Medicare Updates and Reminders

NAHC 2013
Charles Canaan, Kim Campbell, Dan George, & Marilyn Jeske

Agenda

- Consolidated Call Center
- Medicare Review Contractors
  - Medicare Administrative Contractors (MACs)
    - Additional Documentation Requests (ADRs)
  - Comprehensive Error Rate Testing (CERT) Contractor
  - Recovery Audit Contractors (RACs)
  - Zone Program Integrity Contractor (ZPIC)
- Appeals
- Going Beyond Diagnosis® What Is It?
- Electronic Data Interchange (EDI)

October 2013
Consolidated Call Center

On October 1, 2013, Palmetto GBA implemented ONE number to dial for **All J11 Part A, Part B and HHH** to improve service for:

- Electronic Data Interchange (EDI)
- Interactive Voice Response (IVR)
- Provider Contact Center (PCC)

855-696-0705
Medicare Administrative Contractor – Additional Documentation Requests (ADRs)

What is an ADR?

- Request for copies of medical records on a specific beneficiary for specific dates of service
- The provider has 30 days from the date on the ADR to respond to Palmetto GBA with copies of the requested medical records
Claims Selected for Review

- Watch for the envelope containing the ADR
- Providers are also encouraged to monitor the status of their claims through the Direct Data Entry (DDE) system
- To determine the 30 day time period, the date on the ADR letter is the date the claim went to Status and Location (S/L) S B6001, or
  - Use the “ADR Response Calculator” available at www.PalmettoGBA.com/HHH under the Self Service Tools heading

View ADRs in DDE

- At Main Menu select 01 for inquiry
- Select 12 for claims sub-menu
- Tab to the S/LOC field and enter S B6001
- To view/print ADR, select the claim and press enter
- The ADR letter follows claim page 6
- Do not use the F9 key while in these claims; it causes a new ADR to generate
**Why is the Due Date in DDE Greater Than 30 Days from the Date of the Hardcopy Letter?**

- The “Due Date” in DDE reflects the actual date that the claim will be denied if the provider does not respond to the ADR
- The Original Date Requested field reflects the date of the hardcopy letter
- Providers are required to respond to an ADR request within 30 days from the date of the hardcopy letter
- When a response is not received within 45 days of the date of the letter, the claim is denied

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**Methods of ADR Response**

- Paper
  - Post office
  - Courier
- Fax
- CD/DVD
- Electronic Submission of Medical Documentation (esMD)
Helpful Hints

- A copy of the bar coded ADR letter should be on top of each response
- Make sure information/documentation submitted is for the appropriate beneficiary and dates of service

Helpful Hints

- Copies should be legible
- Copy both sides of two-sided documents
- Number all pages
- Use a checklist!!!!!!
  - Available at [www.PalmettoGBA.com/HHH](http://www.PalmettoGBA.com/HHH)
    - Resources
      - Medical Review
      - Responding to a Home Health Additional Documentation Request (ADR)
      - Responding to a Hospice Additional Documentation Request (ADR)
Paper Submission

- Number pages before making a copy
- Be sure to copy the back of a two-sided page
- Paginate multipage documents
- Make sure side and bottom margins do not get cut off
- Double check the copy before mailing it

Paper Submission

- Do not send correspondence intended for other Palmetto GBA departments with your ADRs
- May send more than one ADR response in an envelope, BUT separate each response
- Do not send packages C.O.D.
- Submit all documentation with the original ADR response, subsequent documentation may not reach the Medical Review department prior to the payment decision
Fax

- Make sure the back of two-sided pages are copied
- Make sure the page you intend to fax is readable/legible
- Fax individual records separately
- If your fax machine does not allow you to send all of the documentation in one fax, please mail your response instead
- Medical review fax number: 803-699-2436

CD/DVD

- TIFF or PDF format
- Do not password protect
- Save each ADR response as a separate image
Electronic Submission of Medical Documentation (esMD)

- esMD is completely voluntary
- Providers are encouraged to contact one or more of the Health Information Handlers (HIHs) to determine if esMD services are available to the provider for a reasonable price

CMS Certified HIHs

- HealthPort effective
- IVANS effective
- NaviNet effective
- RISARC effective
- MRO effective
- Health IT Plus effective
- Medical Electronic Attachment (MEA)
- eSolutions
- ApeniMED
- IOD
- Cobius
What Happens After the Review is Completed?

- Following medical review, a decision is made as to whether or not full payment, partial payment, or a denial is warranted.
- If full payment is allowed, the claim will finalize and the provider will see the processed claim on their remittance advice (RA).
- If partial payment is allowed, the provider can access the Remarks section to determine the reason for any denials/down codes of claims on claim page 04 in DDE.

