DISCLOSURE

I have commercial interests in the following organization:

- **Aegis Therapies** as a National Clinical Director. Aegis Therapies provides rehabilitation, wellness and home health services.

Tuesday, April 4, 2017
PRESENTER: Jaclyn Warshauer, PT
National Clinical Director at Aegis Therapies

ACHCA 51st Annual Convocation & Exposition

Medicare ADRs, Denials and Appeals Update

TODAY'S OBJECTIVES

1. Summarize the differences between the various Medicare medical review entities
2. Describe strategies for effectively responding to medical record requests
3. Examine the importance of deciphering SNF and Therapy denials in order to direct your appeal strategy

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THE MEDICARE PROGRAM

1.2 Billion Claims / Year for Medicare

< 1%

12.1%

$43 Billion

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MEDICARE PROGRAM INTEGRITY

- To ensure that taxpayer dollars are spent on legitimate items and services
  - Pay the right amount, to the right party, for the right beneficiary, in accordance with the law and agency policies
- Medicare cannot conduct medical review on every claim
- Targeting of medical review resources to focus on those services that are high risk for improper payment

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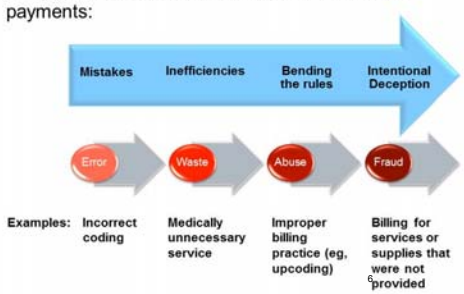
Range of Program Integrity Activities

Program Integrity encompasses a range of activities to target the causes of improper and fraudulent payments:



CMS

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PROGRAM INTEGRITY

- Strategic direction for becoming more effective while reducing the burden on legitimate providers

MEDICARE PROGRAM INTEGRITY RESULTS

- Most current data: FY 2014
- IN FY 2014, Program Integrity activities saved Medicare $18.1 billion
  - $11.9 billion from Prepayment Reviews
  - $2.2 billion from Postpayment Reviews and Audits
  - $2.5 billion in RAC recoveries

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REMEMBER

Not all improper payments constitute fraud, and high improper payment rates do not necessarily indicate a high rate of fraud

- Most Medicare FFS improper payments result from insufficient documentation to determine whether the service or item was medically necessary

Slide from CMS

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SCOPE OF PROGRAM INTEGRITY ISSUES

- Waste alone may account for 30% of overall healthcare costs
- Institute of Medicine estimates the US healthcare system loses about $765 billion/yr, including from fraud
- Overall….few providers will abuse or defraud the system, but nearly all contribute to waste

SOURCE: Fisher, Bynum, Skinner (2009). Slowing the Growth of Health Care Costs – Lessons From Regional Variation, NEJM, 360(9): 849-852; Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press, 2012.

MEDICARE CLAIMS REVIEW ENTITIES

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MEDICARE CLAIMS REVIEW ENTITIES

- CMS contracts with the following contractors in its effort to fight improper payments in the Medicare program:
  - Medicare Administrative Contractor (MAC)
  - Recovery Audit Program (RAs – formerly the RAC)
  - Comprehensive Error Rate Testing Contractors (CERT)
  - Zone Program Integrity Contractor (ZPIC)
  - Unified Program Integrity Contractor (UPIC)
  - Supplemental Medical Review Contractor (SMRC)

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MAC

- Goal: **PREVENTION**
- Reduce payment errors by identifying and addressing provider coverage and coding mistakes
- How?
  - Education of providers on Medicare coverage and coding requirements
  - Identification of aberrancies or patterns of inappropriate billing
    - Through data analysis
  - Performance of medical review of claims and the supporting documentation
    - Following Progressive Correction Action program

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MAC EDUCATION: COVERAGE POLICIES

- Each MAC has the discretion to make coverage decisions about what items or services it considers reasonable and necessary
- Issued in a document called a Local Coverage Determination - "LCD"
  - Specify under what clinical circumstances a service is considered to the reasonable and necessary
  - Assist providers in submitting correct claims for payment
  - The MAC's Medical Review department utilizes the LCD for guidance to assist in coverage and coding audits of claims

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MEDICARE COVERAGE DATABASE

- CMS website that contains all LCDs for each MAC: **Medicare Coverage Database**
  - Searchable database
  - http://www.cms.gov/medicare-coverage-database/

