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Firms provide consulting and financial services to healthcare entities, including for example clinical, reimbursement, financial, billing, compliance, and litigation support to the post-acute sector using experienced team members and a customized, interdisciplinary approach.



1

The Alphabet Soup of Medicare Claim Audits

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2

The Alphabet Soup of Medicare Claim Audits

Learning Objectives:

- ◆ Recognize at least three types of medical record audits applicable to SNFs, along with the types of requests they may receive, common areas of focus and the auditor's objectives based on their scope of work
- ◆ List key members of the Medicare team who should be aware of, and participate in, ensuring medical records assembled in response to an audit request are complete and properly organized
- ◆ Report the various levels of appeal and related time frames, list important actions necessary to preserve appeal rights, and identify the effect of electing over-payment deferral on the appeals process
- ◆ Assess common benchmarks used to identify focus areas for compliance activities in communities, sources of benchmark data for comparative purposes, steps to monitor compliance, and elements of a corrective action plan



3

The Alphabet Soup of Medicare Claim Audits

Topics

- ◆ **Medical Record Audits: “The New Normal”**
 - ◆ The Alphabet Soup of Contract Auditors
 - ◆ Why the Heightened Scrutiny on SNFs?
- ◆ **Payment Compliance and Risk Assessment**
 - ◆ How to Identify and Prioritize Provider Risk
 - ◆ Sources of Benchmarking Data and Their Use
 - ◆ Overpayment Refund Requirements
- ◆ **Management of Medical Record Requests**
 - ◆ Interdisciplinary Involvement
 - ◆ Content and Organization of Responses
 - ◆ Monitoring of Requests and Status
- ◆ **The Medicare Appeals Process**
 - ◆ The Five Levels of Appeals
 - ◆ Appeal Rights and Deadlines
 - ◆ Section 935 Overpayment Deferral Option



4

Medical Record Audits: “The New Normal”

5



Medical Record Audits: “The New Normal”

What to Expect?

- ◆ Fewer audits by Medicare Administrative Contractor (“MAC”)
- ◆ More audits by third party reviewers, including:
 - ◆ Recovery Auditors (“RAs”)
 - ◆ Supplemental Medical Review Contractor (“SMRC”)
 - ◆ Comprehensive Error Rate Testing (“CERT”) program
 - ◆ Uniform Program Integrity Contractors (“UPICs”)
- ◆ More use of pre-payment (vs. post-payment) audits
- ◆ More frequent down-coding and denials
- ◆ Vague or incorrect rationale for denials
- ◆ Increased need to appeal
- ◆ Delay in obtaining ALJ appeal

6



Medical Record Audits: “The New Normal”

Tools Used by CMS to Fight Fraud and Abuse

- ◆ Fraud Prevention System
 - ◆ Predictive Analytic Technology
 - ◆ Suspension of payments
 - ◆ Revocation of billing privileges
 - ◆ Referrals to law enforcement
 - ◆ Medicare-Medicaid Data Match program (“Medi-Medi”)
 - ◆ Share information with public private partners
- ◆ Increased use of third party contracted reviewers
- ◆ False Claims Act
- ◆ Civil Monetary Penalties
- ◆ Program exclusion



7

Medical Record Audits: “The New Normal”

The New Recovery Audit Contractors (RAC)

- ◆ CMS awarded 5 new FFS RAC contracts on 10/31/2016
 - ◆ Region 1 – Performant Recovery, Inc.
 - ◆ Region 2 – Cotiviti, LLC
 - ◆ Region 3 – Cotiviti, LLC
 - ◆ Region 4 – HMS Federal Solutions
 - ◆ Region 5 – Performant Recovery, Inc.
- ◆ Regions 1 – 4 will perform post-payment reviews under Part A and Part B for all providers except DMEPOS and HHA/Hospice
- ◆ Region 5 will perform post-payment reviews of DMEPOS and HHA/Hospice claims nationally
- ◆ CMS approves issues prior to RAC initiating claim audits
- ◆ Approved issues can be accessed at each RAC website



8

Medical Record Audits: “The New Normal”

The New Recovery Auditors

Exhibit A

Medicare FFS RAC Regions

9



Medical Record Audits: “The New Normal”

The New Recovery Auditors

Exhibit B

Medicare FFS RAC Contact Information

10



Medical Record Audits: “The New Normal”

RAC Program Enhancements

- ◆ CMS will post Provider Compliance Tips on its website
- ◆ Establishes a Provider Relations Coordinator
- ◆ Mandates overturn rates of <10% at first level of appeal
- ◆ Requires an accuracy rate of 95%
- ◆ Required to have medical director
- ◆ Encouraged to have panel of specialists
- ◆ Must use consistent and more detailed review information
- ◆ New ADR limits for institutional providers
- ◆ ADR limits must be adjusted as denial rate decreases
- ◆ Establishes ADR limits for new providers
- ◆ CMS to develop a Provider Satisfaction Survey
- ◆ Increased public reporting of RAC data

11



Medical Record Audits: “The New Normal”

