Financial Risks in Medical Review: Responding, Reacting & Rebounding

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Overview

• Medical review is a complicated process of sending documentation and responding to Additional Documentation Requests.
• The financial risks are high with potentially severe cash flow and long term viability issues for the agency.
• This program will identify the current focus areas for ADRs and responding to each one. Specific financial risks will be discussed regarding potential denials and their devastating results to viability. All agencies will find this an important program to attend to prepare for medical review.
Objectives

- Identify focus areas of documentation examined in the ADR process.
- Discuss the agency process of responding to an ADR.
- List strategies to prepare for claim review before the request is made.
- Identify potential financial risks of ADRs

How Did This Happen? Why Us?

Elizabeth Zink Pearson
What Puts You On the Radar!

- What Gets you on the Radar?
  - CMS’ Predictive Modeling Program
    - Analytics on Claims for Aberrant billing
  - Complaints/Survey Findings
    - ZPIC/MAC
  - MAC Medical Review Agenda’s
    - Each MAC Sets Targets
  - Special SMERC/RAC Initiatives
    - CMS Directed
  - Re-billing/RAP Cancels
    - MAC Driven

CMS’ Predictive Modeling Program

- 2012 Fraud Prevention Program Report to Congress
  - Part of a “Twin Tower” initiative to eliminate fraudulent providers
    - Other Tower targeting provider enrollment using complex screening of new providers
      “Automated Provider Screening” or APS
  - State of art predictive analytics using algorithms continually being revamped
    with other sophisticated processes to target FFS
  - 1st yr. (2011)
    - $115.5 Million recovered
    - 536 OIG/Fraud leads
    - Return of $3 for every $1 spent
    - 2013 = $5 return.
  - First targeted 10 highest fraud states & now nationwide
  - Applies to Medicaid program too
What Makes You Interesting to Auditors?

• Any “Aberrant” Patterns in Claims/Billing
  • Suspicion of upcoding
  • Trend to higher paid HHRUG/diagnosis
  • Rebilling/Cancelling RAPS
  • Targeted diagnosis
• Changes in Utilization
  • Increasing/decreasing therapy utilization
• High # Referrals from 1 Source
• CMS continually modifying & enhancing Integration in Claim Processing to improve ability to scrutinize
  • Certifying Physician ID; Patient location information etc.

Complaints/Surveys

• CMS/OIG collaborating to improve response to complaints and information on possible fraudulent claims
  • Tips Hotline Response Process
  • CMS Focused Study on Fraud in Home Health with Focus on S. Florida
    • Attempt to get hard data on actual fraud in industry
    • Trying to verify existing “estimates” of $1 billion in improper payments and fraud 2010-2014
  • CMS Provider Compliance Reporting System
    • Solicitation Notice in May 2015 to develop web-based comprehensive view of MAC/Contractor activity with providers
    • Track providers receiving one-on-one education from MAC and what claims involved for possible claim review
    • Also stated intent to keep providers from facing review by multiple contractors such as MAC & ZPIC review of same claims.
• State Surveyors Citing Records with Questionable Medical Necessity or Lack of evidence of homebound status
  • Report to MAC/CMS/ZPIC
MAC Medical Review Agendas

• Each MAC Establishes Targets for Ongoing Medical Review
  • PrePay Probes on Provider
    • Widespread Probes Targeting Services of Billing Practices that pose risk of fraud
      • i.e., CGS edit on Diagnosis 401.9 (hypertension) with LOS>120 days
    • Provider Specific Edits based on Predictive Modeling/Complaint
    • Beneficiary Specific Edits on individual claims for a beneficiary whose claims already been denied
  • Post-payment Medical Review
    • Comprehensive Medical Review based on complaints/reports of questionable activity; MAC/CMS analytics indicating suspected fraud or abuse, or internal probes
    • Can be extrapolated over several years = look at 30-50 records over a 2 yr. universe and extrapolate any denial rate to all 2 yrs. of claims
    • CERT audit

• CMS Directs Certain Probes/Reviews to be Completed (i.e., F2F)

