider
  - May have different response times; read notifications carefully
  - Have authority to extrapolate the error rate from the sampling to all claims processed within that same period
  - Generally are post payment reviews (except MMR)

*NOTE: Dec 2012 CMS Published Medicare Fee for Services RA Program Myths*

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### Additional Changes Noted by the National Association for the Support of Long Term Care (NASL) on (3-19-2014)

- NASL reports the following:
  - CMS stated to NASL that when they award the new recovery audit contacts, MMR reviews will be done on a post payment basis.
  - This data has NOT been collaborated on CMS website as of the writing of this presentation.

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### Identification

- **RAC – Recovery Auditors**
  - In addition to the program integrity role of the RAC, most recently they are also responsible for providing the ADR review for the Manual Medical Review process
    - 11 States including Ohio – **Prepayment** (no claim paid until after documentation is reviewed)
    - All other states – **Post Payment** (claim is paid initially but all documentation is reviewed)
  - New Recovery Auditors being chosen 2014
"May 22, 2013 - The CMS has begun the process for the new Medicare Fee for Service Recovery Audit Program contracts. The CMS plans to contract with four A/B Recovery Auditors and one national DME and Home Health Hospice Recovery Auditor. Timeline = TBD

**Future jurisdictions to be awarded in 2014**

A/B Recovery Audit Program Regions

Future Changes to RACs (as of 2-18-2014) when new contracts are awarded

<table>
<thead>
<tr>
<th>Region</th>
<th>Current RAC Regions and Contractors</th>
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<tbody>
<tr>
<td>R1</td>
<td>Region 1</td>
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<td>R2</td>
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<td>R3</td>
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When new contracts are awarded:

- Upon notification of an appeal by a provider, the Recovery Auditor is required to report the decision in writing.
- Recovery Auditors must wait 60 days to allow for a discussion before issuing the claim on the initial adjustment. Providers will not have to choose between initiating a discussion and an appeal.
- Providers do not receive confirmation that their documentation request has been received.
- Recovery Auditors are paid their contingency fee after the resolution of improper payments, even if they provide the information.
- Medical documentation request (HIC) limits are based on the entire facility, although requests for the difference in department within the facility, I/O limits are the same for all providers of similar services, and are not adjusted due to a provider's compliance with Medicare rules.

The CMS is establishing revised ADR limits that will be dosed in excess of the state's average rate, starting with lower annual rates. CMS will require Recovery Auditors to adjust the ADR limits set in accordance with a provider's initial rate. Therefore, with four dozen states will have unique ADR limits while others with higher rates will have higher ADR limits.
Identification

Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)

• Primary goal is to investigate instances of suspected fraud, waste, and abuse; these are serious audits with potential fraud implications
• ZPICs develop investigations early, timely, and take immediate action to ensure the Medicare Trust Fund and help identify improper payments that are to be recouped by the MAC via a demand letter
• ZPICs also support victims of Medicare identity theft

Identification: ZPICs Continued

• Actions that ZPICs take to detect fraud, waste, and abuse
  – Investigate potential fraud and abuse for CMS administrative action or referral to law enforcement
  – Conduct investigations and perform data analysis in accordance with the priorities established by CPI's Fraud Prevention System;
  – Identify the need for administrative actions such as payment suspensions and prepayment or auto-denial edits
  – Refer cases to law enforcement for consideration and initiation of civil or criminal prosecution
  – Authorized to extrapolate the error rate from sampling to all claims processed within that same period

NOTE: MLN Matters # SE1204Revised – ZPIC Fact Sheet

Identification

What does a denial look like?
Identification

How are facilities notified of ADRs, Reviews and/or Denials?

- Mail
- Electronic notification - Set up system/personnel to consistently check for ADRs
  - CGS – When a claim is selected for an ADR, the claim is moved to a Fiscal Intermediary Standard System (FISS) status/location ‘S B6001’. Providers are encouraged to use FISS Option 12 (Claim Inquiry) to check for ADRs at least once per week. You will not receive any other form of notification for an ADR. (To check for ADRs using FISS Option 12, key your NPI number, the status/location ‘S B6001’, and press Enter. Claims selected for ADR will appear.)

How are facilities accurately determining the request/notification source?

