"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

Broad River Rehab Reflections: Medicare Audit & Denial Trending

May 19th 2022

Course Overview

Having an understanding of trends in areas of Medicare audit and appeal is essentially to support proactive measures for success upon Medical review.

During this session attendees will gain knowledge related to will cover national and regional based trends in the areas of Medicare Audit and Appeal.

Furthermore, speakers will provide proactive tips and guidance to support success in both technical and medical necessity requirements from payers to support success during targeted probe and audit

Learning Objectives

As a result of this presentation the participant will be able to...

1. Define phases of medical review from ADR to redetermination, reconsideration, and ALJ.

2. Explain current Medicare review trends included targeted probe and educate, focus audit, and PEPPER report focus areas.

3. Define proactive measures providers can use to promote success in areas of technical review and medical necessity in order to support success in cases of audit.

Medicare Helpful Terms

Amount in Controversy (AIC): The required threshold Level 3 and Level 5 appeals. This is dollar amount remaining in dispute. CMS will adjust the AIC annually. (Year 2022 =$180 for Level 3)

Appeal: The process used when a beneficiary, provider, or supplier disagrees with an initial health care item or service determination or a revised determination.

Appellant: A person or entity filing an appeal

Determination: A decision made to either pay in full, pay in part, or deny a claim.

Escalation: When an appellant requests moving a reconsideration pending at the QIC level (second level appeal) or higher to the next level because the adjudicator can't make a prompt decision or dismissal.

Medical review: a review of claims to determine whether services provided are medically reasonable and necessary as well as to follow up on the effectiveness of prior corrective actions.

On-the-Record: A decision based solely on information within the administrative record and evidence sent with the request. There is no hearing held.

Medical Review

Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements.

Medical reviews identify errors through claim analysis and/or medical review activities.

A Medicare contractor may use any relevant information they deem necessary to make a prepayment or post-payment claim review determination.

- This includes any documentation submitted with the claim or through an additional documentation request.

Medical Review

Medicare medical review contractors are required to follow CMS coverage instructions, as well as pertinent coding and billing materials. Coverage criteria may be outlined in statute and/or regulation, or may be further defined in:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)
- CMS' Manuals (such as the Benefit Policy, Claims Processing, and Program Integrity Manuals) which will provide further interpretative medical review guidance.

Who are the Managed Care Reviewers?

Humana

- Internal review process

United Healthcare

- Occasionally will contract with outside reviewing entities (i.e., Cotiviti, SCIO)

Blue Cross Blue Shield (BCBS)

- Internal review process

Aetna

- Also, will occasionally contract with outside reviewing entities

Types of Reviews Conducted

ADR = **Additional Documentation Request/Additional Development Request**

- Can come from Medicare or Managed Care payors
- Can be PRE-PAY or POST-PAY request

PRE-PAY request

- Can come from Medicare or Managed Care payors
- Claim is suspended prior to payment until review of the documentation is completed
- Notified of review request by your BOM viewing the claim in the Medicare billing system OR a letter to the facility

POST-PAY request

- Can come from Medicare or Managed Care payors
- The claim is paid as billed, and the request to review documentation is received later
- Notified of review request by your BOM viewing the claim in the Medicare billing system OR a letter to the facility
- If the review determines an issue, the original paid amount is recouped

Types of Reviews Conducted

TPE = **Targeted Probe and Education**

- Generated by the MAC, based on % usage of a specifically targeted HCPC code (97112, 97530)
- PRE-PAY review conducted prior to issuing full payment

RAC = **Recovery Audit Contractor request**

- POST-PAY request to review records; managed by a contractor on behalf of the MAC (i.e., Cotiviti, SCIO, Strategic Health Solutions, etc.)

CERT = **Comprehensive Error Rate Testing**

- Review of random sample to determine if paid properly under Medicare coverage, coding and payment rules

ZPIC = **Zone Program Integrity Contractor audit**

- Instituted by CMS to identify suspected fraud or irregularities (not a random review)

Types of Reviews Conducted

SMRC= Supplemental Medical Review Contractor

- Instituted by CMS to help lower improper payment rates while protecting the Medicare Trust Fund. SMRC used to determine if claims follow coverage, coding, payment and billing requirements.

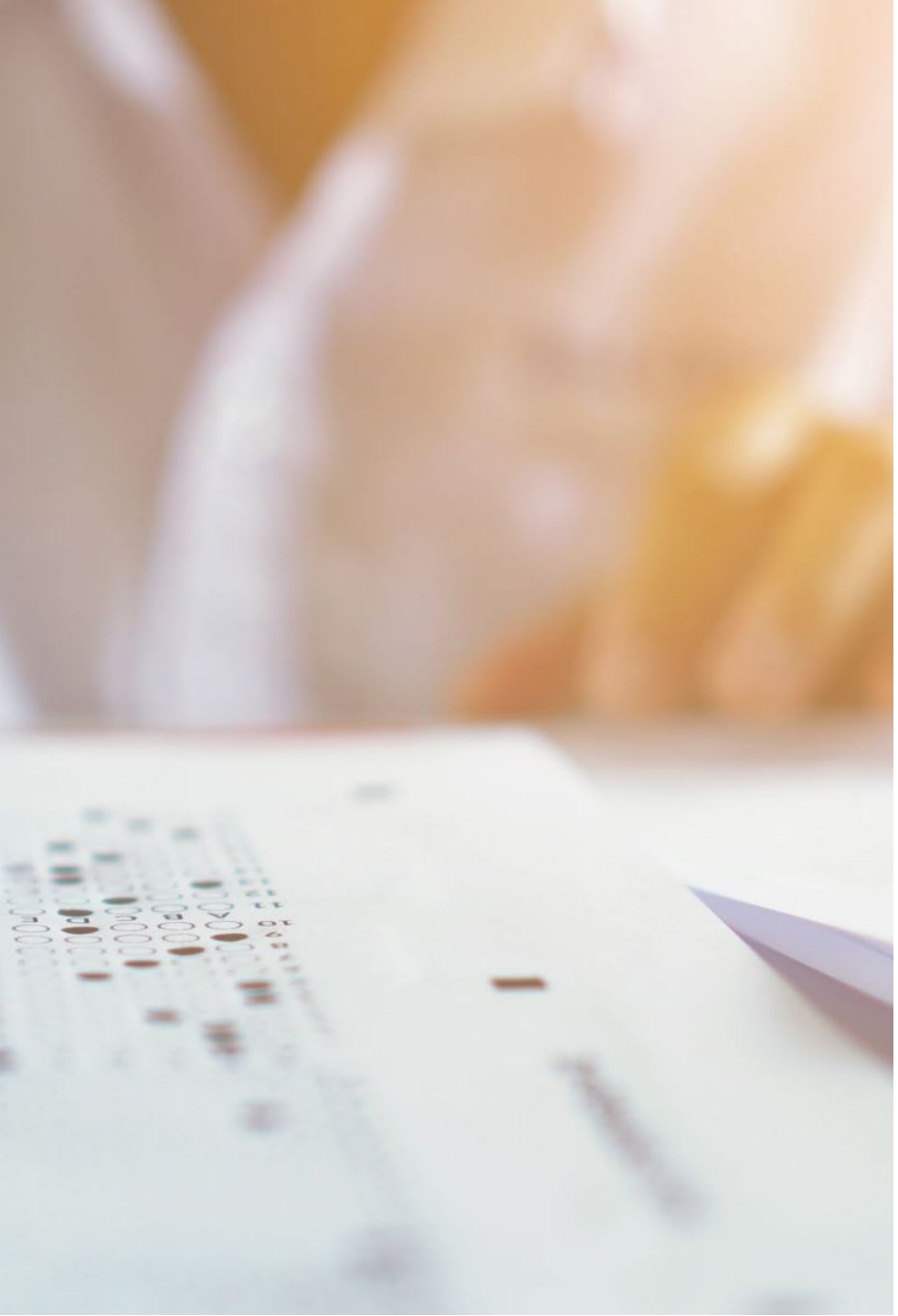
UPIC = Unified Program Integrity Contractor audit

- Instituted by CMS to identify cases of suspected fraud, investigate, and take action to ensure inappropriate payments are recouped

Stages of the Appeal Process

There are four stages of the Appeal Process which include:

- Additional Documentation Request (ADR)
- Redetermination Phase
- Reconsideration Phase
- The Administrative Law Judge Hearing



Additional Documentation Request (ADR)

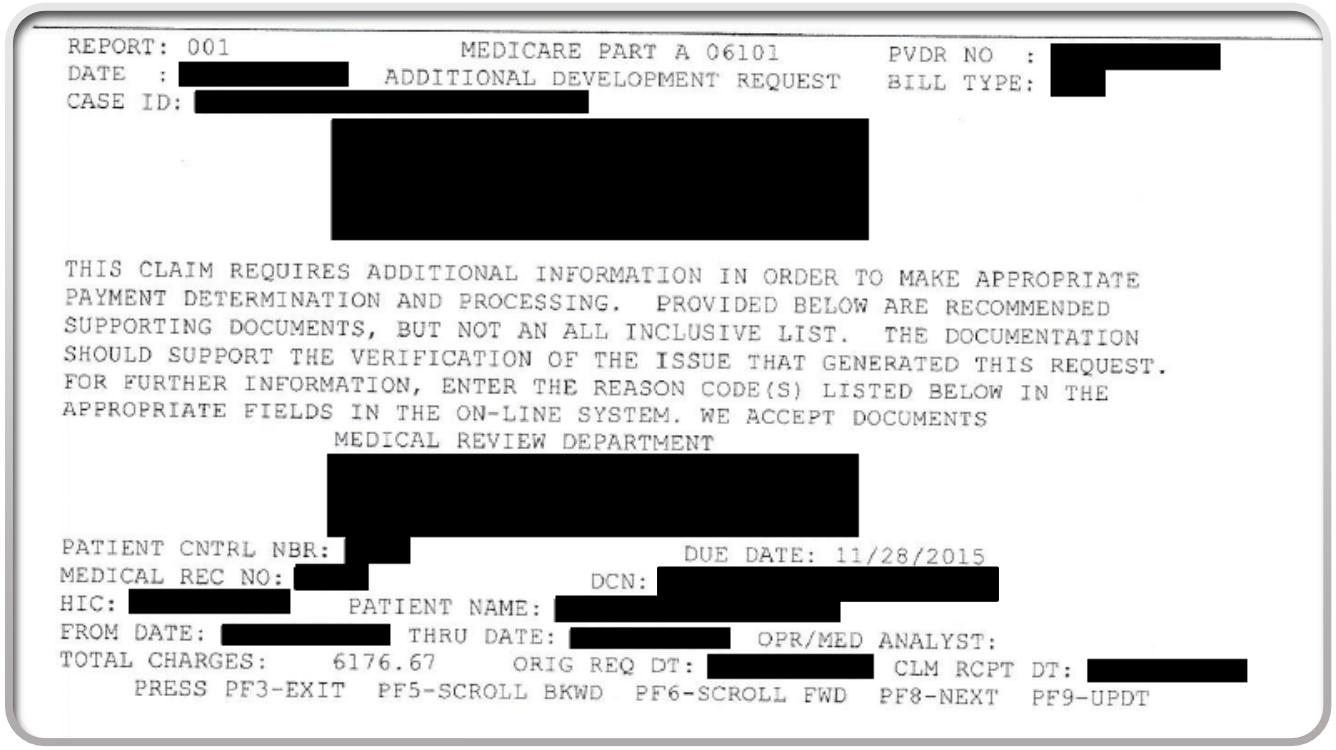
The initial step in this process is the receipt of an Additional Documentation Request (ADR) issued by the medical review department. This request will be received at the facility level.