What Happens After the Review is Completed?

- If payment is denied, the claim will be processed with a denial reason code that begins with the number five (5).
- The denial will be reflected on the providers RA.
- The provider can view remarks on claim page 04 in DDE to obtain a more detailed explanation of the denial reason.
**What is the Next Step for a Provider if the Claim is Denied?**

- Once a claim is reviewed and denied, the claim cannot be reopened.
- If the provider disagrees with the denial, the provider can appeal the decision by submitting a request for a Redetermination.
- Do **NOT** submit a request for a redetermination until the claim is finalized (D B9997).

**NOTE:** If a claim is denied with reason code 56900 (records not received), the provider can submit the documentation and request a reopening of the claim.
What is CERT?

- A Federally mandated program created by the Centers for Medicare & Medicaid Services (CMS) to measure the paid claims error rate for Medicare claims submitted to Medicare Administrative Contractors (MACs).
- Ensures that the Medicare program is paying claims correctly.
- The CERT program measures national, contractor-specific, and service-specific paid claim error rates.

How is CERT Administered?

- The CERT program uses a random and a service-specific (e.g., home health, hospice, etc.) sampling of claims.
- There are two contractors responsible for administering the CERT program on behalf of CMS.
  - The CERT review contractor selects samples of claims from Palmetto GBA.
  - For each claim selected, the CERT documentation contractor (CDC) requests medical records, from the providers, physicians or suppliers that billed for the services, and prepares the documentation for review.
CERT Medical Record Request

Why is the medical record important?

- The review contractor uses medical record documentation to verify that the services were billed correctly.
- Ensure Palmetto GBA’s decisions regarding the payment and processing of the claim(s) were accurate and based on sound policy.

CERT Medical Records Request

After a claim is identified as part of the sample, CERT requests the associated medical records and other pertinent documentation from the provider that submitted the claim.

- The initial request for medical records is made via letter.
- If the provider fails to respond to the initial request within 30 days, CERT sends at least three subsequent letters.
- The CERT contractor also places phone calls to the providers to collect the documentation.
Role of Provider

- Providers play a role in the reduction of error rates. When a medical records request is received, it is imperative that the provider does the following:
  - Be alert and prepared for medical record requests.
  - You have up to 75 days to return the requested information.

Responding to a CERT Request

- What will you receive from CERT?
  - Information on the CERT process
  - Health Insurance Portability Accountability Act (HIPAA) compliance information
  - What documentation to submit
  - Timeframe for responding to the request
  - Claim information

- Note: An Original bar coded sheet will be included that you must use with your mailed response or if you decide to fax your documentation.
Documentation

Upon receipt of medical records, CERT medical review professionals conduct a review of the claims and submitted documentation to determine whether the claim was paid properly.

- These review professionals consist of:
  - Nurses
  - Medical doctors
  - Certified coders

Your documentation is the basis for determining the CERT error rate!

- All procedures, diagnoses, and modifiers submitted on a claim to Medicare should be supported by information in the patient’s medical record.
- The “medical need” for services and procedures must also be documented in the patient’s medical record.
- The legible signature of the person that performed the service is required: Change Request 6698 – Signature Requirements.
Documentation

- Before reviewing documentation, the medical reviewers look at:
  - Common Working File (CWF)
    - Ensure the claim is not a duplicate
  - CMS Eligibility System
    - Confirm the person receiving the services was an eligible Medicare beneficiary
    - Verify there is no other entity responsible for paying the claim (Medicare is primary)

Documentation

- When performing claim reviews, CERT ensures compliance with:
  - Medicare statutes and regulations
  - Billing Instructions
  - National Coverage Determinations (NCDs)
  - Local Coverage Determinations (LCDs)
  - Coverage in CMS Internet Only Manuals (IOMs)
**Improper Payment**

- Based on the review, the CERT contractor determines if a proper payment or an improper payment was made

- An improper payment is defined as:
  - Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements
  - Overpayments
  - Underpayments

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**How Can A Provider Learn More?**

- CERT resources published on the J11 HHH website:
  - [www.PalmettoGBA.com/HHH](http://www.PalmettoGBA.com/HHH)

- CMS CERT website:
  - [www.cms.gov/CERT](http://www.cms.gov/CERT)

- CMS Program Integrity Manual
  - Publication 100-08
Recovery Auditors
(Recovery Audit Contractors or RACs)

RACs

- RACs detect and correct past improper payments
- CMS Recovery Audit Program
RACs and their Regions