MAC Medical Review

• MAC’s Post Medical Review Focus Areas on their Websites:
  • www.palmettogba.com/palmettoproviders; Then link to Medical Review
  • www.ngsmedicare.com/ngs/portal/ngsmedicare; Then Search Medical Review
  • www.cgsmedicare.com/hhh/education; Then search CGS newsletters & HHH Advisory Group Minutes

• Stay Informed/Check Regularly as Part of QA
Other Contractor Medical Review

- RAC’s
  - HHA/Hospice Contract Still in dispute; intent was to have RAC initiating audits this year
  - Work on Statement of Work from CMS = target for audits or referral based on predictive
  - Charts reviewed = random or targeted
  - RAC’s paid contingency fee = 9-12.5% of each claim denied
  - RAC program changes – Many improper denials in RAC hospital audits
    - CMS limited # of ADR requests they can make
    - Delaying payment of contingency fee until after QIC appeal decision
    - Review limited to only 6 month of charts
    - Must offer “discussion period” with provider (if requested) to review findings and negotiate

Other Contractor’s Medical Review

- ZPIC’s
  - ZPIC is supposed to fraud & abuse auditor but often deny simply on medical necessity
  - Post-pay reviews usually for 1+yrs.
  - Review “random” sample of claims and extrapolate over the universe of claims
  - May interview clients
  - Large/huge paybacks

- SMERC
  - CMS driven audits – nationwide 5 claim F2F
  - Strategic Health Solutions
  - Current – New England HHA’s Audits for OASIS in response to an OIG report finding that many HHA’s did not have complete OASIS Data to support pay’t.
What Can I Do To Avoid Audits?

- Educate yourself on targeted claim-types
  - Check Contractor websites regularly on current audit initiatives
    - Including SMERC/Strategic Health Solutions
    - Recent notice from SHS on compliance with physician signature & attestation requirements = next area for audits?
  - Check OIG website/newsletter/Workplan for reports & findings on problem HHA issues – www.oig.hhs.gov
- Establish & maintain vigorous Pre-Bill QA process
  - Much easier/better to vet claims before billing
  - Educate staff on targets & necessary documentation
  - Assure full documentary compliance before billing
  - Assure F2F, Medical Necessity & Homebound Documented
  - Monitor utilization of services
    - Per visit paid staff could be over-utilizing

My Claim Was Denied – What to Do?

- Appeal!!!!
  - Unless clearly non-reimbursable
  - If Pre-pay/ADR – should have already realized it.
- Medicare Appeal Process
  - Part A & C (MA) = 5 levels of appeal
  - Different timelines at each level for request for appeal
    - IMPORTANT – Track due dates/don’t be late
  - Since 2013 - Hold on ALJ hearings (3d level) due to backlog
    - Hospital RAC audits & other denials created log jam in system
    - Medicare law & regulations require hearing & decision within 90 days from request for ALJ hearing.
    - Lawsuit by Medicare Beneficiary advocacy group attempting to force compliance
Claim Appeal Process

- Part A Levels:
  - 1. Redetermination
  - 2. Reconsideration
  - 3. ALJ Hearing
  - 4. Medicare Appeals Counsel/DAB
  - 5. Federal District Court

- Must meet amount in controversy for ALJ and Federal Court
  - $150 for ALJ
  - $1460 for Federal Court
  - Adjusted annually

Claim Appeals – Part A

- Redetermination
  - MAC review – second look
    - Supposed to be someone different
  - Request within 120 days of receipt of RA
  - Request in writing
    - Instructions on the RA
    - Check MAC website for electronic filing
    - CMS-20027
  - Attach Supporting Documentation
  - Sign the request
  - 60 days to Respond with decision
    - Medicare Redetermination Notice (MRN)
    - Revised RA if paid.
Claim Appeals: Part A

- Reconsideration
  - QIC Review
    - Independent review of entire record submitted with request
    - Can include physician review on medical necessity issues
  - 180 days after receipt of Redetermination Decision (MRN/RA)
  - Instructions included on redetermination decision or complete form CMS-20033
  - Include:
    - Copy of RA or MRN
    - Any evidence noted as missing in redetermination
    - All other evidence/documentation relevant to the appeal
    - No minimum amount in controversy required
    - Decision required within 60 days of receipt of Request
    - If not issued in 60 day person – can request escalation to ALJ
    - Submit all documentary evidence – can be excluded in ALJ setting if not submitted here.