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MEDICARE COVERAGE DATABASE

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MEDICARE MACS: LISTED PROBE REVIEWS (FEB 2017)

MAC	Probes Listed on Website
Cahaba – JJ (AL, GA, TN)	IRF: Jt Replacement, LE Fracture, Debility Physician: Subsequent Nursing Facility Care (99231-99233)
CGS – J15 (KY, OH, HH J15)	SNF: RUA, RUB and RUC Therapists in Private Practice HH: Probe and Educate Medical Review
FCSO – JN (FL, Puerto Rico, Virgin Islands)	Biofeedback PTs and OTs in Private Practice Physician: Nursing Facility Evaluation and Mgmt HH: Physician Recertification

MEDICARE MACS: LISTED PROBE REVIEWS (FEB 2017)

MAC	Probes Listed on Website
NGS – J6 (MN, WI, IL)	97532, Mobile Medical Review
NGS – JK (NY, VT, NH, CT, RI, MA)	Mobile Medical Review Part B Therapy: 97532, 97032, 97033, Re-evaluations SNF: RUA, RUB, RUC SNF: Lowest 14 RUGs
Noridian – JE (CA,NV, HI)	Physician: Initial and Subsequent Nursing Facility Care IRF

MEDICARE MACS: LISTED PROBE REVIEWS (FEB 2017)

MAC	Probes Listed on Website
Noridian – JF (AK, WA, OR, ID, MT, WY, ND, SD, AZ, UT)	Targeted Probe & Educate w/ Extrapolation Pilot (Facilities and Private Practice)
Novitas – JH (AR, CO, LA, MS, NM, OK, TX)	IRF: LE Joint Replacement and LE Fractures SNF: RU "Upcoming Focus of Provider Specific Reviews": IRF, SNF, PT in Facilities
Novitas – JL (DE, DC, MD, NJ, PA)	IRF: LE Joint Replacement and LE Fractures

MEDICARE MACS: LISTED PROBE REVIEWS (FEB 2017)

MAC	Probes Listed on Website
Palmetto (Part A/B for NC, SC, VA, WV)	IRF: LE Fractures SNF: RU HH: Claims with BG** and CH** HIPPS Codes, 2CHK*
WPS – J5 (IA, KS, MO, NE, and former Mutual of Omaha)	(Historically has looked at High $$ claims, Part B Therapy (edit 50TPT) and SNF (50SNF) – has new website that has very little information currently.)
WPS – J8 (IN, MN)	(Historically has looked at High $$ claims, Part B Therapy (edit 50TPT) and SNF (50SNF) – has new website that has very little information currently.)

RECOVERY AUDIT PROGRAM (RAC)

- Goal: **DETECT AND CORRECT**
- Detect improper underpayments and overpayments and make corrections
- How?
  - Post-payment claims review
  - Widespread or Targeted review
  - Vulnerabilities identified by the RAC program used by MACs to target their improper payment prevention efforts
  - Paid a contingency fee

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RECOVERY AUDIT PROGRAM (RAC)

- On 10/1/16 CMS awarded the next round of RAC contracts
  - Region 1 – Performant Recovery, Inc.
  - Region 2 – Cotiviti, LLC
  - Region 3 – Cotiviti, LLC
  - Region 4 – HMS Federal Solutions
  - Region 5 – Performant Recovery, Inc.

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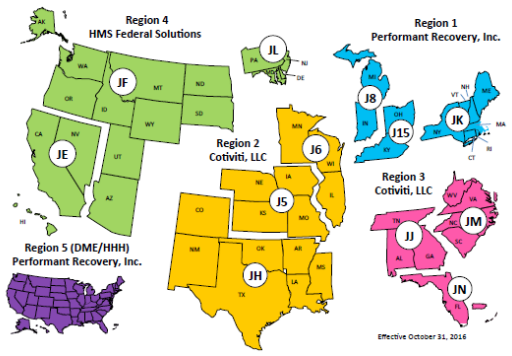
Medicare Fee-for-Service RAC Regions



RAC UPDATE

- Complex review timeframe reduced to 30 days
- 30 day waiting period before sending the claim to the MAC for adjustment
- Confirm receipt of Discussion Request or other correspondence within 3 days
- Broaden review topics to all provider types
- Required review on CMS referrals
- RAC's required to maintain:
  - Accuracy rate of at least 95%
  - Appeal overturn rate of less that 10% at the first level