Identification

• Identification of Potential Audits or Reviews
  - Can you properly identify the source?
  - Where did the correspondence come from?
  - Have a system in place for notifying appropriate parties when receiving a letter or other correspondence from your MAC (Medicare Administrative Contractor) or any other CMS contractor
  - Share information with your consultant and your rehab provider (if not in-house)

Identification

MAC Letterhead

- Cahaba Government Benefit Administrators
- CGS Administrators - OHIO
- First Coast Service Options, Inc.
- CIGNA Government Services
- Highmark Medicare Services
- National Government Services, Inc.
- NHHIC Corp.
- Noridian Administrative Services
- Novitas Solutions, Inc.
- Palmetto GBA
- Wisconsin Physicians Service Insurance Corp.
Identification

**RAC Letterhead**

– Health Data Insights, Inc. (HDI)
– Connolly Consulting Associates, Inc.
– CGI Technologies & Solutions, Inc. -OHIO
– Performant Recovery, previously known as Diversified Collection Services, Inc. (DCS)

Identification

**ZPIC Letterhead (Notify Compliance and Legal)**

• Safeguard Services (SGS)
• AdvanceMed
• Cahaba -OHIO
• Health Integrity

Reporting and Tracking
Reporting and Tracking

- Upon notice – 1st Steps
  - Confirm the following:
    - Who sent the correspondence/notification
    - What are the details of the notification
    - ADR or other record request – remote or in person?
    - Denial of Payment or Demand Letter
    - Timelines and due dates
  - System of tracking to be used
    - Excel spreadsheet
    - Software
  - Who updates the tracking system – Point Person
    - At what intervals

Reporting and Tracking

- Communicate with all appropriate departments and outline who is responsible for what
  - Physician
  - Nursing
  - Therapy
  - Medical Records
  - Billing
- Provide operational guidelines for each department
  - Use checklist of needed items
  - Have backup departments/persons trained in case of sickness or vacation times

Reporting and Tracking

- Notify your compliance and legal departments, as needed
- Notify your facility consultant as appropriate
- If utilizing Contract Therapy company, notify them
  - Review contractual agreement related to denials and appeals
  - Determine additional source(s) of assistance related to the therapy claims
    - Collecting/copying/reviewing therapy records
    - Ensure systems are in place for complete and accurate record retrieval
    - Appeal letter(s) as appropriate
Reporting and Tracking

Step #2

- If the notification is an ADR or other Request for Records
  • Begin process of collecting, copying and reviewing records
  • Set up time frame for each department and/or medical records or outside consultant to submit record(s) utilizing outlined tracking forms/system
  • Designate point person to collect all records, complete final review and timely submission
  • Point person should develop system looking at all denial reasons and begin strategy to prevent...
Reporting and Tracking

- Track All Records Being Submitted*
  - ADR Tracking Form
  - Record Request Tracking Form
  - 1st, 2nd, 3rd, Level of Appeal Tracking Form

- Track Contents of Records Submitted*
  - Nursing Record
  - Physician Notes
  - Therapy Record
  - Dates of Service/ADR/Denial
  - $ amount of claim(s) in question

* Maintain copies of full packets submitted
Documentation

• Following Record Review Provider Will be Notified of Decision
  – ADR – MAC will either deny the claim, pay the claim or provide partial payment of the claim; reason for denial will be provided, although often vague
  – RAC – RAC must notify the provider of any overpayment determination; coverage/coding, payment policy or article that was violated. Demand letter will be sent by the MAC
  – PCS/ZPIC – If suspected fraud, waste or abuse is confirmed, they will identify improper payments to be recouped by the MAC, along with any other reporting they deem appropriate

• ADR Results in Denial
  – notification may be in letter form
  – notification will be on the Medicare Payment Remit
  – notification can be found on-line in the Medicare DDE (Direct Data Entry) system

• Determine the type of denial (to help prevent more in the future)
  – Technical
  – Medical necessity
    • Utilize denial code to determine reason

• Technical Denials
  – no physician orders
  – physician did not sign and/or date certification or re-certification
  – physician did not sign timely
  – a component of therapy was provided but not ordered by the physician
  – patient was not seen by the physician in the past 30 days
  – physician’s signature was stamped, not written
Documentation - Common Denials

Reasons

Medical Necessity - Common Reason for Denials

• Services not reasonable or necessary
  – usually documentation is inadequate to support the claim
  – length of service may be too long
  – medical records do not indicate the services were necessary
    based on patient’s diagnosis and level of functioning

Documentation

Medical Necessity - Reasons for Denials

• Services did not require the skills of a Therapist
  – treatment was routine or redundant and could have been
    provided by an unskilled person
  – patient’s functional level did not indicate a need for skilled
    services

• Services provided constituted a maintenance program
  – patient’s functional progress was limited or non-existent
  – services provided were routine or redundant and could have
    been provided by an unskilled person
  – Some changes in this due to Jimmo vs. Sebelius Settlement

Documentation – Jimmo vs. Sebelius Settlement

Potential Denial Reasons Related to “Maintenance Therapy”

• CMS had to clarify their manuals and educational materials
  regarding when they will cover maintenance programs.