- Most **ADRs** specify a 30–45-day timeline for submission of the documentation.
- Within a timely manner from receipt of the ADR, BRRs Regional Director of Appeals will return the completed therapy packet to the facility designee and/or facility Rehab Director via a high priority email with recommendations made for submission to the requesting entity.
- We strongly encourage our customers to submit the requested documentation to the requesting entity at least one full week prior to the deadline to allow time for processing.
- A copy of the final packet, should be kept in the Billing Office or Rehabilitation Department.

ADR examples

Request from Medicare billing system FISS

(as viewed by your BOM)



REPORT: 001 MEDICARE PART A 06101 PVDR NO :
DATE : [redacted] ADDITIONAL DEVELOPMENT REQUEST BILL TYPE: [redacted]
CASE ID: [redacted]

[redacted]

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS

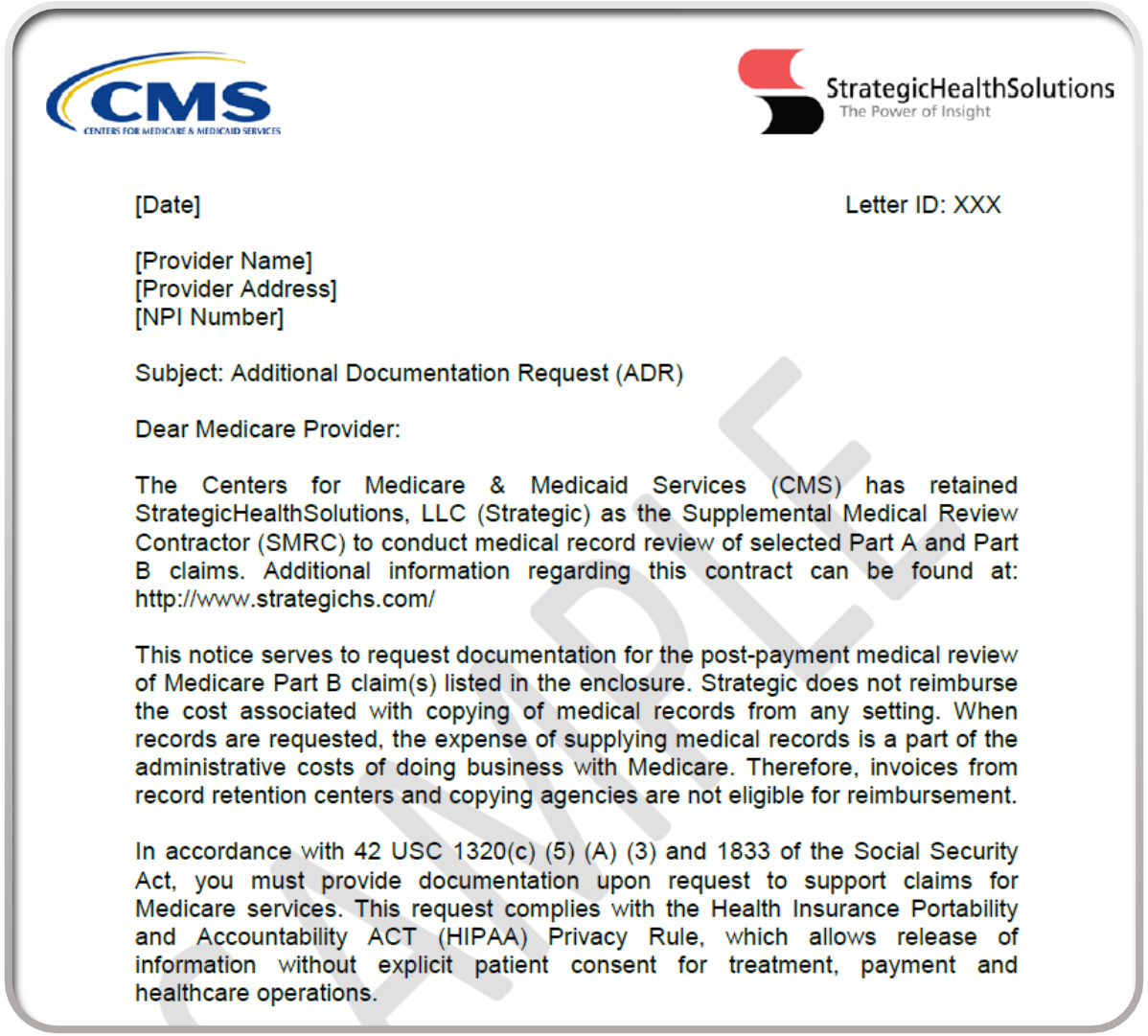
MEDICAL REVIEW DEPARTMENT

[redacted]

PATIENT CNTRL NBR: [redacted] DUE DATE: 11/28/2015
MEDICAL REC NO: [redacted] DCN: [redacted]
HIC: [redacted] PATIENT NAME: [redacted]
FROM DATE: [redacted] THRU DATE: [redacted] OPR/MED ANALYST:
TOTAL CHARGES: 6176.67 ORIG REQ DT: [redacted] CLM RCPT DT: [redacted]
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT PF9-UPDT

Medicare ADR Letter

(received in mail at facility)



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

StrategicHealthSolutions
The Power of Insight

[Date] Letter ID: XXX

[Provider Name]
[Provider Address]
[NPI Number]

Subject: Additional Documentation Request (ADR)

Dear Medicare Provider:

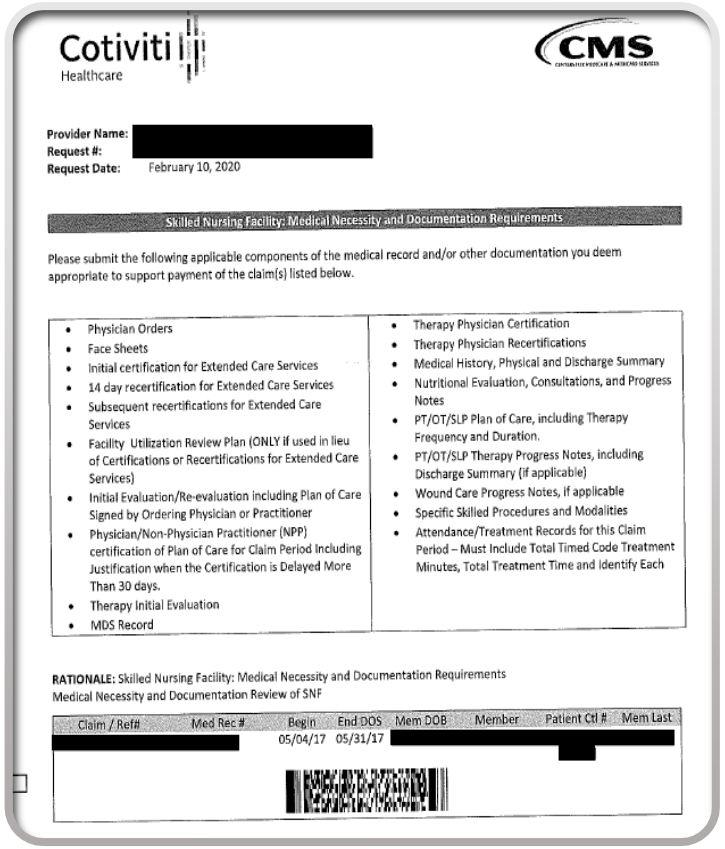
The Centers for Medicare & Medicaid Services (CMS) has retained StrategicHealthSolutions, LLC (Strategic) as the Supplemental Medical Review Contractor (SMRC) to conduct medical record review of selected Part A and Part B claims. Additional information regarding this contract can be found at: http://www.strategichs.com/

This notice serves to request documentation for the post-payment medical review of Medicare Part B claim(s) listed in the enclosure. Strategic does not reimburse the cost associated with copying of medical records from any setting. When records are requested, the expense of supplying medical records is a part of the administrative costs of doing business with Medicare. Therefore, invoices from record retention centers and copying agencies are not eligible for reimbursement.

In accordance with 42 USC 1320(c) (5) (A) (3) and 1833 of the Social Security Act, you must provide documentation upon request to support claims for Medicare services. This request complies with the Health Insurance Portability and Accountability ACT (HIPAA) Privacy Rule, which allows release of information without explicit patient consent for treatment, payment and healthcare operations.

SAMPLE

Recovery Audit Contractor (RAC) Request Letter



Cotiviti Healthcare

CMS

Provider Name: [redacted]
Request #:
Request Date: February 10, 2020

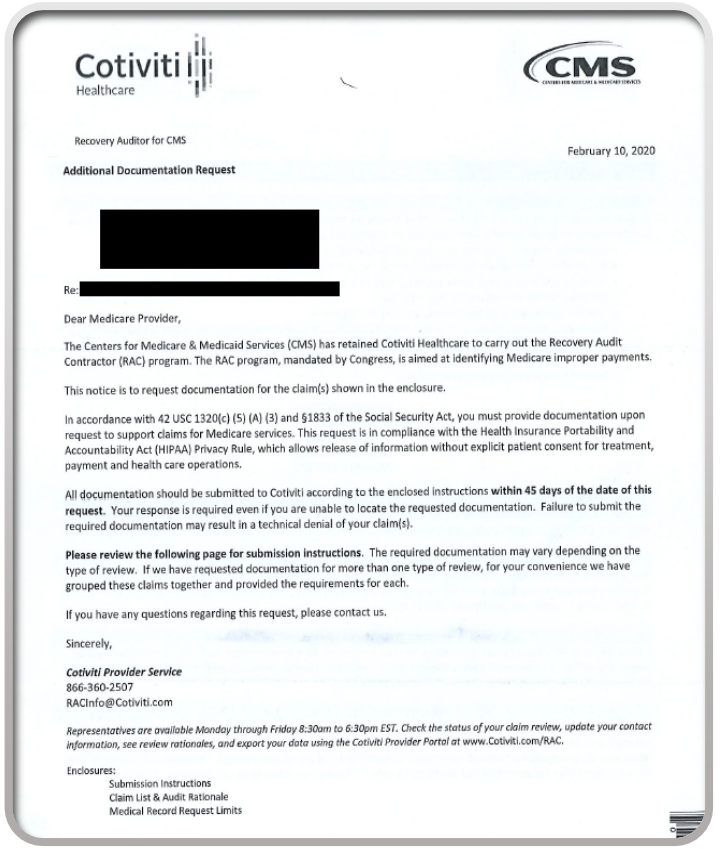
Skilled Nursing Facility: Medical Necessity and Documentation Requirements

Please submit the following applicable components of the medical record and/or other documentation you deem appropriate to support payment of the claim(s) listed below.

- Physician Orders
- Face Sheets
- Initial certification for Extended Care Services
- 14 day recertification for Extended Care Services
- Subsequent recertifications for Extended Care Services
- Facility Utilization Review Plan (ONLY if used in lieu of Certifications or Recertifications for Extended Care Services)
- Initial Evaluation/Re-evaluation including Plan of Care Signed by Ordering Physician or Practitioner
- Physician/Non-Physician Practitioner (NPP) certification of Plan of Care for Claim Period Including Justification when the Certification is Delayed More Than 30 days.
- Therapy Initial Evaluation
- MDS Record
- Therapy Physician Certification
- Therapy Physician Recertifications
- Medical History, Physical and Discharge Summary
- Nutritional Evaluation, Consultations, and Progress Notes
- PT/OT/SLP Plan of Care, including Therapy Frequency and Duration.
- PT/OT/SLP Therapy Progress Notes, including Discharge Summary (if applicable)
- Wound Care Progress Notes, if applicable
- Specific Skilled Procedures and Modalities
- Attendance/Treatment Records for this Claim Period – Must Include Total Timed Code Treatment Minutes, Total Treatment Time and Identify Each

RATIONALE: Skilled Nursing Facility: Medical Necessity and Documentation Requirements
Medical Necessity and Documentation Review of SNF

Claim / Ref#	Med Rec #	Begin	End DOS	Mem DOB	Member	Patient Ctl #	Mem Last
[redacted]		05/04/17	05/31/17	[redacted]			



Cotiviti Healthcare

CMS

Recovery Auditor for CMS

February 10, 2020

Additional Documentation Request

[redacted]

Re: [redacted]

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained Cotiviti Healthcare to carry out the Recovery Audit Contractor (RAC) program. The RAC program, mandated by Congress, is aimed at identifying Medicare improper payments.