Region A
- Performant Recovery
  - CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI and VT
  - www.Performantrac.com

Region B
- CGI
  - IL, IN, KY, MI, MN, OH and WI
  - https://racb.cgi.com/default.aspx

Region C
- Connolly, Inc.
  - AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands
  - www.connollyhealthcare.com/RAC

Region D
- Health Data Insights
  - AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas.
  - https://racinfo.healthdatasights.com
Connolly Inc. Approved Audit Issues

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CGI Federal Approved Audit Issues

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Zone Provider Integrity Contractors (ZPICs)

ZPIC Responsibilities

- ZPIC Responsibilities:
  - Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement
  - Conducting investigations in accordance with the priorities established by Center for Program Integrity’s (CPI’s) Fraud Prevention System
  - Performing medical review, as appropriate
ZPIC Responsibilities

- ZPIC Responsibilities:
  - 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
  - Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution

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
- Refer cases to law enforcement
ZPICs and their Corresponding Zones

Zone 1
- Safeguard Services (SGS)
  - CA, HI, NV, American Samoa, GU and the Mariana Islands

Zone 2
- AdvanceMed
  - WA, OR, ID, UT, AZ, WY, MT, ND, SD, NB, KS, IA, MO, AK

Zone 3
- Cahaba
  - MN, WI, IL, IN, MI, OH, KY

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ZPICs and their Corresponding Zones

Zone 4
- Health Integrity
  - CO, NM, TX and OK

Zone 5
- AdvanceMed
  - AR, LA, MS, TN, AL, GA, NC, SC, VA, WV

Zone 6
- **Under Protest
  - PA, NY, DE, MD, D.C., NJ, MA, NH, VT, ME, RI, CN

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ZPICs and their Corresponding Zones

Zone 7
- Safeguard Services (SGS)
  - FL, PR and VI

What Contractors Do What?
What Contractors Do What??

CERT, Recovery Auditor, ZPIC Responsibilities:
- Identify improper payments
- Submit claim adjustment request to the MAC
- Respond to any audit specific questions you may have, such as their rationale for identifying the potential improper payment

What Contractors Do What??

MAC (Palmetto GBA) Responsibilities:
- Claims processing, including paying providers/suppliers
- Provider outreach and education
- Medical review not for benefit integrity purposes
- Complaint screening
- Claim payment determination
- Claims pricing
- Auditing provider cost reports
What Contractors Do What??

MAC (Palmetto GBA) Responsibilities:

- Issue demand letters
  - Recouping monies lost to the Trust Fund (the CERT, RACs and ZPICs identify these situations and refer them to the MACs for the recoupment)
- Perform the claim adjustments based on CERT, RAC, ZPIC’s review
- Handle administrative concerns such as timeframes for payment recovery and the redetermination (appeals) process
- Include the name of the initiating CERT, RAC, ZPIC and their contact information in the related demand letter

What Contractors Do What??

MAC (Palmetto GBA) Responsibilities...

- Demand letters will be sent to the same address as any other demand letter that is sent from the MAC
- The address that is used to mail the demand letters is the provider’s physical address
- The letter number on the Recovery Auditor demand letters begins with an “R”
Appeals Process – First Level

Redeterminations

- Requesting a redetermination
  - Provider has 120 days from the date on the remit to request a redetermination
    - Any claim on which payment was denied
  - Attach copy of denial letter and Request for Redetermination Form
# Redeterminations

- Appeals Forms: www.PalmettoGBA.com/HHH
  - The following forms are available:
    - 1st Level Appeal
    - 1st Level Appeal – Late Submission
    - Recovery Audit Contractor (RAC)
    - Recovery Audit Contractor (RAC) – Late Submission
    - Comprehensive Error Rate Testing (CERT)
    - Comprehensive Error Rate Testing (CERT) – Late Submission
    - Zone Program Integrity Contractor (ZPIC)
    - Zone Program Integrity Contractor (ZPIC) – Late Submission

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# Going Beyond Diagnosis® What Is It?
Documentation Challenges

“I know it’s in here somewhere...”

“You know what I meant...don’t you?”

“What I really meant to say was...”

What is Needed?

- Studies show that diagnosis alone does not predict:
  - Service needs
  - Length of hospitalization
  - Level of care
  - Functional outcomes
Valuable Documentation

Valuable information allows health care providers to:
- Make predictions
- Make decisions

Health care management planning and delivery is often limited by:
- Missing documentation
- Incomplete documentation

How Do You Measure Success??
Evaluation

How do you know if your Home Health or Hospice agency is successful?