RAC Program Enhancements

- ◆ Reduced time to complete complex reviews
 - ◆ 30 days vs. previous 60 days
 - ◆ Contingency fee will be reduced when not met
- ◆ 30 days allowed for discussion request
- ◆ Correspondence must be confirmed within 3 business days
- ◆ Provider portals must be enhanced
- ◆ Review topics must include all providers/claim types
- ◆ Some review topics will be required
- ◆ Contingency fees not paid until after second level of appeal
- ◆ Must participate in $\geq 25\%$ of ALJ appeals

12



Medical Record Audits: “The New Normal”

Supplemental Medical Review Contractor (“SMRC”)

- ◆ One contractor – Strategic Health Solutions, LLC (Omaha, NE)
- ◆ Conducts nationwide medical review at CMS direction
- ◆ Focus is on areas of payment vulnerability
- ◆ Projects are identified on contractor’s website
- ◆ Current projects involving SNFs:
 - ◆ Y4P0340 – 05/17/2016
 - ◆ Post-payment reviews on Part B therapy over the \$3,700 threshold
 - ◆ Targets providers who furnish more therapy over the thresholds than their peers
 - ◆ Y4P0342 – 08/11/2016
 - ◆ Post-payment reviews of SNF therapy services

13



Medical Record Audits: “The New Normal”

Comprehensive Error Rate Testing (“CERT”)

- ◆ Random audits conducted annually
 - ◆ Are not targeted reviews
 - ◆ Are not based on data mining or predictive analytics
 - ◆ Normal appeal rights apply
- ◆ CERT reviews:
 - ◆ Conducted based on stratified random sampling of claims
 - ◆ Encompass claims submitted to Part A/B and DME MACs
 - ◆ Used to estimate national, service-specific, and MAC-specific rates of improper payments
- ◆ FY 2015 Medicare FFS improper payment rates:
 - ◆ Overall: 12.1% (\$43.3 billion)
 - ◆ SNF Inpatient: 10.4%
 - ◆ SNF Inpatient Part B: 19.4%
 - ◆ SNF Outpatient: 46.5%

14



Medical Record Audits: “The New Normal”

What is Next? - UPICs

- ◆ Uniform Program Integrity Contractor (“UPIC”)
- ◆ **Purpose:** to detect, prevent, and proactively deter fraud, waste, and abuse in the Medicare and Medicaid programs
 - ◆ Consolidate Medicare and Medicaid program integrity (“PI”) efforts
 - ◆ Set national PI goals, priorities and strategies
 - ◆ Combine PI audits now done by MACs, ZPICs, PSCs, and MICs
 - ◆ Leverage fraud detection tools and mechanisms
 - ◆ Share information
 - ◆ Emphasis on “prevention and detection” – not “pay and chase”
 - ◆ Implements a “Unified Case Management System”
- ◆ RACs will not be affected
- ◆ MACs will limit their audits to routine issues

15



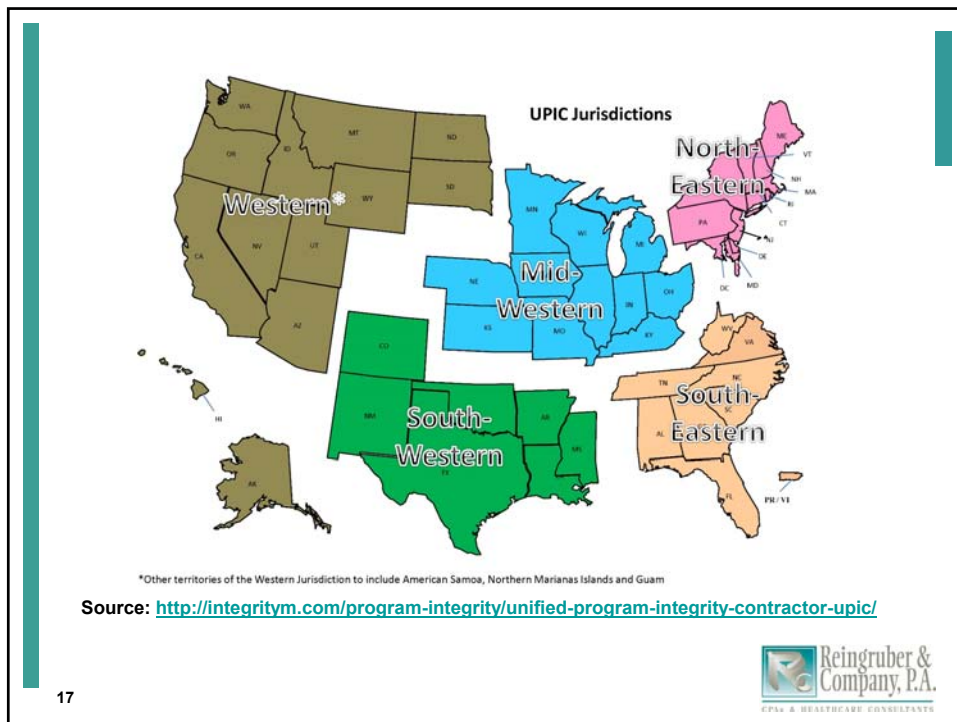
Medical Record Audits: “The New Normal”