This notice is to request documentation for the claim(s) shown in the enclosure.

In accordance with 42 USC 1320(c) (5) (A) (3) and §1833 of the Social Security Act, you must provide documentation upon request to support claims for Medicare services. This request is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information without explicit patient consent for treatment, payment and health care operations.

All documentation should be submitted to Cotiviti according to the enclosed instructions **within 45 days of the date of this request**. Your response is required even if you are unable to locate the requested documentation. Failure to submit the required documentation may result in a technical denial of your claim(s).

Please review the following page for submission instructions. The required documentation may vary depending on the type of review. If we have requested documentation for more than one type of review, for your convenience we have grouped these claims together and provided the requirements for each.

If you have any questions regarding this request, please contact us.

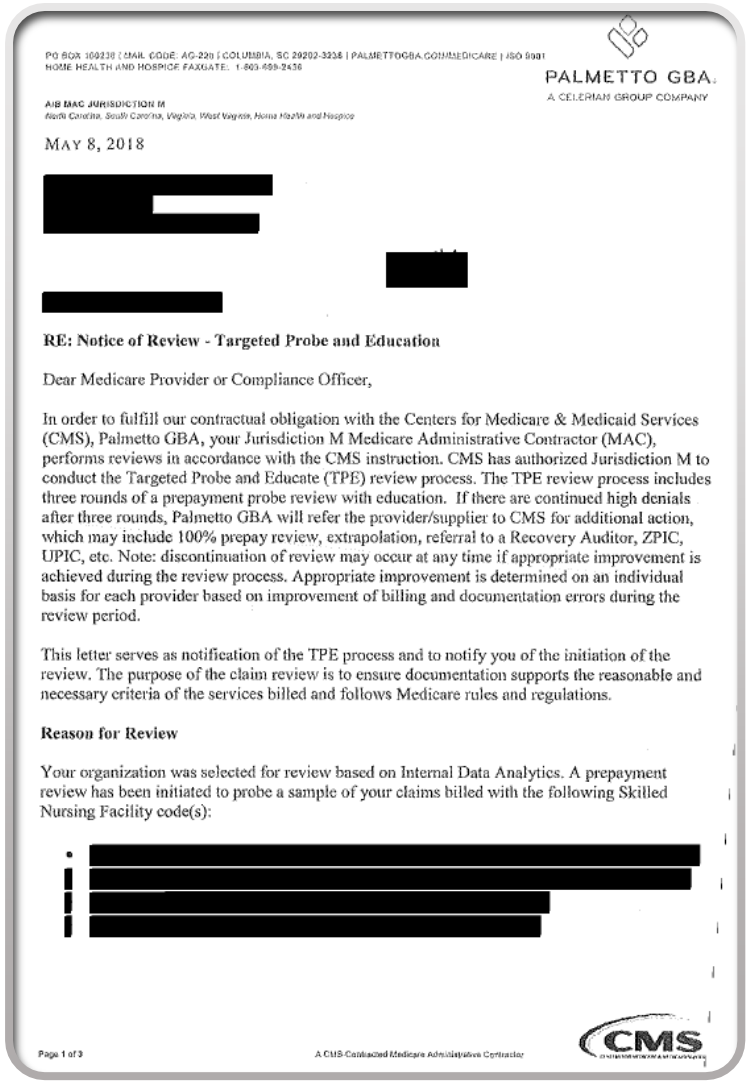
Sincerely,

Cotiviti Provider Service
866-360-2507
RACInfo@Cotiviti.com

Representatives are available Monday through Friday 8:30am to 6:30pm EST. Check the status of your claim review, update your contact information, see review rationales, and export your data using the Cotiviti Provider Portal at www.Cotiviti.com/RAC.

Enclosures:
Submission Instructions
Claim List & Audit Rationale
Medical Record Request Limits

Targeted Probe & Education request (TPE)



PO BOX 100238 | MAIL CODE: AG-220 | COLUMBIA, SC 29202-3238 | PALMETTOGBA.COM/MEDICARE | ISO 9001
HOME HEALTH AND HOSPICE FAXGATE: 1-803-699-2436

PALMETTO GBA
A CELERIAN GROUP COMPANY

AIB MAC JURISDICTION M
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice

MAY 8, 2018

[redacted]

RE: Notice of Review - Targeted Probe and Education

Dear Medicare Provider or Compliance Officer,

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Palmetto GBA, your Jurisdiction M Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction M to conduct the Targeted Probe and Educate (TPE) review process. The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, Palmetto GBA will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, ZPIC, UPIC, etc. Note: discontinuation of review may occur at any time if appropriate improvement is achieved during the review process. Appropriate improvement is determined on an individual basis for each provider based on improvement of billing and documentation errors during the review period.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason for Review

Your organization was selected for review based on Internal Data Analytics. A prepayment review has been initiated to probe a sample of your claims billed with the following Skilled Nursing Facility code(s):

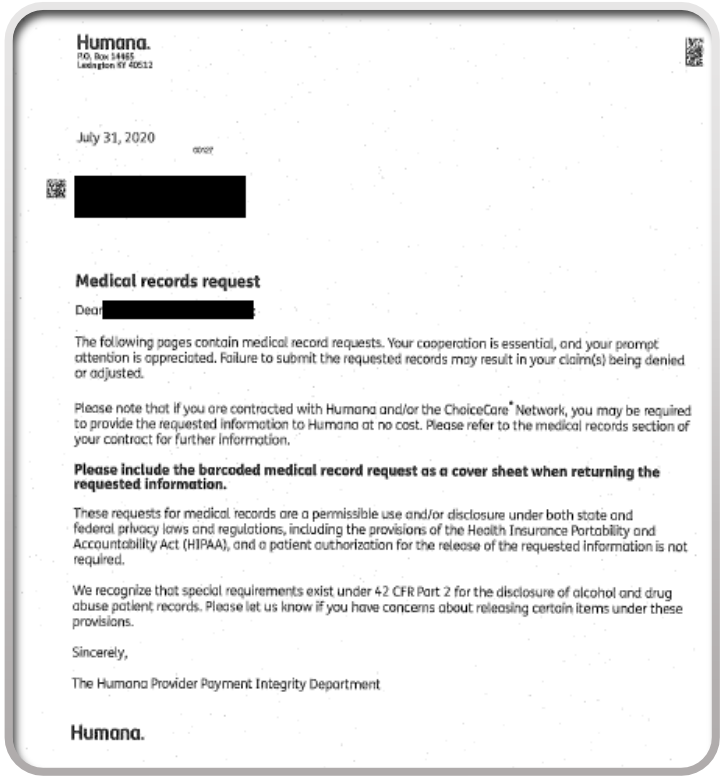
- [redacted]

Page 1 of 3

A CMS-Contracted Medicare Administrative Contractor

CMS

Humana Post-Pay Request Letter



Humana.
P.O. Box 14465
Lexington KY 40512

July 31, 2020

[redacted]

Medical records request

Dear [redacted]:

The following pages contain medical record requests. Your cooperation is essential, and your prompt attention is appreciated. Failure to submit the requested records may result in your claim(s) being denied or adjusted.

Please note that if you are contracted with Humana and/or the ChoiceCare® Network, you may be required to provide the requested information to Humana at no cost. Please refer to the medical records section of your contract for further information.

Please include the barcoded medical record request as a cover sheet when returning the requested information.

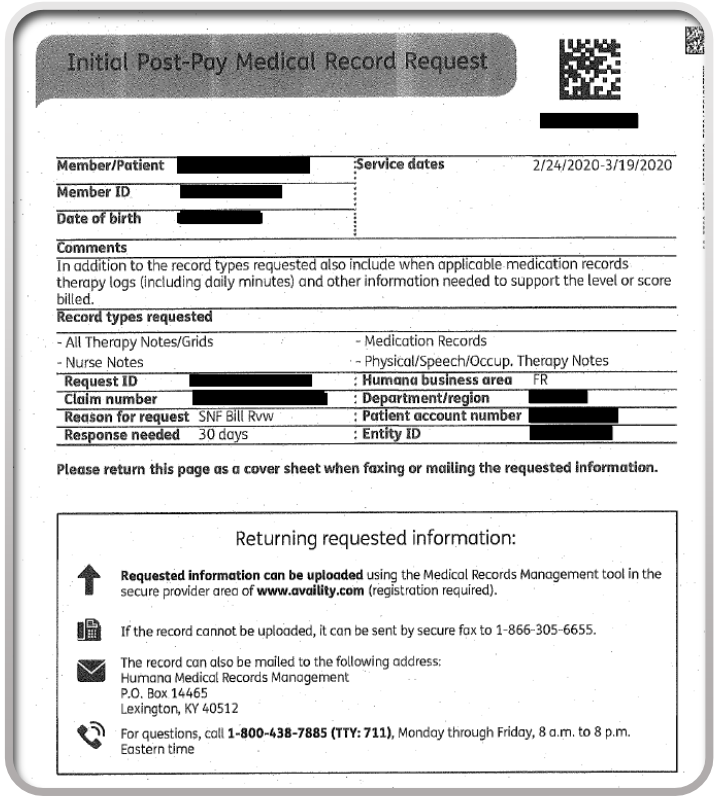
These requests for medical records are a permissible use and/or disclosure under both state and federal privacy laws and regulations, including the provisions of the Health Insurance Portability and Accountability Act (HIPAA), and a patient authorization for the release of the requested information is not required.

We recognize that special requirements exist under 42 CFR Part 2 for the disclosure of alcohol and drug abuse patient records. Please let us know if you have concerns about releasing certain items under these provisions.

Sincerely,

The Humana Provider Payment Integrity Department

Humana.



Initial Post-Pay Medical Record Request

[redacted]

Member/Patient	[redacted]	**Service dates**	2/24/2020-3/19/2020
Member ID	[redacted]		
Date of birth	[redacted]		

Comments
In addition to the record types requested also include when applicable medication records therapy logs (including daily minutes) and other information needed to support the level or score billed.

Record types requested

- All Therapy Notes/Grids
- Nurse Notes
- Medication Records
- Physical/Speech/Occup. Therapy Notes

Request ID	[redacted]	**Humana business area**	FR
Claim number	[redacted]	**Department/region**	[redacted]
Reason for request	SNF Bill Rvw	**Patient account number**	[redacted]
Response needed	30 days	**Entity ID**	[redacted]

Please return this page as a cover sheet when faxing or mailing the requested information.

Returning requested information:

Requested information can be uploaded using the Medical Records Management tool in the secure provider area of **www.availity.com** (registration required).