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RAC UPDATE

- Request Limits
  - Revised ADR limits for institutional providers
  - Diversified proportionally across all claim types of a facility (e.g., inpatient, outpatient)
  - Incrementally applied limits for providers new to RAC reviews
  - Adjusted based on a provider's compliance with Medicare rules
    - Low denial rate = lower ADR limit
    - High denial rate = higher ADR limit
  - Denial rate is reset with new contracts: CMS may grant exceptions
  - RACs can choose limited or extended look-back period

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RAC RISK-BASED, ADJUSTED ADR LIMITS

- Calculated after three 45-day ADR cycles*

# of Claims w/ Improper Payments (minus fully overturned appeals)

# of Claims Reviewed

Table 1:

Denial Rate (Range)	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	5.0%
71 – 90%	4.0%
51 – 70%	3.0%
36 – 50%	1.5%
21 – 35%	1.0%
10 – 20%	0.5%
4 – 9%	0.25%
0 – 3%	No reviews for 3 (45-day) review cycles

27 If auditing based on "adjusted" ADR limits, the look back is limited to 6 months

USE OF EXTRAPOLATION

- CMS will consider allowing Recovery Auditors to use extrapolation to estimate overpayment amounts for:
  - Providers who maintain a high denial rate for an extended time period
  - Providers who have excessively high denial rates for a shorter time period
  - Providers with a moderate denial rate, whose improper payments equal a significantly high overpayment dollar amount

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RAC RESULTS (NATIONALLY)

FY2015 (most current date posted)

Overpayment No. of Claims	596,913
Overpayment Amount Collected	$359,729,011
Underpayment No. of Claims	32,053
Underpayment Amount Restored	$80,964,651
TOTAL No. of Claims Corrected	618,966
TOTAL Amount Corrected	$440,693,663 (82% ↓ from FY2014)

RAC expenditures: $95 Million

ROI: $2.5 : 1 (if you factor in the Underpayments returned)

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COMPREHENSIVE ERROR RATE TESTING (CERT) PROGRAM

- Goal: **MEASURE**
- Annually estimates the amount and rate of improper Medicare payments through conducting reviews of a statistically valid random sample of claims
- How?
  - Randomly selection
  - Post-payment review
  - Results published annually
    - Results can be used to direct the work of the MAC, RA, SMRC
    - Used to guide provider education efforts

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CERT: MOST COMMON DENIAL REASON IN SNF

- **#1: Insufficient Documentation**

Part A Services Excluding Hospital IPPS (TOB)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payment
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
SNF Inpatient	$2,650,891,991	7.8%	6.2% - 9.5%	0.6%	76.7%	0.0%	10.8%	12.0%	6.3%
SNF Inpatient Part B	$146,880,818	6.3%	1.7% - 10.8%	0.0%	60.1%	0.0%	4.1%	35.8%	0.4%
SNF Outpatient	$28,428,091	12.6%	2.4% - 22.8%	0.0%	29.5%	0.0%	0.0%	70.5%	0.1%

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ZONE PROGRAM INTEGRITY CONTRACTORS (ZPIC)

- Goal: **IDENTIFY and PREVENT POTENTIAL FRAUD**
- How?
  - Perform data analysis and conduct medical review
  - Conduct interviews
  - Conduct onsite visits
  - Investigate potential fraud and abuse
  - Refer cases to law enforcement and OIG

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UNIFIED PROGRAM INTEGRITY CONTRACTOR (UPIC)

- Goal: **IDENTIFY and PREVENT POTENTIAL FRAUD, WASTE and ABUSE**
- Combines functions of ZPIC and the Medicaid Program Integrity Contactor (MIC)
- How?
  - Perform managed care and fee for service data analysis and conduct medical review
  - Conduct interviews
  - Conduct onsite visits
  - Investigate potential fraud and abuse
  - Refer cases to law enforcement and OIG

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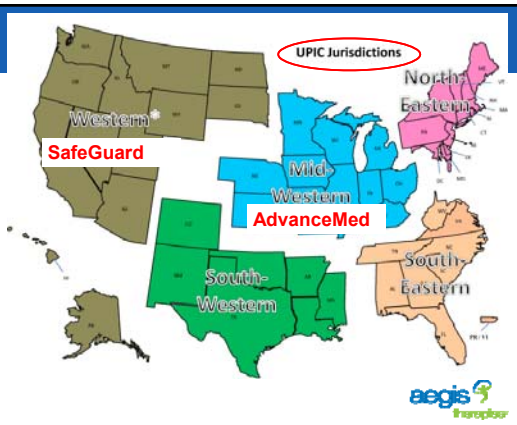