• Therapists must be educated on the correct way
  to document relative to Maintenance Therapy
  – If a patient is being seen for restorative treatment, the expectation
    is that they will progress, therefore the claim would still be at risk of
    denial if he/she only maintained function
  – If a patient is being seen for maintenance, which was identified at
    the start of care and it was clearly defined why the skills of a
    qualified therapist were required, then the claim should not be at
    risk of denial; as long as the patient was appropriately discharged
    once the program could be provided by a non skilled person.
Documentation

Levels of Appeal
• 1st Level – Redetermination
  – Must file request within 120 days from date of receipt of the initial determination notice*
  – No monetary threshold
  – Request is sent directly to the MAC
• 2nd Level – Reconsideration
  – Must file request 180 days from date of receipt of the redetermination*
  – No monetary threshold
  – Request is sent directly to the QIC

Tip: Date of letter may be better point of measure than date of receipt

Documentation

Levels of Appeal
• 3rd Level – Office of Medicare Hearings and Appeals-Administrative Law Judge (ALJ) Hearing
  – Must file request within 60 days from the date of receipt of the reconsideration
  – Monetary threshold – at least $140 remains in controversy
• 4th Level – Medicare Appeals Council -(DAB) Review
  – Must file request within 60 days from the date of receipt of the ALJ hearing decision
  – No monetary threshold
• 5th Level – Judicial Review in Federal District Court
  – Must file request within 60 days from the date of receipt of DAB decision or declination of review by DAB
  – Monetary threshold – at least $1,430 remains in controversy

Documentation

What to do at the 1st Level of Appeal
– Letter of Appeal may be submitted
  • Address reason for denial
– Standard Redetermination Form may be submitted
– Timely submission is required; send UPS overnight with tracking #
– Tracking System Must be implemented
  • Date of denial
  • Date packet is submitted to MAC
  • Patient(s) specific information
  • $ amount denied
  • Date of follow up

Tip: Always go to MAC website for specific instructions
Documentation

What to do at the 2nd Level of Appeal
- When the 1st level appeal has been upheld (denial stayed), then the next step is the 2nd Level Appeals – Reconsideration.
- When Medicare denies on the 1st level appeal, the notification letter they send will list the reasons of the upheld denial.
- It will also include a form for the 2nd level of appeals, known as the QIC (Qualified Independent Contractor) appeal.
- The facility has 180 days to respond to the upheld denial and submit their reconsideration request.
- Follow instructions for submitting the reconsideration request
- Begin tracking of 2nd level appeal similar to that used for 1st level
Tip: Always go to QIC website for specific instructions

What to do at the 3rd Level of Appeal
- The 3rd level appeal is to the Office of Medicare Hearings and Appeals -Administrative Law Judge (ALJ) Hearing
- This hearing request must be filed within 60 days from the date of receipt of the reconsideration for Medicare Part A
- Medicare claims must be filed within six months of the date of the re-determination letter.
- Monetary threshold – at least $140 remains in controversy
- The ALJ will generally issue a decision within 90 days of receipt of the hearing request

3rd Level of Appeal cont.
- A form requesting a hearing to reconsider the denial of the claim should be completed to include:* 
  - Resident HIC number
  - Denied billing period
  - Resident name
  - Reasons why coverage was necessary
- Type of Hearing being requested:
  - In person, telephone, record review
  - Try for telephone
- Form/Packet should be sent certified mail
*Form CMS-20034A/B available at www.hhs.gov/omha/index.html
Documentation

3rd Level of Appeal cont.

- The appeal packet should include the following:
  - 3rd level hearing request form
  - Any forms that may be utilized by the MAC (check in the provider manual to determine the necessary forms)
  - Copy of the re-determination letter sent from Medicare
  - Any additional information to support the claim that was not sent with the 1st level appeal.
    - Do not resend any medical records. The ALJ will have the 1st level appeal packet.
  - Letters of support of treatment from the Physician, Director of Nursing, or family members, if possible. Positive Patient Satisfaction Survey.

Documentation

3rd Level of Appeal cont.

- During the actual hearing you will have about five minutes per claim to justify the need for the therapy, so it is very important that you are organized and are able to point out supporting information quickly
- Once notified by the hearing office of results next steps can be taken
  - Further appeal if claim is stayed
  - A good number of claims are overturned at this level compared to other levels

NOTE: Medicare integrity contractors are pushing for Medicare appeal process reform especially related to ALJ level of the process due to the recent suspension of assignment of new appeals to ALJ (current 2 year backlog)

Documentation

What to do for the 4th Level of Appeal: Review by the Medicare Appeals Council

- If unsatisfied with (ALJ) hearing, the next request is conducted by the Medicare Appeals Council. There are no requirements regarding the amount of money in controversy.
- The request for Medicare Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ’s decision.
- Generally, the Medicare Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from the ALJ level.
What to do for the 5th Level of Appeal: Judicial Review in Federal District Court

- If unsatisfied with the previous decision, any party can request escalation to Federal district court if the Appeals Council
- The amount in controversy (AIC) for 2014 is $1,430.
- The appellant must request a Federal District Court hearing within 60 days of receipt of the Medicare Appeals Council’s decision.