UPIC Contracts

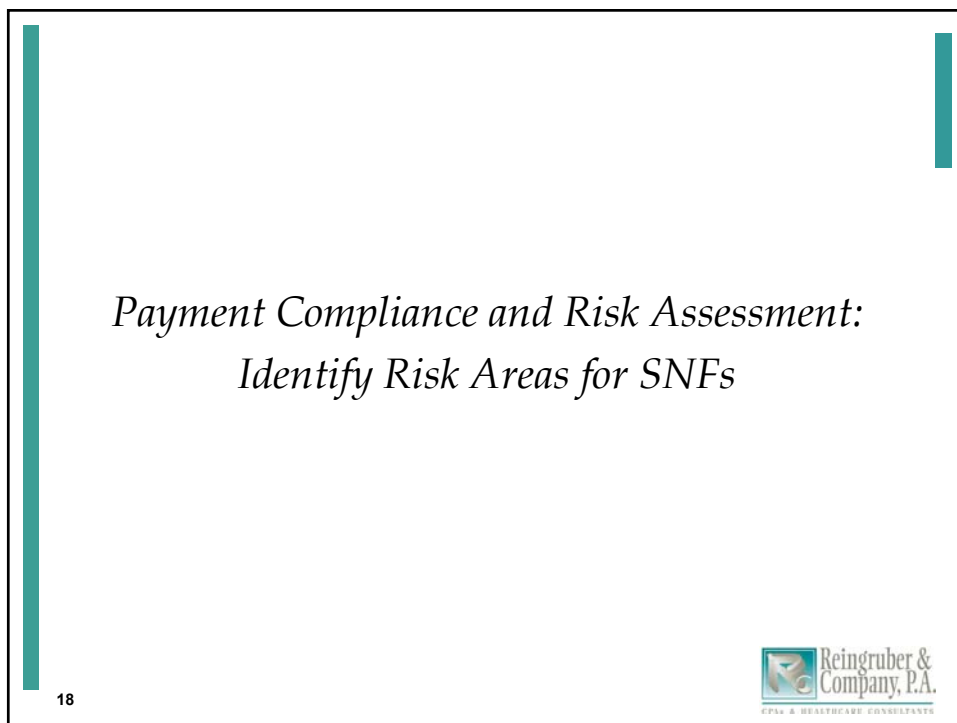
- ◆ UPIC contracts were awarded on 05/24/2016
- ◆ 7 UPIC contractors were identified
 - ◆ AdvanceMed Corporation
 - ◆ Health Integrity, LLC
 - ◆ IntegriGuard, LLC (d/b/a HMS Federal)
 - ◆ Noridian Healthcare Solutions, LLC
 - ◆ Safeguard Services LLC
 - ◆ StrategicHealthSolutions, LLC
 - ◆ TriCenturion, Inc.
- ◆ Each UPIC has a defined geographic jurisdiction

16





Payment Compliance and Risk Assessment: Identify Risk Areas for SNFs



Identify Risk Areas for SNFs

Sources of Data to Guide Compliance Efforts

- ◆ Office of Inspector General (OIG)
- ◆ General Accountability Office (GAO)
- ◆ Recovery Audit Contractor (RAC) Approved Audits
- ◆ Medicare Administrative Contractor (MAC) website
- ◆ PEPPER data
- ◆ Comparative Billing Reports (when available)
- ◆ CASPER Reports
- ◆ CMS Public Use Files
- ◆ CERT website
- ◆ SMRC website

19



Identify Risk Areas for SNFs

OIG 2017 Work Plan for SNF Services

- ◆ Complaint investigation data brief
- ◆ Unreported incidents of potential abuse and neglect
- ◆ SNF reimbursement
- ◆ Adverse event screening tool
- ◆ National background checks for LTC employees
- ◆ SNF PPS requirements
- ◆ Potentially avoidable hospitalizations of Medicare and Medicaid SNF residents
- ◆ Medicare payments for incarcerated individuals (all providers)

20



Identify Risk Areas for SNFs

OIG 2017 Work Plan – Other Areas

- ◆ Medicare payments for incarcerated individuals (all providers)
- ◆ Extent of denied care in Medicare Advantage and CMS oversight
- ◆ Medicare payments for dates of service after death
- ◆ Transfers of Medicaid beneficiaries to hospital ER

21



Identify Risk Areas for SNFs

OIG Reports Relating to SNF Services

- ◆ 12/2010: Questionable Billing by SNFs” (OEI-02-09-00202)
- ◆ 11/2012: Inappropriate Payments to SNFs Cost More Than a Billion Dollars in 2009 (OEI-02-09-00200)
- ◆ 11/2013: Medicare SNF Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040)
- ◆ 06/2014: Fraud Prevention System Identified Millions in Medicare Savings (OEI-02-09-00202)
- ◆ 06/2015: SNF Billing for Changes in Therapy: Improvements Are Needed (OEI-02-13-00611)
- ◆ 09/2015: The Medicare Payment System for SNFs Needs to be Reevaluated (OEI-02-13-00610)