SUPPLEMENTAL MEDICAL REVIEW CONTRACTOR (SMRC) – STRATEGIC HEALTH SOLUTIONS

- GOAL: **AUDIT**
- Conducts postpayment reviews as part of studies directed by CMS
  - Identifies underpayments & overpayments
  - Can perform large volume medical review nationally
    - Unlike the other review contractors that cover specific regions/jurisdictions
- Provides CMS with information on the prevalence of the issues
- Recommends to CMS on how to address the issues that the SMRC identifies

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SMRC – STRATEGIC HEALTH SOLUTIONS CURRENT POSTED PROJECT

- MACRA Outpatient Rehabilitation Therapy Cap
  - Postpayment medical review
  - Providers selection for "high percentage of patients receiving therapy beyond the [$3700] threshold as compared to their peers"

CMS

StrategicHealthSolutions

Date:

Reference ID: Y4P0430-MT1

ATTENTION: COMPLIANCE
PROVIDERNAME

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SMRC – STRATEGIC HEALTH SOLUTIONS
CURRENT POSTED PROJECT

- Skilled Nursing Facilities (SNF) Therapy Services
  - Postpayment medical review
  - Providers selection: "The OIG report noted that SNFs used assessments very differently when decreasing therapy than when increasing it, costing Medicare $143 million over 2 years. Furthermore, SNFs frequently used the new start-of-therapy assessment incorrectly."

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CMS INTERACTIVE MAP FOR REVIEW CONTRACTOR INFORMATION

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#upic

So you got an ADR…

ADR VS DENIAL VS APPEAL

- **ADR** - Additional Development Request
  - Request for Medical Records for medical review to determine if the claim should be paid as billed
    - An ADR is **NOT** a denial
- **Appeal** – process to follow if you disagree with the initial determination
  - After Medical Review of an ADR'd claim
  - After an automated denial (no medical records sent in)

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PRE-PAY ADR

- As the claim is submitted for payment it is suspended because it requires a medical record review to finalize the claim process
  - The claim will go into a pending status until the medical review is completed and the claim adjudicated to match the medical review decision
  - Some payors are no longer sending ADRs in the mail for electronic billers. It will be the biller's responsibility to track if any claims are suspended for an ADR

POST-PAY ADR

- The claim was already paid
  - Could be months or years ago
- Letter sent with details indicating the reason for the ADR and the claims that are ADR'd
- If ADR packet received, claim will be adjudicated to reflect the medical review decision if a denial occurs
  - Claim won't change with a "paid" ADR decision since the claim was already paid
    - If the medical review result is "paid" – there may not be any communication from the payor that the medical review decision was "paid"

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GET PAID THE FIRST TIME!

- **Avoid denials for late submission or insufficient information!**
- **4 very important considerations when compiling an ADR Packet:**
  - Legible
  - Complete
  - Logical Order
  - Timely

COMPILING AN ADR PACKET

- The **pertinent** medical record documents should be included from Start of Care through the DOS in question
  - The reviewer needs to see why the patient was there in the first place, and generally what has happened leading up to the DOS in question
  - The evaluation/initial assessment documentation usually shows the most complete picture of the patient's prior abilities, the cause of the change in function, the medical conditions and co-morbidities
    - This is needed to establish medical necessity and potential

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ADR DOCUMENTATION LIST

- **Not an all inclusive list**
- Sometimes these are generic and some items might not apply to your setting
- Do not limit to documentation written during the DOS – include documentation from prior to the DOS…and sometimes after
- **Copy of ADR must be placed on top of the related medical record packet**

EXAMPLE OF A PART B THERAPY ADR CHECKLIST (NOT THE COMPLETE LIST)

Check the Appropriate Box: Discipline(s) ADR'd: ☐ PT ☐ OT ☐ SLP

Therapy documentation from SOC through the end of the DOS of the claim in question, organized by discipline, in the following order:

Required Items:*

☐ Copy of the ADR (must be placed on topic of packet)
☐ "POC and Certification" Divider
  ☐ Physician-signed and dated POC
☐ "Progress Notes and Recertification" Divider
  ☐ Sequential from SOC: Therapist Progress Reports, Interim Progress Notes, Physician-signed and dated UPOCs, and Discharge Summary (as applicable)
☐ "Daily Notes" Divider
  ☐ Treatment Encounter Note-Cover Sheet (attached to Daily N
  ☐ Daily Narrative Notes (for month in question)
  ☐ CPT Log (for month in question)

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SIGNATURE LOGS

- If there are any hand written signatures in the medical record submitted a signature log is required
  - Be sure to have the clinician include all iterations of their signature on the log

DATE	Clinician/Care Provider Full Name (PRINTED OR TYPED)	Credentials	Record all hand written SIGNATURE versions of the Clinician/Care Provider	Clinician Care Provider Initials
1				

COMMUNICATE

- **Assemble a team that will be involved in gathering and verifying the ADR packet**
  - Designate a point person to coordinate the effort
  - Give a checklist to each team member of the documents they are to gather
    - Be specific… "Physician signed clarification order that covers (ENTER: specific dates)"
  - Communicate hard deadlines that give enough cushion for the verification process of the packet prior to the submission deadline

LEGIBLE AND ORGANIZED

- Ensure every page is legible
- Assemble each discipline's documentation in logical order so it reads like a book
- **Each ADR DOS must have a separate packet**
- Most payors do not want staples. Some don't want paper clips, either. Check ADR and/or payor's website for how to separate multiple ADR packets

TIMELINESS OF SUBMISSION

- **Timeliness is critical**
  - Deadline varies by Medical Review Entity
    - The ADR will give the deadline info
  - Automatic denial for late ADRs
    - For the Medicare MAC, that's day 46
- **Before submitting make an <u>exact</u> copy of the packet**
  - Can reference if the payor indicated that docs were missing
  - Can be used for appeals

SUBMISSION METHODS

- **Many payors have multiple ways to submit**
  - Paper, fax, CD/DVD, esMD
  - Check the ADR and/or their website for options
- If mailing: certified mail or signature confirmation
- If faxing: maintain fax confirmation
- Some payors have time of day limits for accepting the packet
  - E.g., packet received after 5:00 on deadline considered late and claim denied

TRACKING LOG

ADR LEVEL	EACH APPEAL LEVEL
• Payor/Review Entity • Date of ADR • Patient name • Service under review • DOS • $$ at risk • Date ADR packet submitted • Outcome	• Denial Notice Date • Services Denied • Denied $$ • Denial Reason • Plan (e.g., appeal or not) • Date appeal packet submitted • Outcome

WHAT IF THE ADR DEADLINE IS MISSED?

- **Medicare: Automatic denial**
  - FISS Denial Reason Code: 56900
    - Remittance Advice Remark Code: M127 (Missing patient medical record documentation)
  - Submit a request for a Reopening
    - Check payor's website for instructions
  - The Reopening should be submitted to Medical Review with a cover letter indicating it is a reopening request and must be received within **120 days** from the denial date

ADR RESULTS COMMUNICATION

- **Results: Paid, Partially Paid, Denied**
- **If paid, might not be notified**
  - Check Status Location in billing system
- **Pre-pay: Result Letters and Remit Advice**
  - Some payors have gone away from issuing ADR Result Letters
    - Results in FISS/DDE
- **Post-pay: Result Letter and Demand Letter (if denied)**

OUCH!!
YOU GOT A DENIAL!

Now What?!?

GATHERING DENIAL INFO

- **Denial that is result of an ADR review**
  - Claim status will change in FISS. Denial Reason will be noted
    - Pre-pay ADR
  - Results Letter
    - Post-pay ADR
  - Remittance Advice (RA)
- **Automated Denial**
  - Remittance Advice
  - Claim status will change in FISS. Denial Reason will be noted

DENIED SERVICES IN FISS

- **Status Location**
  - P B9997: Partially Paid claim
    - NOTE: This Status Location is also used for a fully PAID claim
  - D B9997: Fully denied
- **Determine the specific discipline, CPT code(s) and date(s) denied**
  - Shown as non-covered lines
- **Determine the Denial Reason Code**
  - Each line could have a different reason for denial

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DENIAL REASON CODES

- **Denial Reason Codes**
  - Represent the cause of denial for the specific revenue code line
  - If medically denied, this code will typically start with a "5"
    - "Medically denied" – based on medical necessity
      - Automated Review: missing ICD code from payor's LCD/NCD
      - Complex Review: denied by a medical reviewer upon review of the medical records