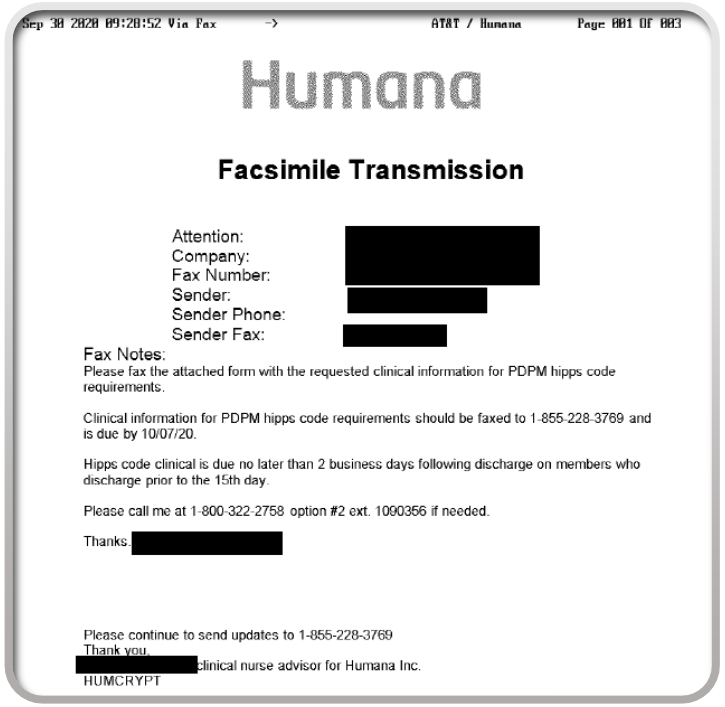
If the record cannot be uploaded, it can be sent by secure fax to 1-866-305-6655.

The record can also be mailed to the following address:
Humana Medical Records Management
P.O. Box 14465
Lexington, KY 40512

For questions, call **1-800-438-7885 (TTY: 711)**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time

Humana
Pre-Pay Request Letter

(via fax)



Sep 30 2020 09:20:52 Via Fax -> AT&T / Humana Page 001 Of 003

Humana

Facsimile Transmission

Attention: [redacted]
Company:
Fax Number:
Sender:
Sender Phone:
Sender Fax:

Fax Notes:
Please fax the attached form with the requested clinical information for PDPM hipps code requirements.

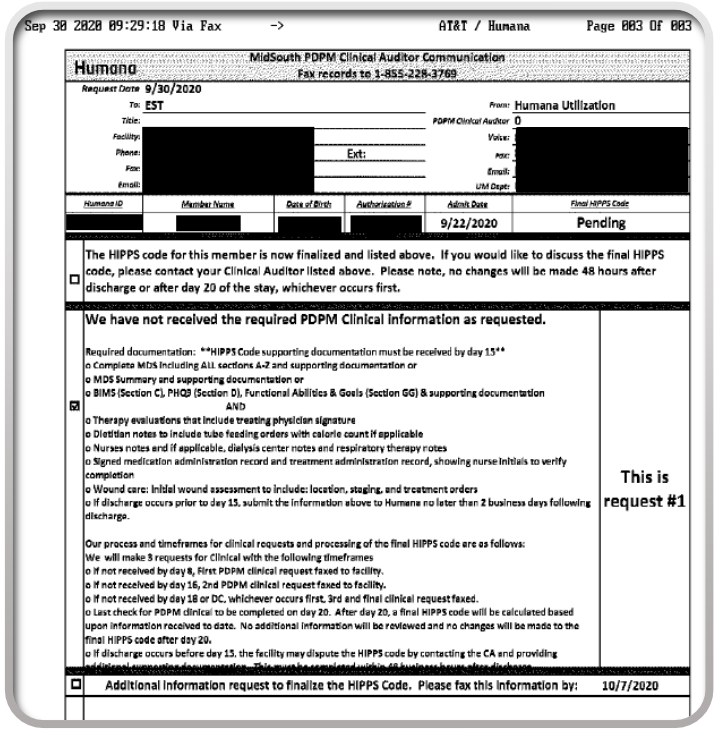
Clinical information for PDPM hipps code requirements should be faxed to 1-855-228-3769 and is due by 10/07/20.

Hipps code clinical is due no later than 2 business days following discharge on members who discharge prior to the 15th day.

Please call me at 1-800-322-2758 option #2 ext. 1090356 if needed.

Thanks, [redacted]

Please continue to send updates to 1-855-228-3769
Thank you,
[redacted] clinical nurse advisor for Humana Inc.
HUMCRYPT



Sep 30 2020 09:29:18 Via Fax -> AT&T / Humana Page 003 Of 003

Humana — MidSouth PDPM Clinical Auditor Communication
Fax records to 1-855-228-3769

Request Date: 9/30/2020
To: EST
From: Humana Utilization
Title:
PDPM Clinical Auditor: 0
Facility:
Phone: [redacted] Ext:
Fax:
Email:
Voice: [redacted]
Fax:
Email:
UM Dept:

Humana ID	Member Name	Date of Birth	Authorization #	Admit Date	Final HIPPS Code
[redacted]	[redacted]	[redacted]	[redacted]	9/22/2020	Pending

☐ The HIPPS code for this member is now finalized and listed above. If you would like to discuss the final HIPPS code, please contact your Clinical Auditor listed above. Please note, no changes will be made 48 hours after discharge or after day 20 of the stay, whichever occurs first.

☑ **We have not received the required PDPM Clinical information as requested.**

Required documentation: **HIPPS Code supporting documentation must be received by day 15**
o Complete MDS including ALL sections A-Z and supporting documentation or
o MDS Summary and supporting documentation or
o BIMS (Section C), PHQ9 (Section D), Functional Abilities & Goals (Section GG) & supporting documentation
AND
o Therapy evaluations that include treating physician signature
o Dietitian notes to include tube feeding orders with calorie count if applicable
o Nurses notes and if applicable, dialysis center notes and respiratory therapy notes
o Signed medication administration record and treatment administration record, showing nurse initials to verify completion
o Wound care: initial wound assessment to include: location, staging, and treatment orders
o If discharge occurs prior to day 15, submit the information above to Humana no later than 2 business days following discharge.

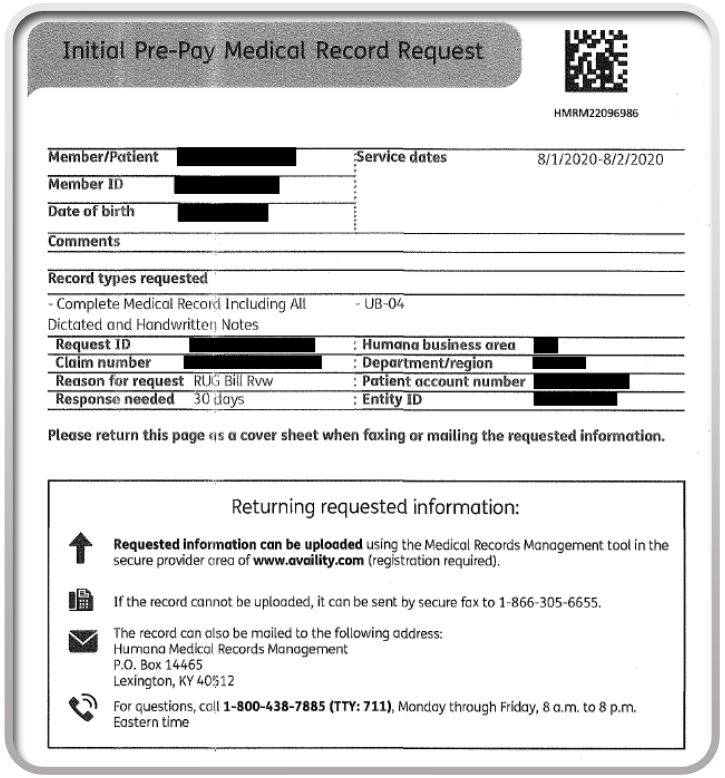
Our process and timeframes for clinical requests and processing of the final HIPPS code are as follows:
We will make 3 requests for clinical with the following timeframes
o If not received by day 8, First PDPM clinical request faxed to facility.
o If not received by day 16, 2nd PDPM clinical request faxed to facility.
o If not received by day 18 or DC, whichever occurs first, 3rd and final clinical request faxed.
o Last check for PDPM clinical to be completed on day 20. After day 20, a final HIPPS code will be calculated based upon information received to date. No additional information will be reviewed and no changes will be made to the final HIPPS code after day 20.
o If discharge occurs before day 15, the facility may dispute the HIPPS code by contacting the CA and providing

This is request #1

☐ Additional information request to finalize the HIPPS Code. Please fax this information by: 10/7/2020

Humana Pre-Pay Request Letter

(via mail)



Initial Pre-Pay Medical Record Request

HMRM22096986

Member/Patient	[redacted]	**Service dates**	8/1/2020-8/2/2020
Member ID	[redacted]		
Date of birth	[redacted]		

Comments

Record types requested

- Complete Medical Record Including All Dictated and Handwritten Notes
- UB-04

Request ID	[redacted]	**Humana business area**	[redacted]
Claim number	[redacted]	**Department/region**	[redacted]
Reason for request	RUG Bill Rvw	**Patient account number**	[redacted]
Response needed	30 days	**Entity ID**	[redacted]

Please return this page as a cover sheet when faxing or mailing the requested information.

Returning requested information:

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The record can also be mailed to the following address:
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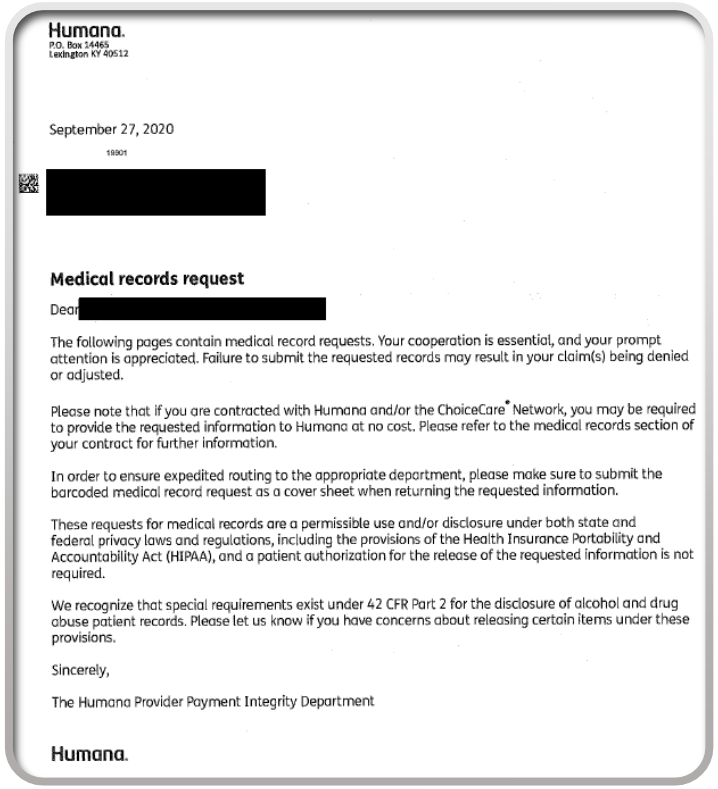
Lexington, KY 40512

For questions, call **1-800-438-7885 (TTY: 711)**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time



Humana.
P.O. Box 14465
Lexington KY 40512

September 27, 2020

[redacted]

Medical records request

Dear [redacted]

The following pages contain medical record requests. Your cooperation is essential, and your prompt attention is appreciated. Failure to submit the requested records may result in your claim(s) being denied or adjusted.

Please note that if you are contracted with Humana and/or the ChoiceCare® Network, you may be required to provide the requested information to Humana at no cost. Please refer to the medical records section of your contract for further information.

In order to ensure expedited routing to the appropriate department, please make sure to submit the barcoded medical record request as a cover sheet when returning the requested information.

These requests for medical records are a permissible use and/or disclosure under both state and federal privacy laws and regulations, including the provisions of the Health Insurance Portability and Accountability Act (HIPAA), and a patient authorization for the release of the requested information is not required.

