Session 802
How to Manage Compliance in the Revenue Cycle

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Additional Development Requests

- Request for medical records
- Information request for ADR obtained through either DDE system
- Have limited time period to respond – 30 days
- This is a prepayment review which occurs at the point of billing
Effective April 1, 2015, Palmetto GBA will require the Initial Therapy Evaluation, current therapy re-evaluation(s) for episode under review and the previous therapy re-evaluation(s) to be submitted with ANY Home Health Therapy records requested for review.

If an initial start of care was requested for review, include the Initial Therapy Evaluation and therapy re-evaluation(s).

On subsequent episodes, include the Initial Therapy Evaluation, current therapy re-evaluation as well as therapy re-evaluation immediately prior to the requested episode. This allows Medical Review to analyze medical necessity of services billed.
Therapy Edits - PGBA

SBGK* - Florida
A total of 15 claims were reviewed, with 3 of the claims either completely or partially denied. The total dollars reviewed was $20,413.86 of which $8,938.33 was denied, resulting in a charge denial rate of 43.8%. The top denial categories identified, based on dollars denied, were:

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>% of Dollars Denied</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPF0A/SAFOA</td>
<td>77.2%</td>
<td>Unable to Determine Medical Necessity of HOPPS Code Billed as Appropriate DASIS Not Submitted</td>
</tr>
<tr>
<td>SPF012/ST012</td>
<td>22.8%</td>
<td>Physician’s Plan of Care and/or Certification Present - Signed but Not Dated</td>
</tr>
</tbody>
</table>

Contract Issues with RAs

- Current RAs are to work at least through 12/31/15. New Contract bidding to start next year.
- January 14, 2015 – Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract. Questions regarding the protest may be directed to the GAO. CMS will post updates on this website, as appropriate.
- December 30, 2014 – CMS has awarded the Region 5 Recovery Audit contract to Connolly, LLC. The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission through the identification and correction of improper payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and home health/hospice (HH/H) claims submitted under Title XVIII of the Social Security Act (the Act). The Recovery Auditor will review all applicable claims types through the appropriate review methods and work with CMS and the DME and HH/H MACs to adjust claims to recoup overpayments and pay underpayments.
- November 4, 2014 – Procurement Update: The new contracts for Recovery Auditor Regions 1, 2, and 4 remain under a pre-award protest, which is expected to continue into late summer of 2015. However, the procurement process continues for Region 3 (Part A / Part B claim reviews), which includes Florida, Tennessee, Alabama, Georgia, West Virginia, Virginia, North Carolina and South Carolina; and, for Region 5, which will be the national contract for DMEPOS and Home Health & Hospice claim reviews. The CMS remains hopeful that these two new contracts will be awarded before the end of this year.
RA Scope of Work

- The RAs are tasked with detecting and correcting past improper payments so that CMS and Carriers/MACs can implement actions that will prevent future improper payments:
  - **Providers** can avoid submitting claims that do not comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** and future Medicare beneficiaries are protected

RA Scope of Work

- RAs review claims on a post-payment basis
- RAs use the same Medicare policies as Carriers and MACs: NCDs, LCDs and CMS Manuals
- Two types of review:
  - Automated (no medical record needed)
  - Complex (medical record required)
- RAs will be able to look back three years from the date the claim was paid
The Collection Process

○ Same as for Carrier and MAC identified overpayments (except the demand letter comes from the RA)
  ○ Carriers, and MACs issue Remittance Advice - Remark Code N432: Adjustment Based on Recovery Audit
  ○ Carrier/MAC recoups by offset unless provider has submitted a check or a valid appeal

What is Different?