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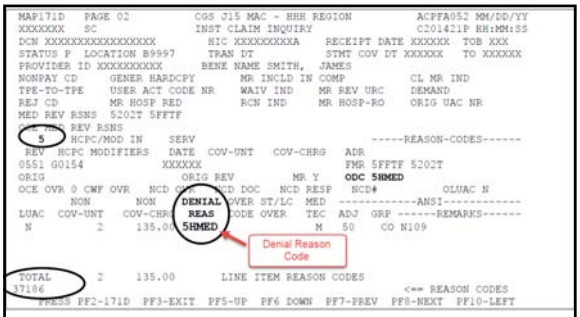

- **5HMED: Medical Necessity of services not supported**

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COMMON THERAPY-RELATED AUTOMATED DENIAL REASON CODES

Denial Reason Code	Explanation
56900	ADR documentation not received timely
W7019 W7020	CCI edit that is not allowed, even with modifier -59 present
W7039 W7040	CCI edit that would be allowed if a modifier -59 was present
55A00*	Claim denied for not having a covered ICD code from the applicable LCD/NCD *some payors use a different Denial Reason Code such as 52NCD or 5LPDN
V8022	Over the Therapy Cap without a KX

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POSSIBLE ROUTES TO OBTAIN PAYMENT AFTER AN AUTOMATED DENIAL

- Must determine first if there are grounds to obtain payment
  - No Grounds: Denial of units > 1 for Service Based Codes
- Facility to re-submit claim with correction
  - It is often suggested to try the claim resubmission route first and if that doesn't work, then appeal to redetermination
- Clerical Reopening (instructions on MAC website)
- Appeal to Redetermination

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MEDICAL REVIEW DENIAL REASON CODES

- **Payor specific**
  - Medical Review departments can make up their own Denial Reason Codes
- The explanation of the Denial Reason Code can be looked up
  - Reason Code Inquiry Screen in FISS
- Some medical reviewers will add denial reason information in the Remarks Page (Page 4) in FISS

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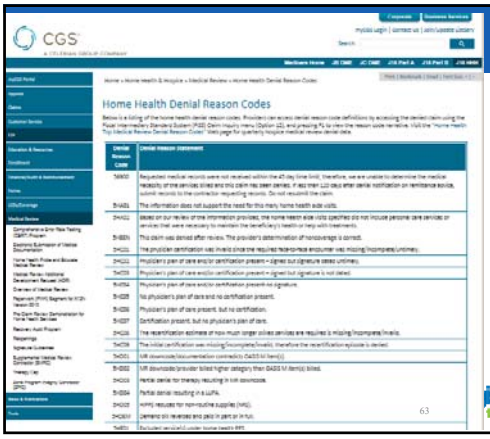

CGS has **over 60** HH Denial Reason Codes

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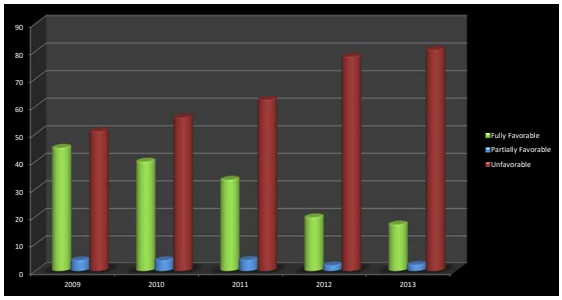
APPEALING A DENIAL

But First, Let's Look at Medicare Statistics for Appeal Results

MEDICARE REDETERMINATION RESULTS 2009-2013



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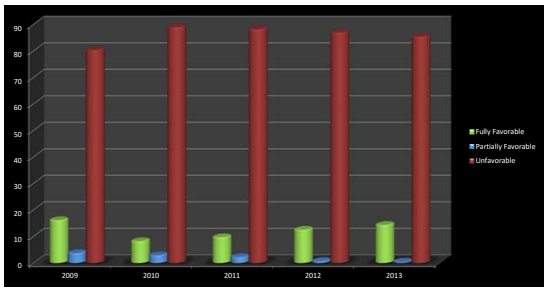
MEDICARE RECONSIDERATION RESULTS 2009 - 2013