Claim Appeal Process – Part A

- ALJ Hearing
  - ALJ’s from Office of Medicare Hearing & Appeals/ “independent”
  - Request within 60 days of receipt of Reconsideration decision
    - Copy your request to all parties involved in QIC Reconsideration
    - Request in writing per instruction on Reconsideration or filing CMS-20034 A/B.
  - Hearing by telephone or videoconference/rarely in person with showing of “good cause.”
  - Claim must be > $150
  - Submit all evidence/argument
  - Hearing = presentation of testimony
    - Your clinicians who cared for patient
    - Dr if you can get him/her.
  - Delay in hearings = Alternatives to ALJ Hearing
    - Settlement Conference Facilitation
    - Statistical Sampling Initiative for large volume appeals (ZPIC)
    - www.hhs.gov/omha
  - Lawsuit by Medicare Advocacy group
    - Attys insist only to benefit Beneficiaries.
Claim Appeals – Part A

• Medicare Appeals Council/DAB
  • Review of ALJ Decision/No hearing & No new evidence
  • Request 60 days from receipt of ALJ decision
  • Instructions for appeal in ALJ decision or file form DAB-101
  • Written argument explaining what part of ALJ decision is incorrect/in error.

• Federal District Court
  • Administrative review in which Court gives CMS/HHS great discretion
  • Only overturn agency decision if DAB/ALJ decision clearly unsupported by law or facts
    • Very tough standard
  • Must have claim > $1460.00

Claim Appeals – Part A

• Tips
  • Always meet timeline – or face losing appeal
  • Review entire claim record for possible need for supplement
    • Note: Must include all evidence at QIC Level 2
  • Consolidate as many claims as possible at level 1
  • Identify “appeal team” to work on meeting deadlines and coordinating responses

• Strategies
  • MAC’s allowed to start recouping after QIC decision
    • Not doing to consistently/ but ca
  • Request Extended Repayment Agreement thereafter
    • Depending on amount at issue = Ask for 5 yr or more to payback
    • Request then goes to CMS Central Office/tales time for review and stops recoupment while in approval process
Claim Appeals: Part C Medicare Advantage Plans

- 2 Appeals Processes: Standard & Expedited (Inpatient hospital only)
- First must ask for an Organization Determination if not provided
- Standard Appeals
  - 1. Reconsideration by Health Plan – 60 days to file
     - Pre-service (Pre-authorized) – decision in 30 days
     - Payment (claim denial) – 60 days to decision
  - 2. Independent Review Entity: Automatic if claim denial upheld
     - Pre-service – 30 days to decision
     - Payment – 60 days to decision
  - 3. ALJ Hearing Claim > $150 60 days to file
     - No time period for decision/hearing
  - 4. Medicare Appeals Council – 60 days to file
     - No time period for decision
  - 5. Federal Court

What to Do!

Marcylle Combs
Responding to ADRs

Provider Notifications

- DDE/VENDOR
- Direct Data Entry
  - Gives providers direct access to information on their claims
- Vendor
  - Specific reporting pulled from the DDE
- SNAIL MAIL
  - MACs delivery is delayed
DDE: Reason Code Inquiry Screen

Daily check of DDE system
• Input NPI# of agency
• SB 6000: status pending ADR
• SB 6001: ADR letter being sent to agency
  • Request date
  • Clock starts ticking
  • Remains on DDE until documentation is submitted and assigned to auditor

Designate ADR Response Team

• Team leader
  • Responsible
  • Understands the rules
    • CoPs, eligibility, reasonable and necessary, LCD’s etc..
  • Organized

• Experts on team
  • Compliance
  • Coding
  • Nursing and therapy services
  • Billing
  • F2F
Establish Timelines

- Know how long you have to respond
  - 30 day rule (still on most letters)
  - 45 days—(April 1st) absolute deadline before automatic denial

- Factor in mail time
  - 5 days for snail mail
  - FedEx or other carriers have overnight capabilities
    - Can send on the 29th day before day 30 deadline
  - Use traceable mail
  - Electronic submission is immediate