22



Identify Risk Areas for SNFs

GAO Reports of Interest to SNFs

- ◆ **06/07/2012:** Program Integrity: Further action needed to address vulnerabilities in Medicaid and Medicare Programs (GAO-12-803T)
- ◆ **06/08/2012:** Medicare: Progress made to deter fraud, but more could be done (GAO-12-801T)
- ◆ **10/15/2012:** CMS has implemented a Predictive Analytics System, but needs to define measures to determine its effectiveness (GAO-13-104)
- ◆ **11/13/2012:** Medicare Program Integrity – Greater prepayment control efforts could increase savings and better ensure proper payment (GAO-13-102)

23



Identify Risk Areas for SNFs

GAO Reports of Interest to SNFs

- ◆ **11/28/2012:** Types of providers involved in Medicare cases and CMS efforts to reduce fraud (GAO-13-213T)
- ◆ **02/27/2013:** GAO's 2013 High-Risk Update: Medicare and Medicaid (GAO-13-433T)
- ◆ **09/30/2013:** Health Care Fraud and Abuse Program (GAO-13-746)
- ◆ **10/25/2013:** Medicare Program Integrity (GAO-14-111)
- ◆ **06/25/2014:** Medicare Fraud: Further actions needed to address fraud, waste and abuse (GAO-14-712T)
- ◆ **07/18/2014:** Medicare Program Integrity – Increased oversight could improve post-payment claim review (GAO-14-474)
- ◆ **10/30/2015:** Nursing Home Quality – CMS Should Continue to Improve Data and Oversight (GAO-16-33)

24



Identify Risk Areas for SNFs

GAO Reports of Interest to SNFs

- ◆ 04/13/2016: Medicare Claim Review Programs Could Be Improved with Additional Pre-payment Reviews and Additional Data (GAO-16-394)
- ◆ 05/10/2016: Medicare FFS – Opportunities Remain to Improve Appeals Process (GAO-16-366)
- ◆ 09/07/2016: CMS Should Improve Accessibility and Reliability of Expenditure Data for SNFs (GAO-16-700)
- ◆ 11/18/2016: Consumers Could Benefit from Improvements to Nursing Home Compare and 5 Star Rating System (GAO-17-61)

25



Identify Risk Areas for SNFs

Department of Justice Press Releases

- ◆ 03/02/2015: New York Catholic SNF chain to pay \$3.5 million to resolve allegations of inflated claims for rehabilitation therapy
- ◆ 03/30/2015: Maine SNF to pay \$1.2 million to resolve allegations concerning inflated claims for rehabilitation therapy
- ◆ 04/15/2015: \$1.3M settlement with Asbury Health Center resolves FCA allegations resulting from services not supported by physician certification
- ◆ 04/21/2015: Government sues SNF chain for allegedly providing medically unnecessary therapy
- ◆ 04/30/2015: Maine SNF to pay \$300,000 to resolve allegations concerning claims for rehabilitation therapy
- ◆ 05/21/2015: Watsonville, CA SNF owners, operators and manager agree to pay \$3.8 million to settle allegations of false claims for materially substandard or worthless services

26



Identify Risk Areas for SNFs

Department of Justice Press Releases

- ◆ 06/16/2015: Florida SNF agrees to pay \$17 million to resolve FCA allegations
- ◆ 10/29/2015: Government intervenes in lawsuits alleging SNF chain SavaSeniorCare provided medically unnecessary therapy
- ◆ 11/30/2015: SNF company agrees to pay \$3+ million to resolve kickback allegations
- ◆ 12/23/2015: Arlington SNF agrees to pay \$600,000 to settle FCA violations for patient care issues
- ◆ 01/20/2016:
 - ◆ Kindred/RehabCare to pay \$125 million to resolve FCA allegations
 - ◆ Four SNFs using Kindred/RehabCare to pay \$8.225 million

27



Identify Risk Areas for SNFs

Department of Justice Press Releases

- ◆ 03/30/2016: Creation of 10 Elder Care Justice Task Forces to pursue SNFs who provide grossly substandard care
- ◆ 07/22/2016: 3 charged in \$1 billion scheme involving money laundering and health care fraud
- ◆ 09/09/2016: LA SNF, 2 MDs pay \$3.5 million for scheme to recruit patients from "Skid Row" for unnecessary hospital and SNF stays
- ◆ 09/19/2016:
 - ◆ North American Health Care to pay \$28.5 million to settle claims for medically unnecessary therapy
 - ◆ Chairman of the Board and Sr. VP of Reimbursement to pay \$1.5 million