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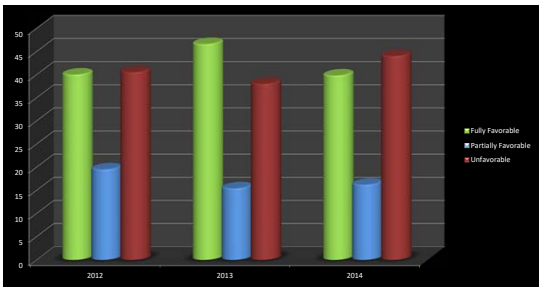
MEDICARE ALJ RESULTS 2012-2014



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APPEALING A DENIAL

- If you get a denial from any of the Medicare medical review entities, you follow the "normal" appeal process

MAC
RA
ZPIC
CERT
SMRC

→ Begin the appeal at the **Redetermination*** Level at the MAC

*Some allow a Discussion Period first

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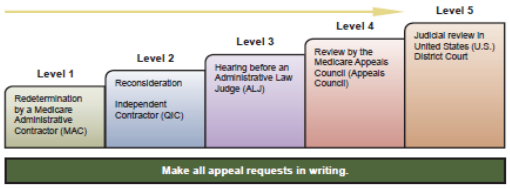
DISCUSSION PERIOD

- When the review entity allows a Discussion Period
  - Allows provider time to submit additional information/doc
  - Do not submit appeal while in a requested Discussion Period
    - Appeal will override the Discussion Period
  - Discussion Period does not extend appeal timeframe
- RAC
  - Requested within 30 days of receipt of Review Results Letter
- SMRC
  - Written request received by SMRC within 30 days of date of Results Letter
  - Discussion Period info on Strategic Health Solution's website

MEDICARE APPEALS

Appealing Medicare Decisions



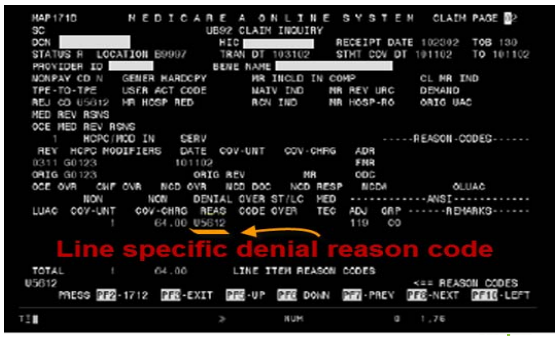
Make all appeal requests in writing.

- Medicare MLN: Medicare Parts A & B Appeals Process

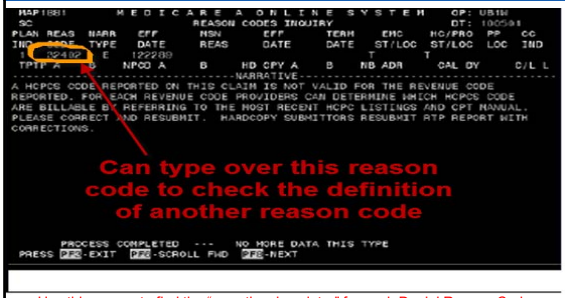
MUST KNOW WHAT YOU'RE APPEALING

- Appeal is a rebuttal to a specific denial
- Therefore, you will need to know
  - What specifically was denied
  - Why it was denied
- If there is not a denial notification letter indicating what was denied and the specific reason for the denial, it will take working with the biller to access the denied claim to look at the claim denial specifics

FROM PAGE 02, PUT THE CURSER ON A CPT LINE WITH A DENIAL AND HIT F2. THE LINE ITEM DETAIL INFORMATION WILL COME UP FOR THAT PARTICULAR LINE, INCLUDING THE LINE SPECIFIC DENIAL REASON CODE.



REASON CODE INQUIRY SCREEN



Use this screen to find the "narrative descriptor" for each Denial Reason Code

IN SUMMARY

- Effective denials management takes an interdisciplinary team
  - Executive Director, Medical Records, Nursing, Therapy, Billing
- It's important to keep up to date on the current Medicare auditing landscape
- Know your own data related to the current probe issues to determine if you might be at risk for a probe selection
  - Have a response plan in place

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RESOURCES AVAILABLE

- Payor's websites
  - Each Medicare MAC will have information on Medical Review and Appeals on their websites
    - Search their sites
    - Includes any MAC specific appeal forms

RESOURCES AVAILABLE

- CMS website
  - Medical Review:
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/

RESOURCES AVAILABLE

- CMS Website
  - Appeals
  - https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html

THANK YOU!

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