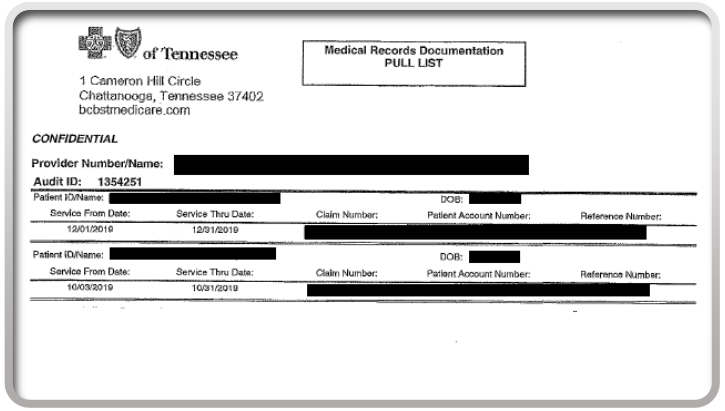
We recognize that special requirements exist under 42 CFR Part 2 for the disclosure of alcohol and drug abuse patient records. Please let us know if you have concerns about releasing certain items under these provisions.

Sincerely,

The Humana Provider Payment Integrity Department

Humana.

BCBS Request for Documentation



of Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbstmedicare.com

Medical Records Documentation PULL LIST

CONFIDENTIAL

Provider Number/Name: [redacted]

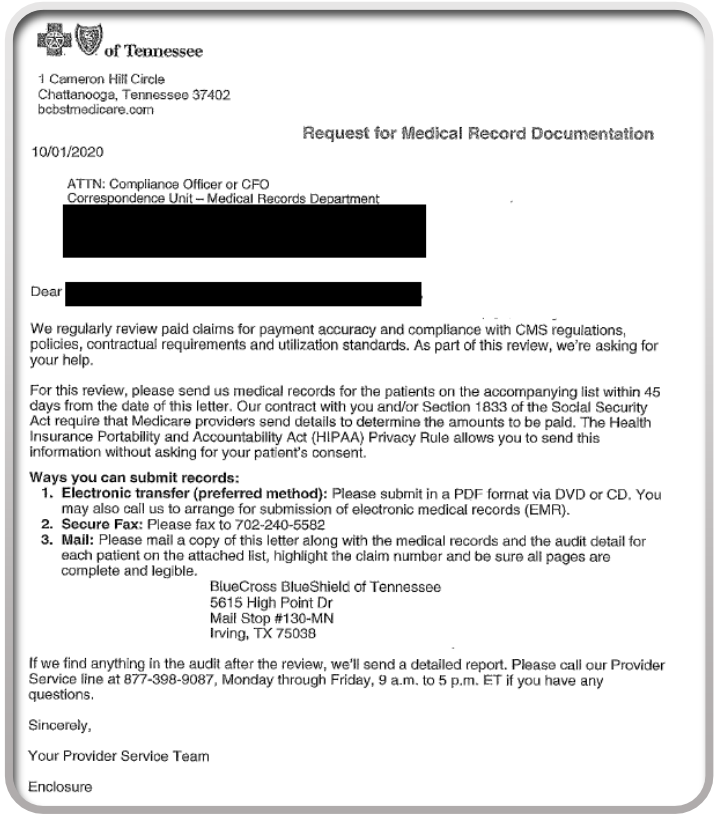
Audit ID: 1354251

Patient ID/Name: [redacted] DOB: [redacted]

Service From Date:	Service Thru Date:	Claim Number:	Patient Account Number:	Reference Number:
12/01/2019	12/31/2019	[redacted]		

Patient ID/Name: [redacted] DOB: [redacted]

Service From Date:	Service Thru Date:	Claim Number:	Patient Account Number:	Reference Number:
10/03/2019	10/31/2019	[redacted]		



of Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbstmedicare.com

Request for Medical Record Documentation

10/01/2020

ATTN: Compliance Officer or CFO
Correspondence Unit – Medical Records Department
[redacted]

Dear [redacted]

We regularly review paid claims for payment accuracy and compliance with CMS regulations, policies, contractual requirements and utilization standards. As part of this review, we're asking for your help.

For this review, please send us medical records for the patients on the accompanying list within 45 days from the date of this letter. Our contract with you and/or Section 1833 of the Social Security Act require that Medicare providers send details to determine the amounts to be paid. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule allows you to send this information without asking for your patient's consent.

Ways you can submit records:

1. **Electronic transfer (preferred method):** Please submit in a PDF format via DVD or CD. You may also call us to arrange for submission of electronic medical records (EMR).
2. **Secure Fax:** Please fax to 702-240-5582
3. **Mail:** Please mail a copy of this letter along with the medical records and the audit detail for each patient on the attached list, highlight the claim number and be sure all pages are complete and legible.

   BlueCross BlueShield of Tennessee
   5615 High Point Dr
   Mail Stop #130-MN
   Irving, TX 75038

If we find anything in the audit after the review, we'll send a detailed report. Please call our Provider Service line at 877-398-9087, Monday through Friday, 9 a.m. to 5 p.m. ET if you have any questions.

Sincerely,

Your Provider Service Team

Enclosure

What happens next?

Once the documentation is submitted for the ADR, the requesting entity reviews the documentation for billing accuracy, medical necessity, and support of skilled services provided.

A review decision should be reached within 60 days. The decision letter will be issued to the facility. **BOM's** need to **KEEP AN EYE OUT**!

Depending on the decision received, the review will be considered favorable, partially favorable, or unfavorable.

If a favorable decision is received the appeals process ends and the facility should expect payment on the claim.

If a partially favorable or unfavorable decision is received, you may proceed to the next level in the appeal process (Redetermination, Reconsideration, Administrative Law Judge).

Redermination

This is the **first level** of the appeal process.

At the first level of the appeal process, the Medicare Administrative Contractor(MAC) processes the redetermination.

Appellants have *120 days* from the date they receive the initial claim denial to file a request for redetermination.

This level does not require a minimum amount in controversy.

Reconsideration

This is the **second level** of the appeal process.

A Qualified Independent Contractor (QIC) processes this level of appeal.

Appellants have *180 days* from the date they receive the redetermination decision to file a request for reconsideration.

The QIC process may include an independent review of medical necessity issues by a panel of physicians or other appropriate health care professionals.

This level does not require a minimum amount in controversy.

Administrative Law Judge (ALJ)

This is the **third level** of the appeal process.

Appellants have *60 days* from the date of receipt of the QIC reconsideration decision to file a request for a hearing before an ALJ at the Office of Medicare Hearings and Appeals (OMHA), which is independent from CMS.

This allows parties a fair and impartial forum to address disagreements with CMS Medicare coverage and payment determinations.

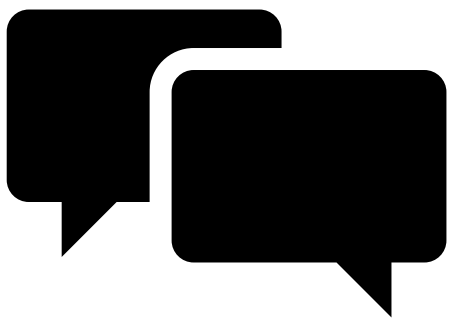
- Usually held by telephone, unless a review on the record is requested.
- This telephone hearing is the only verbal argument the appellant has throughout the Medicare appeals process.

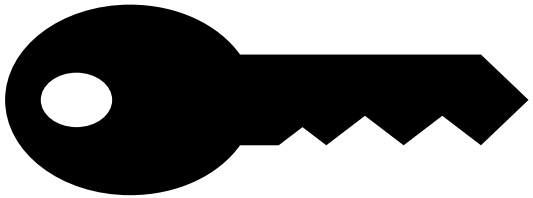
A minimum amount in controversy is required for a hearing. This amount is adjusted annually by CMS.

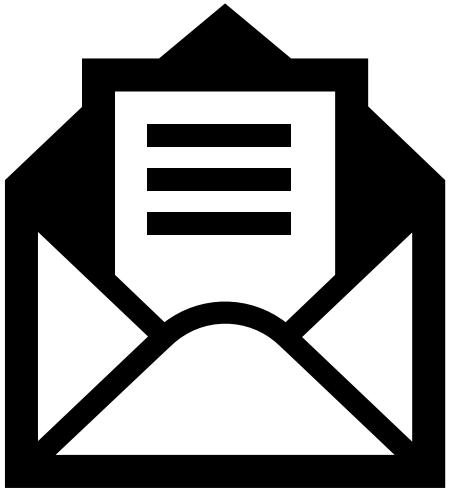
Overview of Timely Filing

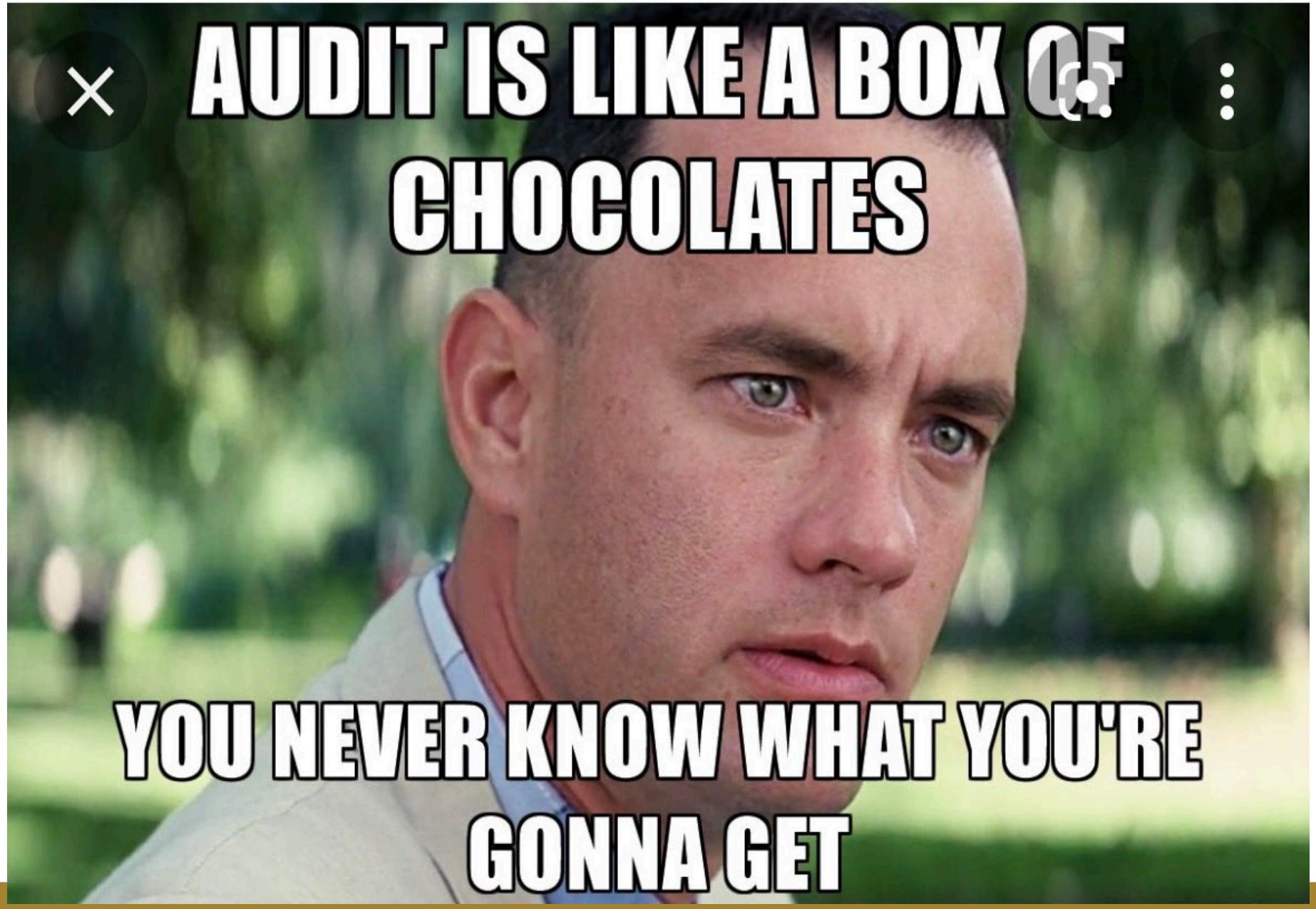
- The strict deadlines for **Medicare** appeals are:
  - Redetermination (1st level) = 120 days from date of ADR decision
  - Reconsideration (2nd level) = 180 days from date of Redetermination decision
  - Administrative Law Judge (3rd level) = 60 days from date of Reconsideration decision.
- The deadline for **Managed Care** appeals are stated within the review results letter. Typically, Managed Care entities allow 30-45 days for each level of appeal.