28



Identify Risk Areas for SNFs

Department of Justice Press Releases

- ◆ **09/28/2016:** RI SNF and COO agree to pay \$2.2 million to resolve allegations of inflated Medicare claims
- ◆ **10/12/2016:** Former CEO, COO charged in \$16 million fraud and kickback scheme
- ◆ **10/13/2016:** SNF and Director of LTC pay \$2.5 million to resolve false claims for rehabilitation therapy
- ◆ **10/24/2016:**
 - ◆ SNF chain pays \$5.3 million to resolve false claims to Medicare and Medicaid for substandard SNF care
 - ◆ Life Care Centers to pay \$145 million for false claims for medically unnecessary rehabilitation therapy

29



Identify Risk Areas for SNFs

Medicare Administrative Contractor (MAC)

- ◆ **Consult your MACs website for:**
 - ◆ Top claim submission errors
 - ◆ Educational materials
 - ◆ Advisory Group
 - ◆ Publications
 - ◆ Documentation checklists
 - ◆ Other job aids/tools

30



Identify Facility Specific Risks

PEPPER

- ◆ TMF Health Quality Institute develops PEPPER data under contract with CMS
- ◆ Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- ◆ Comparative data report summarizes an individual SNF's claims
- ◆ Use to help guide your compliance efforts
- ◆ Identifies where your billing patterns vary from other SNFs
- ◆ SNF PEPPER Q4FY15 were available in April 2016
- ◆ www.pepperresources.org

Only 54.9% of SNFs have downloaded their PEPPER!

31



Identify Facility Specific Risks

PEPPER

- ◆ Identifies “target areas” that have been determined to be at high risk for improper payments for specific provider types
- ◆ Compares individual provider data to that of providers in the same state, same jurisdiction and in the country
- ◆ PEPPER for individual providers is not available to the public – it may only be accessed by an authorized provider official

32



Identify Facility Specific Risks

PEPPER

- ◆ Released annually in mid-April
- ◆ Reflects trends for most recent three years
- ◆ Website includes instructional materials to help interpret results
- ◆ For April 2016, SNF target areas are as follows:
 - ◆ Therapy RUGs with high ADLs
 - ◆ Non-therapy RUGs with high ADLs
 - ◆ Change of Therapy (COT) Assessments
 - ◆ Ultra-High Therapy RUGs
 - ◆ 90+ Days Episodes of Care

33



Identify Facility Specific Risks

Comparative Billing Reports ("CBRs")

- ◆ Contains detailed information that CMS uses to compare a provider's billing patterns with those of its peers
- ◆ May be helpful in conducting self-audits
- ◆ Available free of charge
- ◆ Allows requestor to identify dates of service desired
- ◆ Shows RUG codes and other data compared to peers
- ◆ Consult your MAC's website for any CBR information
 - ◆ Example: FCSO CBR info is at the following link:
<https://medicare.fcso.com/CBR/261865.asp>

34



Identify Facility Specific Risks

CMS Public Use Files (PUF) for SNFs

- ◆ Most recent statistics available are for CY 2013
- ◆ Statistics are provided by state, nation, and individual SNF
- ◆ Examples of statistics available:
 - ◆ Part A days by RUG-IV category
 - ◆ Therapy minutes:
 - ◆ RU and RV days
 - ◆ % RU and RV within 10 minutes of threshold
 - ◆ Length of stay

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/SNF.html>

35



“Hot Spots” in SNF Compliance

36



“Hot Spots” in SNF Compliance

Part A

- ◆ Above average therapy utilization
 - ◆ High percentage of RU days
 - ◆ High percentage of RU and RV days combined
- ◆ Above average lengths of stay
- ◆ Long duration of therapy RUG days, especially with:
 - ◆ No improvement in ADL index
 - ◆ Fluctuating ADL index
 - ◆ Low ADL index
- Therapy minutes at or just above minimum for rehab level

37



“Hot Spots” in SNF Compliance

Part B

- ◆ Extended treatment duration
- ◆ Intensive treatment frequency
- ◆ High use of –KX modifier
- ◆ Higher frequency of therapy exceeding \$3,700 threshold
- ◆ Questionable functional reporting for Part B therapy services
- ◆ Continued therapy under Part B when Part A benefits exhaust
- ◆ Documentation weaknesses
- ◆ ICD-10 codes on claims that omit rehab treatment diagnoses

38



Identify and Prioritize Facility Specific Risks

39



Identify and Prioritize Facility Specific Risks

Know Your Benchmarks - Part A

- ◆ Rehab RUG percentages by classification level
- ◆ Average Medicare length of stay
- ◆ Average Medicare daily reimbursement
- ◆ Part A patients in lower 14 RUG categories
- ◆ A-B-C end splits in Rehab RUGs
- ◆ Average number of rehab minutes in excess of minimum
- ◆ Discharge status
- ◆ Hospital readmissions

40



Identify and Prioritize Facility Specific Risks

Know Your Benchmarks – Part B

- ◆ Analyze statistics in total and by discipline:
 - ◆ Charges billed each month
 - ◆ Average length of treatment
 - ◆ Average treatment frequency
 - ◆ Use of KX modifier
 - ◆ Average caseload by month
 - ◆ Percentage on caseload exceeding cap
 - ◆ Percentage on caseload exceeding threshold
 - ◆ End of therapy in relation to caps and threshold