Establish Timelines

- 1st level appeals
  - 120 days from the date of the initial determinations
  - Services with remark code MA130 must be corrected and resubmitted not appealed

- 2nd level appeals (reconsideration)
  - 180 from receipt of redetermination. Submit this for to the qualified independent contractor

- ALJ (3rd level)
Establish Timelines

- Notification of staff
  - Initially (within 5 days)
  - Expect any additional information within 10 days
  - Review of chart initially then when all information completed
  - Additional information from physicians or hospital may take much more time

- Factor in
  - Staff who have left employment
  - Physicians
  - Vacations
  - Information that is missing

Develop Internal Tools

- ADR checklist to avoid technical denials
  - Date of request
  - Due date
  - Type of request (CERT, ZPIC, probe edit, etc.)
  - Documentation essentials
    - F2F, signatures, POC, etc..
  - G-codes on notes vs bill
  - Amount billed and result
  - Notifications of field and time
  - Appeal?
Sample Checklist

Spreadsheet to track ADR

• ADR first level
• APPEAL—tracking
## Example of ADR tracking spreadsheet

<table>
<thead>
<tr>
<th>Provider</th>
<th>Name</th>
<th>HIC</th>
<th>PCN</th>
<th>MR #</th>
<th>DCN</th>
<th>From Dt</th>
<th>Thru Dt</th>
<th>ADR Date</th>
<th>Total Charges</th>
<th>S/L</th>
<th>Rsn1</th>
<th>Rsn2</th>
<th>TOB</th>
<th>Days in S/L</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>charles</td>
<td>5555</td>
<td>8888</td>
<td>7676</td>
<td>7676</td>
<td>03/09/15</td>
<td>05/05/15</td>
<td>05/14/15</td>
<td>$1,080.0</td>
<td>0586</td>
<td>1001</td>
<td>39700</td>
<td>55888</td>
<td>329</td>
</tr>
<tr>
<td>123</td>
<td>doris</td>
<td>5555</td>
<td>8888</td>
<td>7676</td>
<td>7676</td>
<td>03/06/15</td>
<td>05/04/15</td>
<td>05/14/15</td>
<td>$4,042.0</td>
<td>0586</td>
<td>1001</td>
<td>39700</td>
<td>55888</td>
<td>329</td>
</tr>
<tr>
<td>123</td>
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<td>5555</td>
<td>8888</td>
<td>7676</td>
<td>7676</td>
<td>03/16/15</td>
<td>03/27/15</td>
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<td>888</td>
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<td>02/27/15</td>
<td>04/27/15</td>
<td>05/05/15</td>
<td>$3,240.0</td>
<td>0586</td>
<td>1001</td>
<td>39700</td>
<td>55888</td>
<td>329</td>
</tr>
</tbody>
</table>

## DDE: Reason Code Inquiry Screen

Results of audit

- **Input**
  - MCR # of beneficiary
  - Date ranges of ADR
  - NPI # of agency

- **Payment codes**
  - SB90: pending payment
  - SB99: claim payment made (partial or full)
    - Compare billed claim to payment to determine partial or full
  - D: denial
Develop Internal Tools

• Calendars for episode time period
• Template for summary of services
• Items sent to auditor
• Clinical record review audit form
• Analyze pattern of requests for trends

Submission of ADR

• Electronic
  • Scan to PDF
  • Save and upload
  • MAC website or Vendor
• Paper submission
  • Specific mailing address
Example Cover Letter

Date: May 22, 2015

In response to the request received 4/24/15, the following is a description of the documents being submitted for. Note the record submitted are from an electronic device if you should have any questions please notify us:

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>Medicare Number</th>
<th>Date of Service requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover letter</td>
<td>(PAGE 1)</td>
<td>1</td>
</tr>
<tr>
<td>Original request</td>
<td>(PAGE 2-4)</td>
<td>3</td>
</tr>
<tr>
<td>Face to Face Encounter, Face to Face, Face to Face</td>
<td>(PAGE 5-7)</td>
<td>3</td>
</tr>
<tr>
<td>Medical Narrative</td>
<td>(PAGE 8-11)</td>
<td>4</td>
</tr>
<tr>
<td>Initial Start of care 4/85</td>
<td>(PAGE 12-15)</td>
<td>4</td>
</tr>
<tr>
<td>Initial Start of care SN OASIS</td>
<td>(PAGE 16-28)</td>
<td>13</td>
</tr>
<tr>
<td>Start of care Physical Therapy Eval</td>
<td>(PAGE 28-33)</td>
<td>6</td>
</tr>
<tr>
<td>Start of care Speech Eval</td>
<td>(PAGE 34-37)</td>
<td>4</td>
</tr>
<tr>
<td>Start of care Occupational Therapy Eval</td>
<td>(PAGE 38-43)</td>
<td>6</td>
</tr>
<tr>
<td>CMS 485 4/1/15-4/1/15</td>
<td>(PAGE 45-48)</td>
<td>4</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>(PAGE 55-67)</td>
<td>35</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>(PAGE 88-122)</td>
<td>45</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>(PAGE 135-211)</td>
<td>79</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>(PAGE 222-273)</td>
<td>62</td>
</tr>
<tr>
<td>Homecare Aid</td>
<td>(PAGE 274-299)</td>
<td>26</td>
</tr>
<tr>
<td>Medication Profile</td>
<td>(PAGE 300-306)</td>
<td>7</td>
</tr>
<tr>
<td>Electronic Signature</td>
<td>(PAGE 307)</td>
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<tr>
<td>Signature Logs</td>
<td>(PAGE 308-309)</td>
<td>2</td>
</tr>
<tr>
<td>Total Pages</td>
<td></td>
<td>309</td>
</tr>
</tbody>
</table>

EXAMPLE OF F2F additional documentation

Directions on using these scenarios...
Choose one of the 3 scenarios below that fits the F2F information you have obtained. Place the scenario that fits your patient at the top of your summary. Remove the dates and type in the actual F2F date. (See Sample in completed summary folder). Also we place a F2F cover sheet with the same sample used in your summary right before the F2F information we send.

#1 This version has F2F forms, visit note, and attestation letter

Face-to-Face Encounter: The Face-to-Face Encounter requirements for this patient have been met according to guidance provided in CMF NMB Matters article SE1046 released on December 31, 2014. The Face-to-Face Encounter documentation meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services. Included are the completed Face-to-Face Encounter form, a copy of the actual physician visit note, and a letter from the physician summing the required criteria for Face-to-Face Encounter Information. This patient’s Face-to-Face Encounter occurred on 10/20/2014 which falls within the required timeframe.

#2 This version has F2F forms and visit note only

Face-to-Face Encounter: The Face-to-Face Encounter requirements for this patient have been met according to guidance provided in CMF NMB Matters article SE1046 released on December 31, 2014. The Face-to-Face Encounter documentation meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services. Included are the completed Face-to-Face Encounter form and a copy of the actual physician visit note from the encounter visit. This patient’s Face-to-Face Encounter occurred on , which falls within the required timeframe.

#3 This version has F2F form and attestation letter only

Face-to-Face Encounter: The Face-to-Face Encounter requirements for this patient have been met according to guidance provided in CMF NMB Matters article SE1046 released on December 31, 2014. The Face-to-Face Encounter documentation meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services. Included are the completed Face-to-Face Encounter form with the required criteria for Face-to-Face Encounter Information. This patient’s Face-to-Face Encounter occurred on 12/20/2011 which falls within the required timeframe.
Before Submission of Documentation

• Examine photocopies
  • Can you read them?
  • Are they all there?
  • Was it two sided?

• Number the pages

• Are all requested items attached?

• Are you submitting to correct entity?

• Attach copy of request with documentation
  • If responding to multiple claims, separate each response and attach copy of request
  • Be sure each bundle is well secured (one staple, upper left; no paperclips or rubber bands)

Medicare Managed Care

• CIP

• HUMANA
  • Process is much the same with particulars from the managed care organization

• Many more--
Preventative Steps

• Conduct regular record review/QA on charts
  • Update records a necessary for missing orders etc.. – bullet proof your records
  • Review records based on audit targets
• Education on current areas of review
  • Current—A1C, short term and long term goals for therapy, new F2F guidelines
• Home care 101
  • Reviews of the basic—intermittent care, reasons for recertifications etc.