Communication is KEY!








AUDIT IS LIKE A BOX OF CHOCOLATES
YOU NEVER KNOW WHAT YOU'RE GONNA GET

Audit Trends

Medicare Targeted Probe and Educate

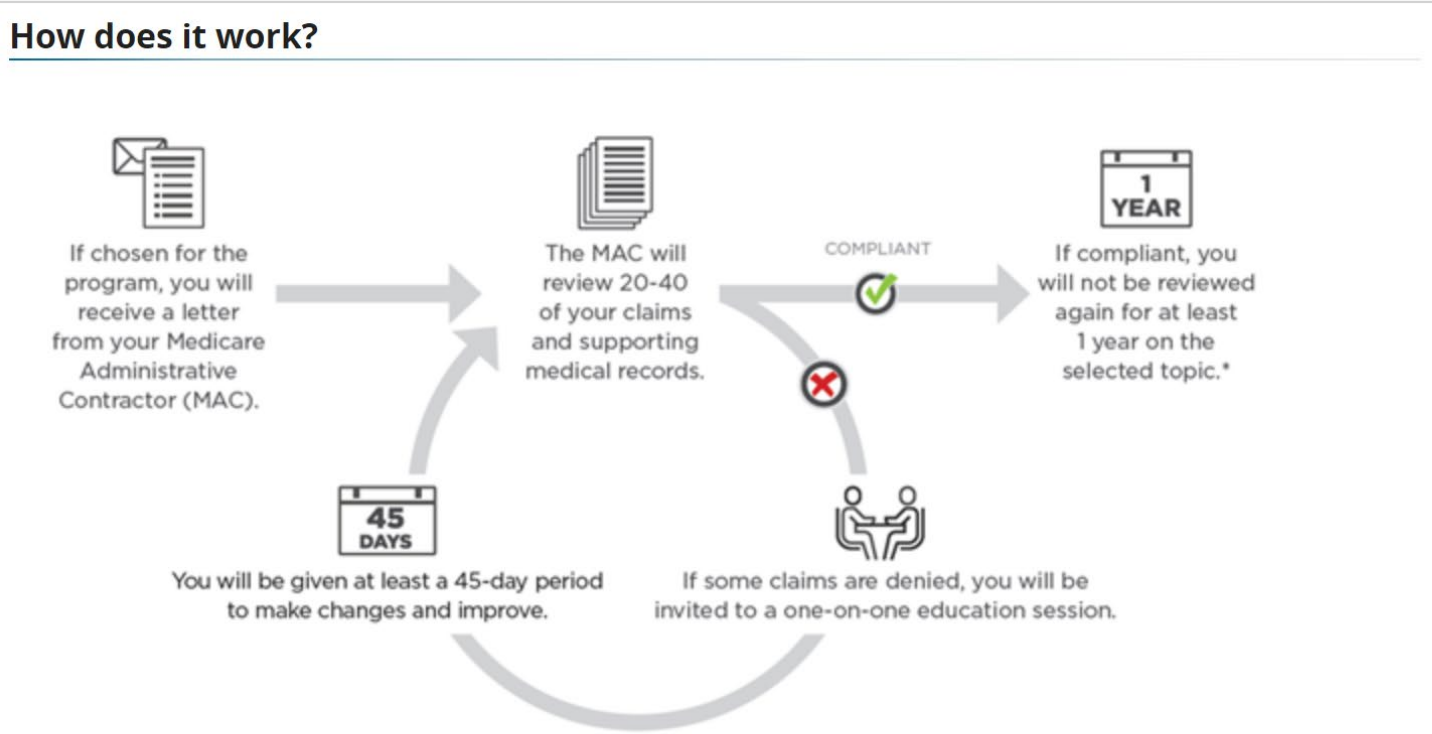
Targeted Probe and Educate

When Medicare Claims are submitted accurately, everyone benefits.

CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

Targeted Probe and Educate Cycle



**MACs may conduct additional review if significant changes in provider billing are detected*

Tips! Simple Steps to Prevent Denials

- The signature of the certifying physician was not included
- Documentation does not meet medical necessity
- Encounter notes did not support all elements of eligibility
- Missing or incomplete initial certifications or recertification

CMS and Program Integrity

- Changes in payment that result from changes in the coding or classification of SNF patients vs. actual changes in case mix.
- Changes in the volume and intensity of therapy services provided to SNF residents under PDPM compared to RUG-IV.
- Compliance with the group and concurrent therapy limit.
- Any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.
- Any potential consequences (e.g., overutilization) of using cognitive impairment as a payment classifier in the SLP component.
- Facilities whose beneficiaries experience inappropriate early discharge or provision of fewer services (e.g., due to the variable per-diem adjustment).
- Stroke and trauma patients, as well as those with chronic conditions, to identify any adverse trends from application of the variable per-diem adjustment.
- Use of the interrupted-stay policy to identify SNFs whose residents experience frequent readmission, particularly facilities where the readmissions occur just outside the 3-day window used as part of the interrupted-stay policy.

What are we seeing in appeals?

1. Reviewers are becoming extremely savvy…
2. Reviewers are honoring the PDPM system and taking a close look at IDT documentation consistency
3. Audits have been added to the DOJ website for provisions provided as part of the PHE (i.e. telehealth)
4. Medical record support of key PDPM areas (BIMS and PHQ-9 beyond the MDS alone

OIG- Nursing Home Capabilities and Collaboration to Ensure Resident Care During Emergencies

Nursing homes face a broad range of challenges from public emergencies, such as emerging infectious disease outbreaks and natural disasters. To protect residents and prevent disruption of care during emergencies, nursing homes must develop and maintain an emergency preparedness program that addresses a wide range of issues, from maintaining emergency supplies to collaborating with local emergency responders. Despite these requirements, recent emergencies have exposed weaknesses in nursing home emergency preparedness. This study will survey the challenges nursing homes face in preparing for emergencies, with specific focus on the their capabilities for managing resident care during emergencies, as well as their collaboration with community partners (e.g., other health care providers, emergency management agencies). We will present our findings in a data brief. We will also use a portion of the data collected for this study for a new Key Performance Indicator that will track the prevalence and severity of challenges experienced by nursing homes over time.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
February 2022	CMS, ASPR	Nursing Home Capabilities and Collaboration to Ensure Resident Care During Emergencies	Office of Evaluation and Inspections	OEI-06-22-00100	2022

Pro-Active Tips

KNOW YOUR PAYERS

AVOID TECHNICALITY RISKS WITH EMR AND LCD SET UPS

ESTABLISH INTERNAL SYSTEMS FOR REVIEW OF MEDICAL NECESSITY

USE CURRENT INDUSTRY RESOURCES AND YOUR OWN DATA TO ANALYZE “OUTLIERS”

ESTABLISH A CULTURE OF TRAINING AROUND MEDICAL REVIEW

"A ***Knowledgeable*** and ***Compassionate*** partner"

PEPPER

Program for Evaluating Payment Patterns Electronic Report

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an educational tool that supports CMS's **efforts to protect the Medicare Trust Fund**. PEPPER summarizes a provider's Medicare fee-for-service claims data for services in **areas that have been identified as at high risk for improper payments.**

Target Area:

High **PT** and OT Case Mix (new as of the Q4FY21 release)

Target Area Definitions:

- **Numerator:** count of SNF claims where the first character of the Health Insurance Prospective Payment System (HIPPS) code, representing the Physical and Occupational Therapy component, is one of the following: C, D, F, G, J, K, N, or O

- **Denominator:** count of all SNF claims

PT Clinical Categories	Section GG Function Score	PT Case-Mix Group	PT Case-Mix Index	Urban Rate	Rural Rate
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.45	$ 94.74	$ 108.00
	6-9	TB	1.61	$ 105.20	$ 119.91
	10-23	TC	1.78	$ 116.31	$ 132.57
	24	TD	1.82	$ 118.92	$ 135.55
Other Orthopedic: (Non-Surgical Orthopedic/ Muscoloskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	0-5	TE	1.34	$ 87.56	$ 99.80
	6-9	TF	1.52	$ 99.32	$ 113.21
	10-23	TG	1.58	$ 103.24	$ 117.68
	24	TH	1.1	$ 71.87	$ 81.93
Medical Management: (Medical Management, Acute Infections, Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.07	$ 69.91	$ 79.69
	6-9	TJ	1.34	$ 87.56	$ 99.80
	10-23	TK	1.44	$ 94.09	$ 107.25
	24	TL	1.03	$ 67.30	$ 76.71
Non-Orthopedic Surgery And Acute Neurologic: (Non-Orthopedic Surgery , Acute Neurologic)	0-5	TM	1.2	$ 78.41	$ 89.38
	6-9	TN	1.4	$ 91.48	$ 104.27
	10-23	TO	1.47	$ 96.05	$ 109.49
	24	TP	1.02	$ 66.65	$ 75.97

Target Area:

High PT and **OT** Case Mix (new as of the Q4FY21 release)

Target Area Definitions:

- **Numerator:** count of SNF claims where the first character of the Health Insurance Prospective Payment System (HIPPS) code, representing the Physical and Occupational Therapy component, is one of the following: C, D, F, G, J, K, N, or O

- **Denominator:** count of all SNF claims

OT Clinical Category	Section GG Function Score	OT Case-Mix Group	OT Case-Mix Index	Urban Rate	Rural Rate
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.41	$ 85.77	$ 96.46
	6-9	TB	1.54	$ 93.68	$ 105.35
	10-23	TC	1.6	$ 97.33	$ 109.46
	24	TD	1.45	$ 88.20	$ 99.19
Other Orthopedic: (Non-Surgical Orthopedic/Muscoloskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	0-5	TE	1.33	$ 80.90	$ 90.99
	6-9	TF	1.51	$ 91.85	$ 103.30
	10-23	TG	1.55	$ 94.29	$ 106.04
	24	TH	1.09	$ 66.30	$ 74.57
Medical Management: (Medical Management, Acute Infections Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.12	$ 68.13	$ 76.62
	6-9	TJ	1.37	$ 83.34	$ 93.72
	10-23	TK	1.46	$ 88.81	$ 99.88
	24	TL	1.05	$ 63.87	$ 71.83
Non-Orthopedic Surgery And Acute Neurologic: (Non-Orthopedic Surgery , Acute Neurologic)	0-5	TM	1.23	$ 74.82	$ 84.14
	6-9	TN	1.42	$ 86.38	$ 97.14
	10-23	TO	1.47	$ 89.42	$ 100.56
	24	TP	1.03	$ 62.65	$ 70.46

PEPPER Report

SNF PEPPER
912736, Provider Q12736
Table 3 Your Facility's Statistics for High PT and OT Case Mix (only valid for FY2020 and later)