41



Identify and Prioritize Facility Specific Risks

Avoid Increasing Risk Unintentionally

- ◆ Use “Triple Check” to ensure Medicare claim accuracy
- ◆ Focus on MDS scheduling and coding compliance
- ◆ Ensure ICD-10 codes on claims support skilled services
 - ◆ PT, OT, ST
 - ◆ Nursing services
 - ◆ Wound care
 - ◆ Isolation (when coded on MDS)
- ◆ Establish clinical oversight over decision to bill Medicare for unrelated services to hospice enrollee
- ◆ Develop controls to ensure timely response to ADRs

42



Identify and Prioritize Facility Specific Risks

Avoid Increasing Risk Unintentionally by:

- ◆ Monitoring denial rates
- ◆ Taking corrective action when denials/down-coding occur and:
 - ◆ Results are accepted without appeal; or
 - ◆ Appeal is unsuccessful
- ◆ Periodically modifying compliance efforts as risks change
- ◆ Carefully addressing employee compliance questions and concerns
- ◆ Providing ongoing education and resources to employees

43



Identify and Prioritize Facility Specific Risks

Understand Your Risk Profile

- ◆ Recognize that each facility's risk profile may be different
- ◆ Remember that risks are an inherent part of this business
- ◆ Assessing your risk profile
 - ◆ Monitor pertinent benchmarks
 - ◆ Identify risks to which you are exposed
 - ◆ Quantify the potential dollar amount of these risks
 - ◆ Implement protective measures related to each risk area
 - ◆ Develop a defensive plan of action if one or more risks are realized
 - ◆ Update your risk profile at least annually

44



Identify and Prioritize Facility Specific Risks

Implement a Plan to Reduce Risk Exposure

- ◆ **Validate compliance in areas of highest risk**
 - ◆ Internal audits
 - ◆ External audits
 - ◆ Vendor audits (e.g., therapy contractor)
- ◆ **Develop Corrective Action Plan for identified concerns**
 - ◆ Document training efforts
 - ◆ Follow up until concerns are resolved
- ◆ **Provide staff with “official” sources of guidance**
- ◆ **Make prompt refunds when overpayments are identified**
- ◆ **Track claim denials and appeal outcomes**
- ◆ **Fine-tune triple check procedures**
- ◆ **Manage compliance from the top down**

45



Sources of Benchmarking Data

46



Sources of Benchmarking Data

% of Rehab RUGs by Classification Level: National

Rehab RUG Category	FY 2011	FY 2012	FY 2013
Rehabilitation Ultra High	50.2%	54.2%	58.4%
Rehabilitation Very High	29.8%	27.9%	26.5%
Rehabilitation High	11.9%	11.0%	9.6%
Rehabilitation Medium	8.0%	6.8%	5.4%
Rehabilitation Low	.01%	0.1%	0.1%
Total	100%	100%	100%

Source: Pepperresources.org



47

Sources of Benchmarking Data

RUGs by Hierarchy: National	FY 2011	FY 2012	FY 2013
Rehabilitation Plus Extensive Services	2.5%	1.8%	1.7%
Rehabilitation	87.9%	88.5%	90%
Extensive Services	0.6%	0.7%	0.7%
Special Care	4.6%	5.1%	4.3%
Clinically Complex	2.5%	2.2%	1.9%
Behavioral Symptoms/Cognitive Problems	0.4%	0.3%	0.2%
Reduced Physical Function	1.5%	1.4%	1.2%
Total	100%	100%	100%



48

Sources of Benchmarking Data

% of PPS assessments which were COTs during the 4th quarter of FY 2013, FY 2014, and FY 2015 per Pepperresources.org

	<u>National</u>	<u>Florida</u>
Q4 FY 2013	11.9	11.3
Q4 FY 2014	11.2	10.7
Q4 FY 2015	10.7	10.0

Source: Pepperresources.org



49

Sources of Benchmarking Data

Average Length of Stay for all RUGs during the 4th quarter of FY 2015 per PEPPER

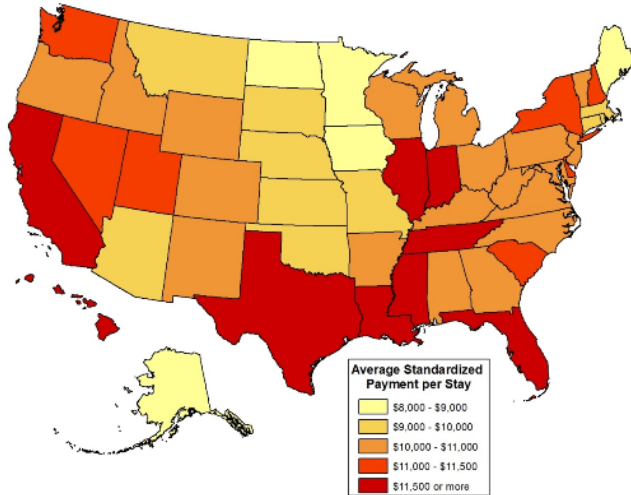
<u>National</u>	<u>Florida</u>
18.6	19.1