Other Strategies

• Summaries
• Colored folders for types of edits
• Audit charts BEFORE submission of claims
• Communication between OASIS assessing nurse and nurse making visits in between OASIS time points
• Highlight pertinent data
  • Homebound
  • Primary diagnosis and other pertinent diagnoses
• List of items requested in the CERT letter is not all-inclusive. Providers should send all information necessary to support coverage and medical necessity of the services billed
• Send the minimum necessary
Careless Mistakes When Submitting Information

- Lack of dates
- All OASIS relating to the time period
- Therapy short term and long term goals
- A1C results q 90 days
- Lack of credentials behind signatures
- Coding sheet
- E signature policy

Be Proactive

- Keep up with changes/trends with CMS
  - OIG Work Plan
  - PGBA communications
  - RAC issues related to home health
    - Connolly
  - NAHC/TAHC
  - Coding updates
LCD Coverage Guidance

1. Documentation should show that patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient.
2. The results of the most recent HbA1c.
3. Documentation must be legible, relevant and sufficient to justify the services billed. This documentation must be made available to the A/B MAC upon request.

Institute Audits

• Know your vulnerabilities
  • Previous denials
  • Survey results
  • High utilization of services, outliers, diagnoses, etc..
    • Examine OIG report for targeted areas
  • Established benchmarks
    • Outcomes
    • Potential Avoidable Events
    • OASIS Errors
    • Outliers
    • Length of stay
    • Therapy Utilization
Performance Improvement

• Institute PI plans for identified problem areas
  • Before or after audit (as applicable)

Financial Impact

Valerie Cornett
ADRs

Concerns

1. Denials - Financial Statement impact
2. Cash Flow impact
3. Resources stressed

Denials – a Tale of Two Audits

Traditional Medicare
- 40 claims pulled
- Prepayment – 1,250
  (if rap was paid) X 40 = $50,000

Managed Care
- Look back
- Instead of claims, they can pull X
  claims on the same patient.
- 150 episodes pulled post Payment
Denials
• Is the $$$ gone for good?
• Appeal process – can take two years
• Tremendous waiting period

Denials
• Once the claim is denied...there is uncertainty.

• Do you feel it is collectable?
• Do you feel it is uncollectable?
• How do you record it?
• Must you record it?
Financials

- When you feel it is possibly uncollectable, you must record it.
- How much do you record?
  - Are there reserves for denials already recorded?
  - What is your denial history? What is our % of denial?
  - Statistically, F2F made this estimate impossible.
- Create an Entry
  - Create a journal entry to record the allowances for the claim.

Denials

Accounts Receivable at the patient detail level will change – ONLY when you have exhausted your appeals process and determined you will not collect.

If you win...
  Detailed AR balances will remain the same
  Reverse the allowance recorded for the claim – positive impact

If you lose...
  The claim is written off, no net effect to the Balance Sheet and Income Statement, (offset with the reversal of the allowance for uncollectable)
Cash Flow

Traditions Medicare

- 28 claims pulled first
  - 50% denied for F2F – 56K
- Entered – Second level of audits – began the next 90 days without cash
- Because denial rat was over 33%, 118 claims pulled – 236K
- Trending a loss of 130K
- Due to slowness of intermediary, they didn’t meet their audit numbers
- Placed on another quarter
- Pulled 34 more
- 68K more

Managed Care

- You have already been paid.
- Appeals
- If denied, payment deducted from a remittance or you will receive a demand letter

Cash Flow

- Based on your rate of denial....the edit can go on for quarter after quarter
Resources

• Soft Cost – Not so Soft Cost

• Who will you use to edit and submit the charts?
• Who will appeal?
• What is not getting done when they are assigned to this?

It's good to have money and the things that money can buy, but it's good, too, to check up once in a while and make sure that you haven't lost the things that money can't buy.

~George Horace Lorimer
• A woman went to the doctor who told her she only had 6 months to live.
  "Oh my God!" said the woman. "What shall I do?"
  "Marry an auditor," suggested the doctor.
  "Why?" asked the woman.
  "Will that make me live longer?"
  "No," replied the doctor. "But it will SEEM longer."