○ Demand letter is issued by the RA
○ RA will offer an opportunity for the provider to discuss the improper payment determination with the RA (this is outside the normal appeal process)
○ Issues reviewed by the RA will be approved by CMS prior to widespread review
○ Approved issues are posted to RA website before widespread review
2015 RA Improvements

- CMS will establish ADR limits based on a provider’s compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits. The ADR limits will be adjusted as provider’s denial rate decreases, ensuring the provider that complies with Medicare rules has less Recovery Audit reviews.
- Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. This provides more immediate feedback to the provider on the outcome of their reviews.
- Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.

2015 RA Improvements

- Recovery Auditors will not receive a contingency fee until after the second level of appeal is exhausted. Previously, Recovery Auditors were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare’s statutes, coverage determinations, regulations and manuals.
- Note: if claims are overturned on appeal, providers are paid interest calculated from the date of recoupment. For more information please visit
- Recovery Auditors will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to do so will result in CMS placing the Recovery Auditor on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions.
Provider Type | CMS Approved Issues | RA
--- | --- | ---
HH | Post-pay review of outpatient therapy claims above $3,700 threshold | CGI, Connolly, HDI, Performant
HH | Pre-pay review of outpatient therapy claims above $3,700 threshold | CGI
HH | Skilled nurse episodes beyond third episode | CGI, Performant
HH | No skilled service | CGI, Performant
HH | Medical necessity | Connolly
HH | Request for Anticipated Payment (RAP) without corresponding final claim | Connolly
HH | Incorrect billing of partial episode payment (PEP) adjustment | Connolly
HH | Hospice related services billed by HH | Connolly
HH | Outcome & Assessment Information Set (OASIS) assessment not completed timely | Connolly
HH | Episodes with five to nine visits | HDI
Hospice | Hospice claims for more than 20 contiguous months | Performant
Hospice | Excessive units of physician services; face-to-face (FTF) encounter documentation | HDI

### RA Record Requests

**Medical Records Requests**
- Once a provider has received a request from the RAC for supporting documentation, the medical records must be submitted within 45 calendar days. More time may be asked for by the provider as long as the extension request is received by the RAC prior to the 45th day.
- The RA has 60 days to review the chart and return findings
Zone Program Integrity Contractors (ZPIC)

- Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:
  - Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
  - Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
  - Performing medical review, as appropriate;
  - Performing data analysis in coordination with CPI's Fraud Prevention System;
  - Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
  - Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

Zone Program Integrity Contractors (ZPIC)

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.
Over the last year, Zone Program Integrity Contractors (ZPICs) have turned much of their attention to prepayment review. Unlike postpayment audits, if your organization is placed on ZPIC prepayment review, there is very little you can do other than try to identify the nature of deficiencies noted so that remedial action can be taken. Being placed on prepayment review does not trigger any type of an administrative appeals process, thereby potentially making prepayment reviews incredibly damaging for a small provider. In addition, there is no concrete method for getting off ZPIC prepayment review – it is left essentially to the discretion of the contractor. Recent rule making has eliminated the time restrictions for a ZPIC to keep a provider on prepayment review so theoretically a ZPIC could maintain a prepayment review action forever.

ZPIC Zones

<table>
<thead>
<tr>
<th>ZPIC</th>
<th>Zone</th>
<th>States in Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard Services (SGS)</td>
<td>1</td>
<td>California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>2</td>
<td>Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska</td>
</tr>
<tr>
<td>Cahaba</td>
<td>3</td>
<td>Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky</td>
</tr>
<tr>
<td>Health Integrity</td>
<td>4</td>
<td>Colorado, New Mexico, Texas, and Oklahoma</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>5</td>
<td>Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia</td>
</tr>
<tr>
<td>Under Protest</td>
<td>6</td>
<td>Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut</td>
</tr>
<tr>
<td>Safeguard Services (SGS)</td>
<td>7</td>
<td>Florida, Puerto Rico, Virgin Islands</td>
</tr>
</tbody>
</table>
Complete Review Packet

- Need to obtain all information on patient requested
- Perform both clinical and billing audit
- Compare that information with any previous audits which may have been completed
- Review ADR notice to determine if you have reviewed all requested information and if all copies were made

What to Review

- Are all physician orders present and signed?
- Do all clinicians follow POC and additional MD orders?
- Is there clear documentation to support all ordered skills?
- Is the documentation specific – especially for wound care, IV administration, flushes, injectables, etc.?
Additional Information to Review

- Does every visit have an order to support the frequency? Are there orders for any PRN visits performed and is the need for the PRN visit valid?