Source: Pepperresources.org



50

Skilled Nursing Facility Average Standardized Payment per Stay, by State, 2013

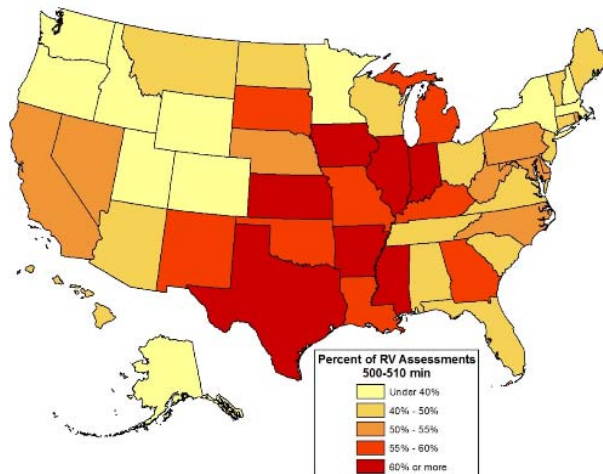


Source: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-09.html>

51



Percent of RV Assessments Between 500-510 Minutes, by State, 2013

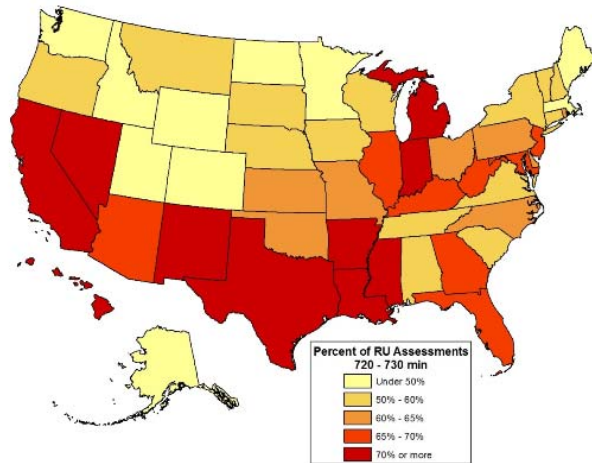


Source: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-09.html>

52



Percent of RU Assessments Between 720-730 Minutes, by State, 2013



Source: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-09.html>

53



Monitor Therapy Service

54



Monitor Therapy Service

High Risk Areas in Therapy Delivery

- ◆ Ineffective oversight of therapy department
- ◆ Presuming all or most patients start in RU
- ◆ Therapy that is driven by non-patient related reasons
- ◆ Management goals to achieve certain rehab levels
- ◆ Minutes that meet or just slightly exceed required minimum
- ◆ Continuing therapy when medical necessity is not well supported
- ◆ Discounting recommendations of evaluating therapist
- ◆ Documentation that does not support skilled interventions
- ◆ Inappropriate assignment of treatment minutes to supervised modalities

55



Monitor Therapy Service

Common Therapy Documentation Weaknesses

- ◆ Routine use of 90-day plans of care
- ◆ Incomplete documentation of evaluation
- ◆ Goals that are:
 - ◆ Poorly defined
 - ◆ Not supported by evaluation
 - ◆ Not updated as treatment proceeds
 - ◆ Overlapping between disciplines

56



Monitor Therapy Service

Common Therapy Documentation Weaknesses

- ◆ Progress notes that:
 - ◆ Do little to support benefits of treatment
 - ◆ Do not address barriers to improvement
- ◆ PTs and OTRs who do not “actively participate” in treatment
 - ◆ Inadequate supervision of therapy assistants
 - ◆ Infrequent treatments by evaluating therapists
 - ◆ Progress notes written by assistants
- ◆ Treatment minutes not identified by mode of delivery
- ◆ Weak or missing discharge summaries
- ◆ Significant co-treatments without supporting rationale

57



Nursing ↔ Therapy Communication

58



Nursing ↔ Therapy Communication

Strengthen Interdisciplinary Teamwork

- ◆ Integrate IDT assessments/Information
 - ◆ Social services/admissions
 - ◆ Nursing assessment
 - ◆ Therapy evaluations
- ◆ Share Hospital Documentation with IDT
 - ◆ History & Physical
 - ◆ Discharge Summary
 - ◆ Consultations (Specialists)
 - ◆ Diagnostic Test Results
 - ◆ Therapy documentation

59



Nursing ↔ Therapy Communication

- ◆ Obtain data for all hospital services during current benefit period
 - ◆ Multiple I/P hospital stays
 - ◆ Acute hospital → IRF → SNF
 - ◆ Acute hospital → psych → SNF
 - ◆ ER visits
 - ◆ Observation stays