Evaluation involves assessing the strengths and weaknesses of programs, policies, personnel, products, and organizations to improve their effectiveness.

American Evaluation Association
Measuring Quality

- Process
- Outcomes
- Satisfaction (Impact)

Process Evaluation

- Process evaluations are geared to fully understanding how a program works – how does it produce the results that is does

Basic Guide to Program Evaluation. © Copyright Carter McNamara, MBA, PhD, Authenticity Consulting, LLC. Adapted from The Filed Guide to Nonprofit Program Design, Marketing and Evaluation
Process Evaluation

Process evaluation verifies what the program is and whether it is being implemented as designed.

Workbook for Designing a Process Evaluation Produced for the Georgia Department of Human Resources Division of Public Health By Melanie J. Bliss, M.A. James G. Emshoff, Ph.D. Department of Psychology Georgia State University July 2002

Process Evaluation

When conducting a process evaluation, keep in mind these three questions:

- 1. What is the program intended to be?
- 2. What is delivered, in reality?
- 3. Where are the gaps between program design and delivery?

Workbook for Designing a Process Evaluation Produced for the Georgia Department of Human Resources Division of Public Health By Melanie J. Bliss, M.A. James G. Emshoff, Ph.D. Department of Psychology Georgia State University July 2002
Outcome Evaluation

Outcome evaluation measures the results or output of a process

- Outcome evaluation provides information on how well your program is accomplishing its goals
- Outcome evaluations aim to assess treatment effectiveness

Outcome Evaluations. Evaluation of Psychoactive Substance Use Disorder Treatment. ©World Health Organization, 2000
Impact Evaluation

Impact evaluation assesses the changes that can be attributed to a particular intervention, such as a project, program or policy, both the intended ones, as well as ideally the unintended ones.


Going Beyond Diagnosis®

- Going Beyond Diagnosis® puts the notions of 'health' and 'disability' in a new light.
- It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability.
Human Functioning

- Disability is not something that only happens to a minority of humanity.
- Going Beyond Diagnosis® 'mainstreams' the experience of disability and recognizes it as a universal human experience.

Human Functioning

Going Beyond Diagnosis® takes into account the social aspects of disability and does not see disability only as 'medical' or 'biological' dysfunction.
## Old School vs. New School

<table>
<thead>
<tr>
<th>Old School of Thought:</th>
<th>New Way of Thinking:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability began where health ended</td>
<td>Stresses health and functioning rather than disability</td>
</tr>
<tr>
<td>Once disabled, you were put in a separate category</td>
<td></td>
</tr>
</tbody>
</table>

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### Biopsychosocial Approach

- Going Beyond Diagnosis® is based on the biopsychosocial approach
- A coherent view of different perspectives of health: Biological, Individual, and Social
Structure

Going Beyond Diagnosis

Classification

Parts

Components

Constructs/qualifiers

Part 1: Functioning and Disability

Body Functions and Structures

Activities and Participation

Part 2: Contextual Factors

Environmental Factors

Personal Factors

Change in Body Functions

Change in Body Structures

Capacity

Performance

Facilitator/Barrier

Interaction of Concepts

Health Condition (disorder/disease)

Body function & structure (Impairment)

Activities (Limitation)

Participation (Restriction)

Environmental Factors

Personal Factors

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Components

<table>
<thead>
<tr>
<th>Body Functions &amp; Structures</th>
<th>Activities &amp; Participation</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functions</td>
<td>Capacity</td>
<td>Barriers</td>
</tr>
<tr>
<td>Structures</td>
<td>Performance</td>
<td>Facilitators</td>
</tr>
</tbody>
</table>

Functioning & Disability

Problems in body function or structure such as significant deviation or loss
Functioning & Disability

- Activity limitations are difficulties an individual may have in executing activities
- Participation restrictions are problems an individual may experience in involvement in life situations

Contextual Factors

**Environmental factors** make up the physical, social, and attitudinal environment in which people live and conduct their lives.
Contextual Factors

<table>
<thead>
<tr>
<th>Person</th>
<th>Environment</th>
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</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Products</td>
</tr>
<tr>
<td>Age</td>
<td>Close milieu</td>
</tr>
<tr>
<td>Other health conditions</td>
<td>Institutions</td>
</tr>
<tr>
<td>Coping style</td>
<td>Social Norms</td>
</tr>
<tr>
<td>Social background</td>
<td>Culture</td>
</tr>
<tr>
<td>Education</td>
<td>Built-environment</td>
</tr>
<tr>
<td>Profession</td>
<td>Political factors</td>
</tr>
<tr>
<td>Past experience</td>
<td>Nature</td>
</tr>
<tr>
<td>Character style</td>
<td></td>
</tr>
</tbody>
</table>