- Are all supplies which are used ordered?

- If the medication profile is requested, are all medications listed and updated? (This will include any medications documented on during the course of the episode).

Common Denial Reason Codes

- Inadequate Face to Face Documentation

- Medical Review Down Code – Lack of Medical Necessity

- Primary Diagnosis found on OASIS and POC is not the condition most related to the Plan of Care

- Contradictions between OASIS documentation and ongoing clinical notes

- Unsigned/Dated or missing orders for services provided.
Medical Necessity

- Submitted information does not support medical necessity for the care
- Does the documentation support reasonable and medically necessary care for this patient
- Clinical information on the OASIS, POC and ongoing clinical documentation vary. This is why correct documentation is so important, both clinically and financially.

CERT
CERT

The Centers for Medicare & Medicaid Services (CMS) calculates the Medicare Fee-for-Service (FFS) improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, CERT evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.

The fiscal year (FY) 2014 Medicare FFS program improper payment rate is 12.7 percent, representing $45.8 billion in improper payments, compared to the FY 2013 improper payment rate of 10.1 percent or $36.0 billion in improper payments (1). The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2014. The reporting period for this improper payment rate is July 1, 2012 - June 30, 2013.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Improper Payment Rate</th>
<th>Improper Payment Amount (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitals</td>
<td>9.2%</td>
<td>$10.4B</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>53.1%</td>
<td>$5.1B</td>
</tr>
<tr>
<td>Physician/Lab/Ambulance</td>
<td>12.1%</td>
<td>$11.0B</td>
</tr>
<tr>
<td>Non-Inpatient Hospital Facilities</td>
<td>13.1%</td>
<td>$19.2B</td>
</tr>
<tr>
<td>Overall</td>
<td>12.7%</td>
<td>$45.8B</td>
</tr>
</tbody>
</table>

All public reports produced by the CERT program are available through the "CERT Reports" link on the section navigation tray to the left. The improper payment rate is released annually in the HHS AFR in the "Other Accompanying Information" section, which can be accessed through the HHS AFR link in the Related Links section at the bottom of this page.

OIG Work Plan 2015

Home Health

New for home health is an assessment of providers’ general compliance with home health prospective payment system requirements. This will include a review of sufficiency of documentation, and may specifically focus on newly enrolled home health agencies, which are designated by CMS as high-risk providers.

As a continuation from the 2014 Work Plan, the OIG will assess the extent to which home health agencies are employing individuals with criminal convictions, in violation of applicable state and local laws. Notably, states vary widely on how they define criminal convictions, so multi-state providers should review their screening processes to ensure compliance.
Corrective/ProActive Plan

Practice Compliance

• Implement & reinforce clear message of compliance at all times
• Maintain Compliance through training & ongoing monitoring
• Authority to enforce is mandatory

Current Risks

• Identify program integrity initiatives & common billing/payment errors
• Assess your agency’s greatest areas of risk
• Identify data needs to monitor risk areas
Corrective/ProActive Plan

Establish Compliance Monitoring

• Documentation controls
• Assign compliance responsibilities to appropriate personnel
• Implement compliance with billing
• Ensure tracking to identify compliance trends

Corrective/ProActive Plan

Test Compliance Processes

• Develop timeline for testing compliance
• Third set of eyes – random peer reviews
• Pre & Post Billing reviews of claims
Online Links

RA Website:  http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/


Program Integrity Manual:

Thank You For Coming!
Please Complete Evaluations!

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