Recovery Audit (RAC) What occurs if overpayment determination made

Options…

- Discussion Period – Provider will need to provide additional information to convince the RAC that they should not pursue recoupment of funds; timeframe is day 1 – 40 from receipt of demand or review letter
- Rebuttal – Provider will provide information explaining why the recoupment will cause financial hardship for the facility; timeframe is day 1 – 15 from receipt of the demand letter
- Redetermination – Request for 1st level of appeal; timeframe is day 1 – 120 from receipt of demand letter; however to avoid offset at day 41, request must be submitted by day 30

*Note: “as mentioned in an earlier slide – new RA program changes indicate that the provider will not need to choose between the “Discussion Period” and the “Redetermination”.

Assessment
Assessment

• What is your facility’s position?
  – Never experienced ADRs
  – ADRs are often paid
  – Denied claims are never overturned
  – Denied claims are often overturned – what level?
  – Systems are in place for managing and tracking ADRs, Denials, Integrity Contractor Audits
  – Systems will be implemented when needed
  – A RAC or ZPIC will never happen to us
  – It has happened to us and we learned a costly lesson

Assessment

• Tracking your facility percentage(s)
  – What portion of billing claims result in:
    • ADR
    • Denial
  – What portion of denied claims are appealed
  – What portion of appealed claims are overturned
    • At what level?
  • Based on above data, is your facility at risk of being put on focused medical review?
    – Error rate?

Assessment

• What have you learned?
  – Trended reasons for denials
    • Poor documentation
    • Contradictions between therapy and nursing
    • Coding errors
    • Poor billing practices/systems
Assessment

- Documentation Compliance Guidelines
  - Diagnosis Codes – use codes listed in the Facility MAC LCD to support skilled PT, OT, ST services on therapy claims
  - Reason for Referral to Therapy – establishes the medical necessity and must be specific to why the patient requires therapy
  - Onset Date – the date the current reason for therapy started; onset date beyond 6 months from SOC will require further explanation
  - Prior Level of Function – Medicare typically only pays to return a patient to their prior level

Assessment

- What systems are in place for ensuring quality documentation in the medical record to support skilled services (nursing and rehab)?
- Contract Therapy – Quality Assurance Program in place with results of comprehensive medical record reviews, including plans of correction and process improvement
- Facility Billing Consultant Services
- Facility Compliance Department Review(s)

Assessment

- **Ensuring A Proactive Approach – Being Prepared for Program Integrity Audits**
  1. Conduct “pre” integrity audit; review medical records and billing; have an external source or someone not directly related to patient care conduct the audit; choose claims with high risk factors (RUH, long LOS)
  2. Identify inaccurate billing practices – consider use of modifiers, consistency of primary Dx on billing claims and documentation and between departments; establish a team triple check process each billing period

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Assessment

• Ensuring A Proactive Approach – Being Prepared for Program Integrity Audits

3. Charge Master – modify as needed for varying lengths of treatment; untimed codes = one unit; system should not allow errors

4. Identify reasons for billing inaccuracies – poor practices such as therapists over 100% productivity; accurate use of timed and service based codes and CCI edits by therapy

5. All evaluations for skilled therapy are provided after admission to the SNF

Assessment

6. Staff Orientation – include section on accurate billing practices and understanding of Medicare regulations

7. Incorporate results of compliance and internal audits into staff performance reviews to establish ownership

8. Educate therapy, nursing and physician staff on documentation to support medical necessity so “all” progress notes support services being provided

9. Perform audits of therapy services regularly for understanding of QA, Compliance and Internal Audit systems

Assessment

10. Identify an internal Program Integrity Coordinator – responsible for receiving any record requests, having records reviewed and submitting records according to timeframes (or request extensions)

NOTE: Internal systems reviews and QA programs help to identify trends which require correction and will relieve apprehension of any program integrity review
Assessment

• Remember:
  – Documentation must be completed and in the medical record in order to be used to defend a billing claim and/or to appeal a denial. Having the documentation in place is the first step to minimizing risk or leading to a successful appeal, if needed
    • Systems should be in place for checking that documentation is complete and up to date in the record

NOTE: When conducting pre integrity audits be reminded to look for any potential underpayments as a look back of only 60 days is allowed to capture that billing

Summary

• Educate your facility team on types of audits and reviews that may occur in your setting
• Ensure systems are in place for tracking ADRs, record requests, appeals at all levels, etc
• Know what the “next steps” are in the process for appealing denied claims and/or recoupment
• Establish proactive system for ensuring accurate billing and quality documentation
  • Prevention is easier and less costly than correction!

Questions?
Thank you