60



Nursing ↔ Therapy Communication

IDT Teamwork

- ◆ Nurses' notes can be critical during claim audits for therapy services
 - ◆ Document/confirm nursing ↔ therapy communication
 - ◆ Document changes in patient's status
 - ◆ Note improvement of functional skills and/or carry over from therapy
- ◆ Social service assessments/notes can be helpful to therapists
 - ◆ Prior level of function (PLOF)
 - ◆ Potential barriers to successful return to prior residential setting
 - ◆ Amount and type of family or caregiver assistance

61



Nursing ↔ Therapy Communication

IDT Teamwork (continued)

- ◆ Nursing ↔ Therapy Communication
 - ◆ Scheduled doctor visits
 - ◆ Scheduled off-site diagnostic tests or treatments
 - ◆ Family visits
 - ◆ Special events
 - ◆ Patient illnesses or changes in condition
 - ◆ Changes in medication
 - ◆ Unique patient characteristics
 - ◆ Necessary to minimize frequency of missed treatments and refusals

62



Management of Medicare Audits and Denials

63



Management of Medicare Audits and Denials

Management Oversight of Critical Processes

- ◆ **Additional Development Requests (ADR) and other audits**
 - ◆ Tracking timely response
 - ◆ Monitor resolution (favorable, fully unfavorable, or partially unfavorable)
 - ◆ All denials should be analyzed by therapy and/or nursing depending on RUG
- ◆ **Denials and Related Appeals**
 - ◆ Management should be aware of all decisions to accept denial without appeal
 - ◆ Ensure interdisciplinary approach to appeal preparation
 - ◆ Prepare position paper to accompany each level of appeal
 - ◆ Address “deficiencies” identified in the denial determination

64



Management of Medicare Audits and Denials

Systematize Responses to Medical Review

- ◆ Establish a “Medicare team” to assemble and review documents assembled for medical review requests
- ◆ Recommended team members include:
 - ◆ Director of Nurses/Nurse Designee
 - ◆ Director of Rehab
 - ◆ Business Office Manager
 - ◆ MDS Coordinator
 - ◆ Medical Records
- ◆ Ensure timely, complete, and organized response
- ◆ Consider “Bates stamping” submission
- ◆ Retain a copy of everything that is sent to requestor
- ◆ Log all requests until decision received

65



Management of Medicare Audits and Denials

Common Causes of Denials

- ◆ Incomplete record submissions
- ◆ Non-compliance with documentation requirements
- ◆ Illegible documentation
- ◆ Illegible signatures
- ◆ Lack of credentials with clinical documentation
- ◆ Inclusion of irrelevant information
- ◆ Conflicting documentation
- ◆ Nursing or therapy notes that raise questions about the skilled nature of assessments and/or interventions

66



Management of Medicare Audits and Denials

Pursue Appeals for Denials

- ◆ Medicare team should evaluate basis for denial and develop appeal rationale
- ◆ Position paper should be prepared to present basis for appeal
- ◆ Successful resolution of disputed issues often requires pursuing the first three levels of appeal (to the ALJ)
- ◆ The decision not to appeal a denial should be carefully considered and a Corrective Action Plan developed to avoid recurrence when no appeal will be sought
- ◆ Log all denials and appeal deadlines until their resolution

67



Management of Medicare Audits and Denials

Medicare Levels of Appeal

- ◆ Redetermination Request
- ◆ Reconsideration Request
- ◆ Administrative Law Judge
- ◆ Appeals Council Review
- ◆ Judicial Review in U. S. District Court

*****Pursuit of appeals through first three levels
should be relatively routine*****

68



Management of Medicare Audits and Denials

Deferral of Overpayment Recoupment

- ◆ Section 935 of MMA 2003 permits a deferral of overpayment recoupment through the first two levels of appeal
- ◆ Certain steps are required to obtain a Section 935 deferral of recoupment
 - ◆ Rebut proposed recoupment within 15 days of “First Request” letter
 - ◆ Submit a 935 Redetermination Appeal within 30 days of First Request letter
 - ◆ If Redetermination Decision is unfavorable, you must submit Reconsideration Request within 60 days

69



Management of Medicare Audits and Denials

<u>Level of Appeal</u>	<u>Type of Appeal</u>	<u>Regular Deadline</u>	<u>935 Recoupment Deferral Deadline</u>
1st	Redetermination	120 days	30 days
2nd	Reconsideration	180 days	60 days
3rd	ALJ	60 days	N/A
4th	MAC	60 days	N/A
5th	Federal District Court	60 days	N/A

70



Tips for Success in Managing Claim Audit Risk

71



Tips for Success in Managing Claim Audit Risk

- ◆ Monitor CMS info on SNF payment vulnerabilities
- ◆ Identify and prioritize your Medicare compliance risk areas
- ◆ Establish interdisciplinary team to respond to claim audits
- ◆ Reassess corporate compliance plan effectiveness
- ◆ Conduct periodic audits of high risk areas
- ◆ Promptly investigate and refund overpayments
- ◆ Implement a Corrective Action Plan when issues are identified
- ◆ Establish an entity wide culture of compliance from the top down

72



The Alphabet Soup of Medicare Claim Audits

Question and Answer Session



73