Reasonable & Necessary Services

- Diagnosis
- Impairment
  - Structural
  - Functional
- Activity Limitation
- Participation Restriction
- Disability
Going Beyond Diagnosis® Resources

- www.PalmettoGBA.com/HHH
  - Learning and Education
  - Going Beyond Diagnosis Series
  - Palmetto GBA blog
Electronic Data Interchange (EDI)

J11 Website - EDI
J11 Website - EDI

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Enrolling a New Provider

- Complete EDI Enrollment Packet
  - EDI Application
  - EDI Enrollment Agreement
  - Provider Authorization Form – if using a clearinghouse/billing service to submit your claims
  - DDE Enrollment Form – id requesting DDE IDs

Forms must be filled out correctly and completely in order to be processed
Allow 20 business days for processing before contacting EDI for a status

**NOTE:** You must receive a Welcome Letter from Provider Enrollment before submitting EDI Enrollment Forms

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Updating an Existing Provider

- Complete an EDI Application
- Complete a Provider Authorization Form – if switching to a different clearinghouse/billing service to submit claims
Applying for a DDE ID

- Complete the DDE Enrollment Form – paper

OR

- Complete the DDE ID Online Request Form
  - Must provide complete name
  - Must provide existing DDE ID if applicable to person
  - If an ID exists, but is not provided, a new ID will NOT be assigned
  - Once assigned, ID belongs to that individual regardless of employment

DDE IDs

- An individual ID is required for each user
- IDs can NOT be shared or transferred
- An ID can access multiple provider numbers
- For an ID to remain active, user must logon once every 29 days
- Recertification is done via email notification
- If an individual leaves your employment, contact us to delete their access to your NPIs
DDE ID Password Reset

- System will prompt any invalid responses
- Your RACF and Pin are required to use
- This is a self-service option. No call is necessary
- Password can only be reset once in a 24-hour period
- The DDE Manual can be downloaded from our web site – www.PalmettoGBA.com/medicare

EDI System Status

![EDI System Status](http://palmettogba.com/Internet/status.nsf/System+Status?OpenFrame_...)

This status is for Palmetto GBA, Railroad Medicare, and CGS customers including 31, 311 and 315 MACs.

Last Refreshed on 05/19/2013 03:49:09 PM EST

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## EDI System Status Log - Open

### Open Issues

<table>
<thead>
<tr>
<th>Tracking Number</th>
<th>PLM0017</th>
<th>Issue Opened (DateTime):</th>
<th>08/19/2013</th>
<th>Issue Resolved (DateTime):</th>
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<tbody>
<tr>
<td>Description of Issue:</td>
<td>Those connecting to GPNet dial-up number (903-776-0000) are unable to connect.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact:</td>
<td>Customers using this number will be unable to connect to GPNet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Status:</td>
<td>Technicians are currently researching the issue. We have no ETA.</td>
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<td></td>
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## EDI System Status Log - Resolved

### Resolved Issues

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<tr>
<th>Tracking Number</th>
<th>PLM0016</th>
<th>Issue Opened (DateTime):</th>
<th>05/31/2013</th>
<th>Issue Resolved (DateTime):</th>
<th>06/04/2013</th>
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</thead>
<tbody>
<tr>
<td>Systems Affected:</td>
<td>J1 Part A</td>
<td>J11 Part A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of Issue:</td>
<td>The Statement Due Date and Statement Through Date in the 2300 DTP segments of the 835 file are the same, but were processed with the submitted dates.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact:</td>
<td>The Statement Through Date in the 835 file was incorrect. The issue began on 05/20/13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Status:</td>
<td>Remits created after 06/03/13 are displaying correctly.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Tracking Number</th>
<th>PLM0015</th>
<th>Issue Opened (DateTime):</th>
<th>05/30/2013</th>
<th>Issue Resolved (DateTime):</th>
<th>05/30/2013</th>
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<tbody>
<tr>
<td>Description of Issue:</td>
<td>Delayed distribution of some 835, 996 and 277CA files from 5/29/13 and 5/30/13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact:</td>
<td></td>
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</tbody>
</table>

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Contact Us

- EDI Web Site:
  http://www.palmettogba.com/edi
- Email us:
  medicare.edi@PalmettoGBA.com
- Call us:
  1-855-696-0705
  Hours of operation are 8:00 AM – 5:00 PM ET
- Join our listserv to receive EDI information

QUESTIONS?