YOUR SNF	FY 2019	FY 2020	FY 2021
Outlier Status	No data	Not an outlier	Not an outlier
Target Area Percent		75.9%	82.6%
Target Count		2,149	2,104
Denominator Count		2,831	2,546
Target (Numerator) Average Length of Stay		Not Calculated	Not Calculated
Denominator Average Length of Stay		Not Calculated	Not Calculated
Target (Numerator) Average Payment		Not Calculated	Not Calculated
Target (Numerator) Sum of Payments		Not Calculated	Not Calculated

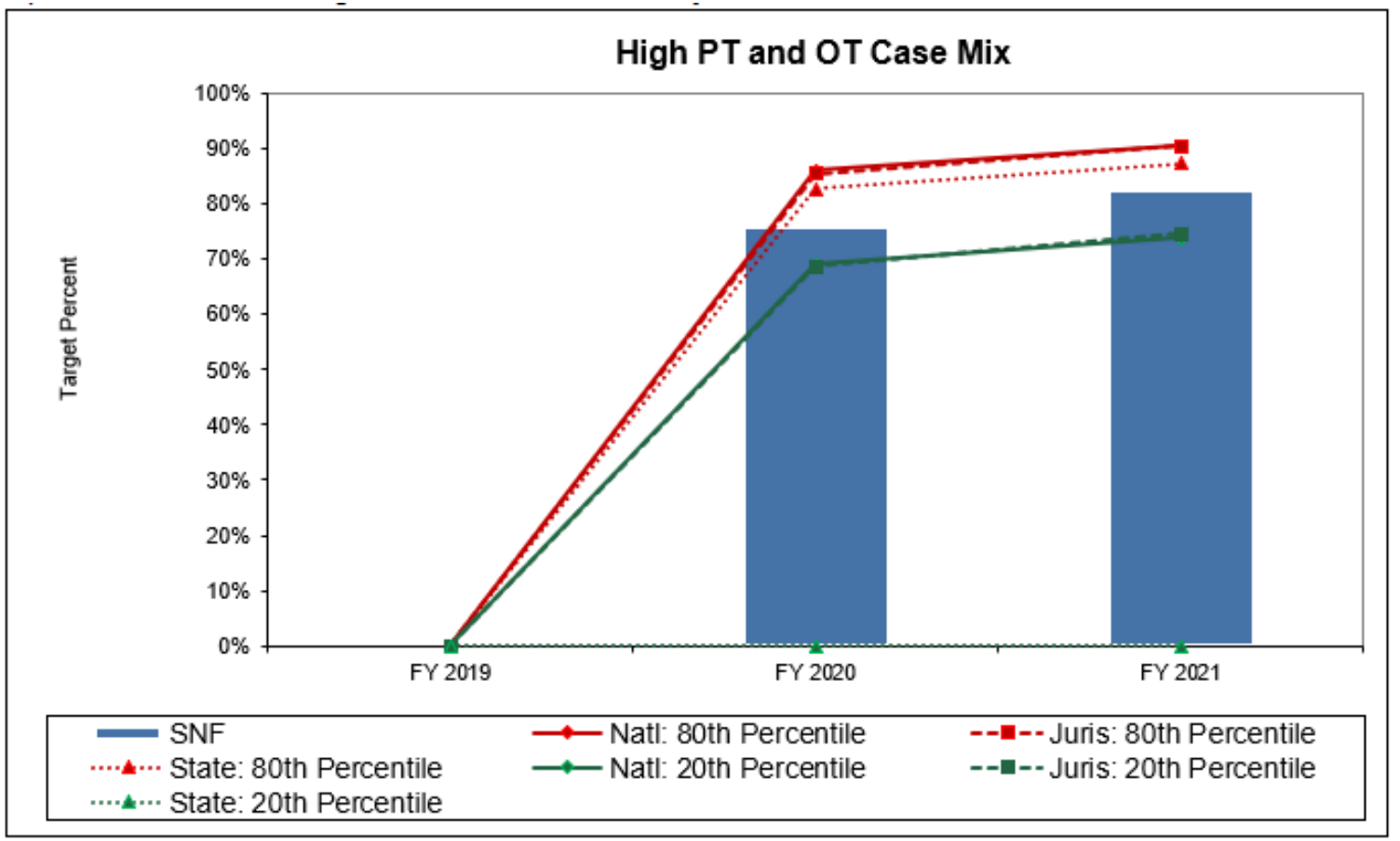
No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.
Table 4 Comparative Data for High PT and OT Case Mix

COMPARATIVE DATA	FY 2019	FY 2020	FY 2021
National 80th Percentile	0.0%	86.0%	90.4%
Jurisdiction 80th Percentile	0.0%	85.6%	90.5%
State 80th Percentile	0.0%	82.8%	87.4%
National 20th Percentile	0.0%	69.1%	73.9%
Jurisdiction 20th Percentile	0.0%	68.7%	74.5%
State 20th Percentile	0.0%	65.2%	71.0%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS
This could indicate issues with MDS coding of the functional score of the patient. The SNF should review medical record nursing and therapy documentation to ensure the appropriateness of MDS coding, specifically related to the ten items in Section GG used for the PT and OT component.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS
This could indicate issues with insufficient medical record documentation needed to accurately reflect the functional score of the patient. The SNF should review with nursing and therapy staff the accuracy or completeness of the medical record, specifically related to the ten items in Section GG used for the PT and OT component.



Target Area:

High **SLP** Case Mix (new as of the Q4FY21 release)

Target Area Definitions:

- **Numerator:** count of SNF claims where the second character of the HIPPS code, representing the Speech Language Pathology component, is one of the following: C, F, I, or L

- **Denominator:** count of all SNF claims

1. Presence of Acute Neurologic Condition (ICD-10), 2. SLP-Related Comorbidity (MDS Section I and O), or 3. Cognitive Impairment (CFS Table)	1. Mechanically Altered Diet (K0510C2) or 2. Swallowing Disorder (K0100A - K0100D)	SLP Case-Mix Group	SLP Case-Mix Index	Urban Rate	Rural Rate
None	Neither	SA	0.64	$ 15.61	$ 19.67
None	Either	SB	1.72	$ 41.95	$ 52.87
None	Both	SC	2.52	$ 61.46	$ 77.46
Any One	Neither	SD	1.38	$ 33.66	$ 42.42
Any One	Either	SE	2.21	$ 53.90	$ 67.94
Any One	Both	SF	2.82	$ 68.78	$ 86.69
Any Two	Neither	SG	1.93	$ 47.07	$ 59.33
Any Two	Either	SH	2.7	$ 65.85	$ 83.00
Any Two	Both	SI	3.34	$ 81.46	$ 102.67
All Three	Neither	SJ	2.83	$ 69.02	$ 86.99
All Three	Either	SK	3.5	$ 85.37	$ 107.59
All Three	Both	SL	3.98	$ 97.07	$ 122.35

PEPPER Report

SNF PEPPER
912736, Provider Q12736
Table 5 Your Facility's Statistics for High SLP Case Mix (only valid for FY2020 and later)

YOUR SNF	FY 2019	FY 2020	FY 2021
Outlier Status	No data	High Outlier	High Outlier
Target Area Percent		33.0%	32.8%
Target Count		934	834
Denominator Count		2,831	2,546
Target (Numerator) Average Length of Stay		Not Calculated	Not Calculated
Denominator Average Length of Stay		Not Calculated	Not Calculated
Target (Numerator) Average Payment		Not Calculated	Not Calculated
Target (Numerator) Sum of Payments		Not Calculated	Not Calculated

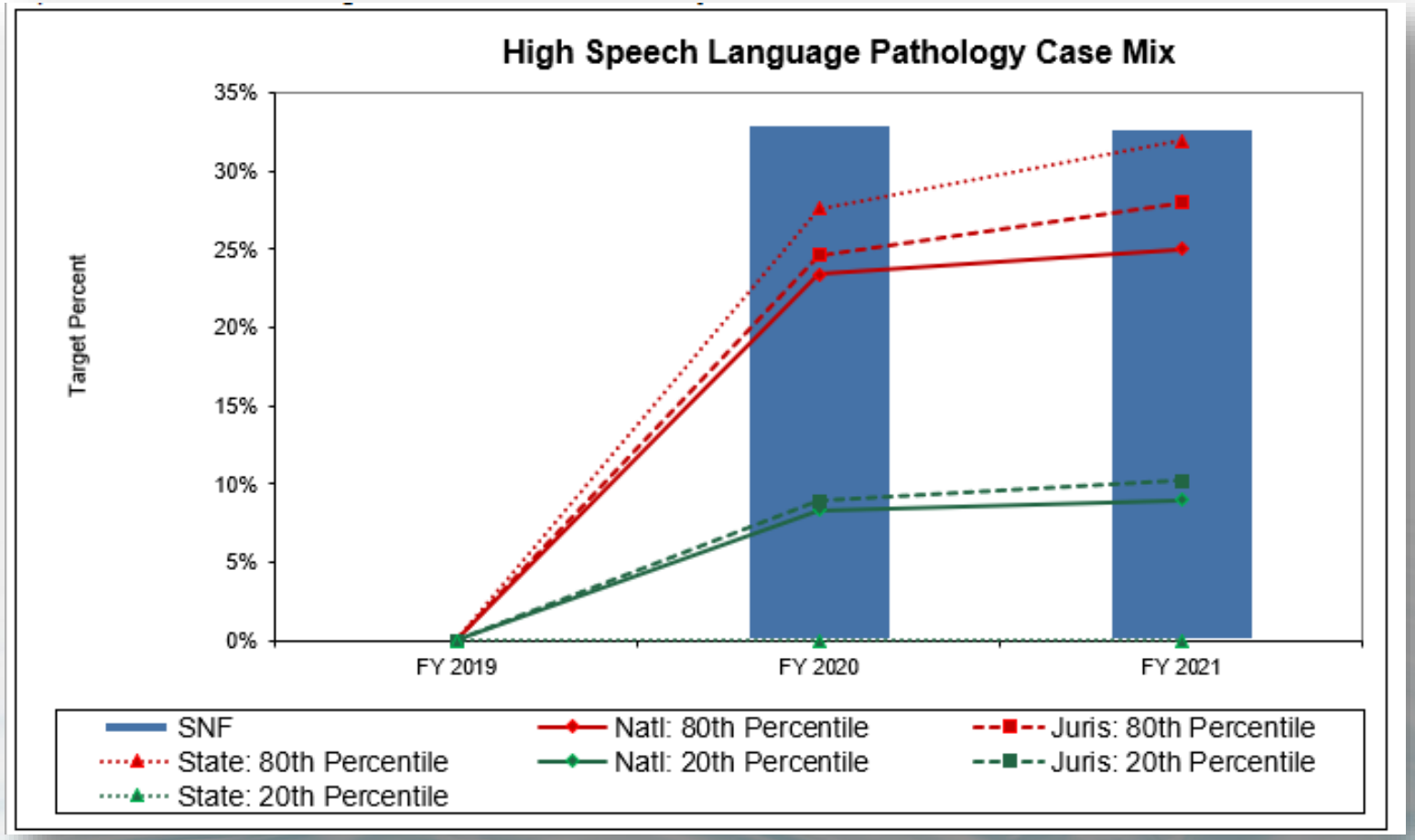
No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.
Table 6 Comparative Data for High SLP Case Mix

COMPARATIVE DATA	FY 2019	FY 2020	FY 2021
National 80th Percentile	0.0%	23.4%	25.0%
Jurisdiction 80th Percentile	0.0%	24.6%	28.0%
State 80th Percentile	0.0%	27.6%	31.9%
National 20th Percentile	0.0%	8.4%	9.0%
Jurisdiction 20th Percentile	0.0%	9.0%	10.3%
State 20th Percentile	0.0%	9.4%	10.9%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS
This could indicate issues with MDS coding of the five patient characteristics included in the speech language pathology (SLP) component: acute neurologic condition, SLP-related comorbidity, cognitive impairment, swallowing disorder, or mechanically altered diet. The SNF should review documentation to ensure that all SLP component patient characteristics coded on the MDS are substantiated in the medical record.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS
This could indicate issues with insufficient medical record documentation needed to accurately reflect the five patient characteristics included in the speech language pathology (SLP) component: acute neurologic condition, SLP-related comorbidity, cognitive impairment, swallowing disorder, or mechanically altered diet. The SNF should review with nursing, therapy, and other staff the accuracy or completeness of the medical record documentation to ensure that all SLP component patient characteristics are adequately captured on the MDS.



Target Area:

20 Days

Target Area Definitions:

- **Numerator:** count of episodes of care ending in the report period with a length of stay (LOS) of 20 days
- **- Denominator:** count of episodes of care ending in the report period

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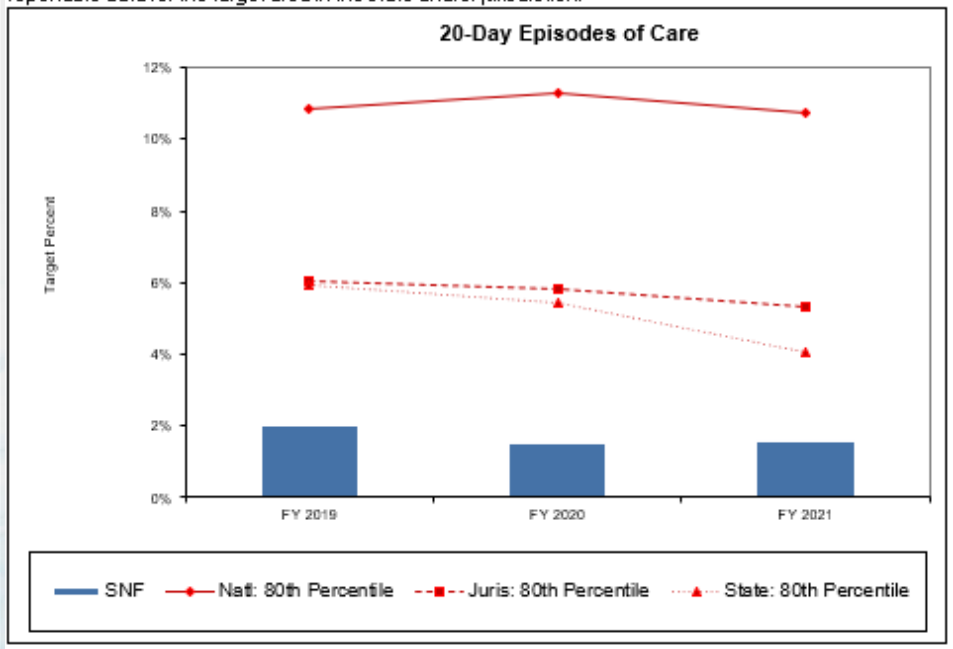
912736, Provider Q12736
Table 7 Your Facility Statistics for 20-Day Episodes of Care

YOUR SNF	FY 2019	FY 2020	FY 2021
Outlier Status	Not an outlier	Not an outlier	Not an outlier
Target Area Percent	2.1%	1.6%	1.6%
Target Count	22	16	15
Denominator Count	1,066	1,032	926
Target (Numerator) Average Length of Stay	20.0	20.0	20.0
Denominator Average Length of Stay	46.2	51.6	50.9
Target (Numerator) Average Payment	$14,042	$13,539	$16,677
Target (Numerator) Sum of Payments	$308,929	$216,627	$250,151

No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.
Table 8 Comparative Data for 20-Day Episodes of Care

COMPARATIVE DATA	FY 2019	FY 2020	FY 2021
National 80th Percentile	10.8%	11.3%	10.7%
Jurisdiction 80th Percentile	6.0%	5.8%	5.3%
State 80th Percentile	5.9%	5.5%	4.1%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.



SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS

This could indicate that the SNF is continuing treatment beyond the point where services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 20 days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review the appropriateness of plans of care and discharge planning.

Target Area:

90+ Days

Target Area Definitions:

- **Numerator:** count of episodes of care ending in the report period with a LOS of 90+ days
- **- Denominator:** count of episodes of care ending in the report period

SNF PEPPER
912736, Provider Q12736
Table 9 Your Statistics for 90+ Days Episodes of Care

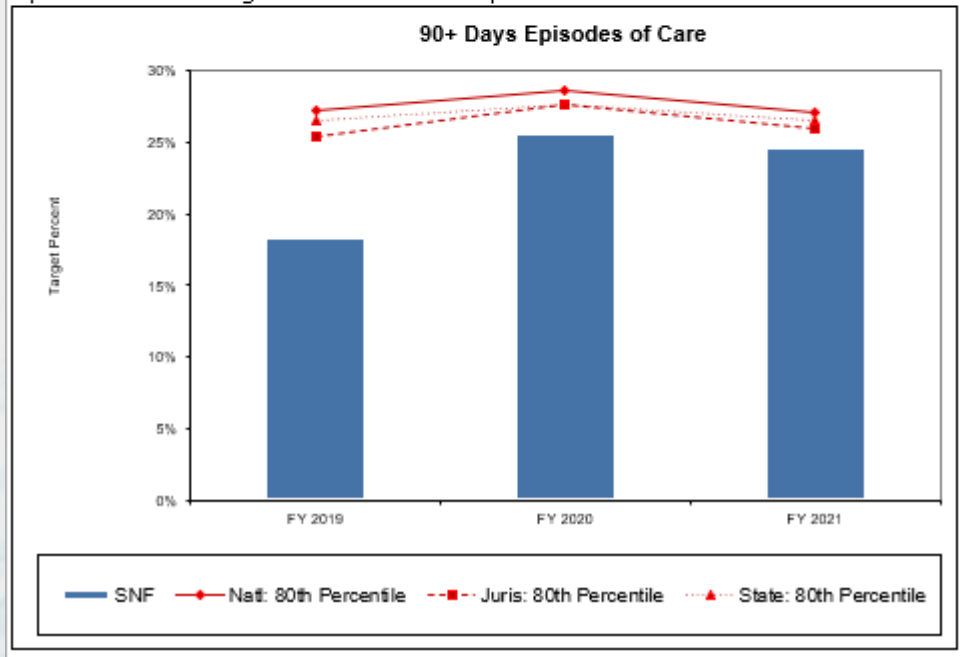
YOUR SNF	FY 2019	FY 2020	FY 2021
Outlier Status	Not an outlier	Not an outlier	Not an outlier
Target Area Percent	18.4%	25.6%	24.6%
Target Count	196	264	228
Denominator Count	1,066	1,032	926
Target (Numerator) Average Length of Stay	98.8	98.8	99.0
Denominator Average Length of Stay	46.2	51.6	50.9
Target (Numerator) Average Payment	$57,896	$59,450	$68,181
Target (Numerator) Sum of Payments	$11,347,550	$15,694,676	$15,545,295

No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements

Table 10 Comparative Data for 90+ Days Episodes of Care

COMPARATIVE DATA	FY 2019	FY 2020	FY 2021
National 80th Percentile	27.3%	28.6%	27.1%
Jurisdiction 80th Percentile	25.4%	27.6%	25.9%
State 80th Percentile	26.5%	27.7%	26.5%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.



SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS

This could indicate that the SNF is continuing treatment beyond the point where those services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 90+ days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review appropriateness of plans of care and discharge planning.

Target Area:

3 – 5 Day Readmission

Target Area Definitions:

- **Numerator:** count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period

- **Denominator:** count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20

SNF PEPPER
912736, Provider Q12736
Table 11 Your Facility Statistics for 3- to 5-Day Readmissions

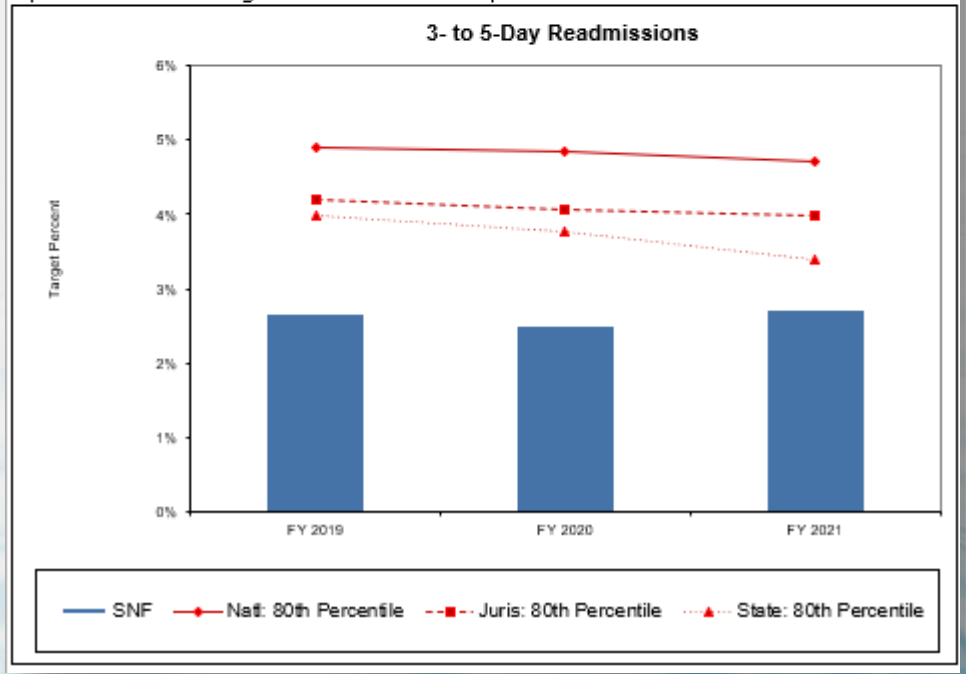
YOUR SNF	FY 2019	FY 2020	FY 2021
Outlier Status	Not an outlier	Not an outlier	Not an outlier
Target Area Percent	2.7%	2.5%	2.7%
Target Count	71	68	67
Denominator Count	2,655	2,711	2,459
Target (Numerator) Average Length of Stay	Not Calculated	Not Calculated	Not Calculated
Denominator Average Length of Stay	Not Calculated	Not Calculated	Not Calculated
Target (Numerator) Average Payment	Not Calculated	Not Calculated	Not Calculated
Target (Numerator) Sum of Payments	Not Calculated	Not Calculated	Not Calculated

No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirement

Table 12 Comparative Data for 3- to 5-Day Readmissions

COMPARATIVE DATA	FY 2019	FY 2020	FY 2021
National 80th Percentile	4.9%	4.9%	4.7%
Jurisdiction 80th Percentile	4.2%	4.1%	4.0%
State 80th Percentile	4.0%	3.8%	3.4%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.



SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS

This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby resetting the variable per diem adjustment. A sample of readmission cases should be reviewed to identify the appropriateness of admission, discharge, quality of care, post-discharge care, and billing errors. The facility is encouraged to generate data profiles for readmissions to its facility within three to five consecutive calendar days. Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, and principal and secondary diagnoses.

Helpful Resources

Skilled Nursing Facilities Training & Resources (cbrpepper.org)

Work Plan | Office of Inspector General | U.S. Department of Health and Human Services (hhs.gov)

Medicare Fee for Service Recovery Audit Program | CMS

Find Out More

Contact Us:

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Ask an Expert https://www.broadriverrehab.com/expert/

Broad River Rehab Reflections are the third Thursday of each month.

QUESTIONS?