

FREE WEBINAR



Claim Reviews: A Survivor's Guide

Prepare **NOW** for
Medicare Claim Audits

Tues, July 11 | 1:30 PM CT



ZIMMET HEALTHCARE
SERVICES GROUP, LLC



Your Speaker



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VP of MDS Policy and Education
Zimmet Healthcare



Disclaimer

Thank you for joining the presentation today. The information presented here is accurate as of July 11, 2023. However, as we all know, updates to regulations, policies, guidelines, and circumstances occur frequently. Therefore, it is essential that you stay informed by continuing to consult authoritative sources about new developments and seek expert guidance relevant to your specific facts and circumstances

Today We Will Discuss...

- The most recent CMS memo regarding the SNF 5-Claim Probe and Educate Review
- The most frequent reasons for Medicare Part A claim denial
- Documentation best practices to support your Medicare claims
- Step-by-step procedures to prepare and respond to this, or any, Medicare audit

Poll #1



Skilled Nursing Facility 5-Claim Probe and Educate Review

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12015	Date: May 4, 2023
	Change Request 13164

SUBJECT: Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to have the MACs perform a 5 claim probe and educate medical review on every SNF in their jurisdiction. The purpose of this widespread review is to lower the SNF improper payment rate.

EFFECTIVE DATE: June 5, 2023

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 5, 2023

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12015	Date: May 04, 2023
	Change Request 13164

Transmittal 12015 issued May 04, 2023, is being rescinded and replaced by Transmittal 12032, dated May 10, 2023, to designate the CR type as Confidential. All other information remains the same.
NOTE: This information cannot be shared outside of your organization. Do not post any of the information on the Internet or Intranet.

SUBJECT: Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12037	Date: May 15, 2023
	Change Request 13164

Transmittal 12032 issued May 10, 2023, is being rescinded and replaced by Transmittal 12037, dated May 15, 2023, to make a minor clarification (that claims will be adjusted/denied if an improper payment is identified) and remove the confidential designation. All other information remains the same.

SUBJECT: Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to have the MACs perform a 5 claim probe and educate medical review on every SNF in their jurisdiction. The purpose of this widespread review is to lower the SNF improper payment rate. As always, if the MAC identifies an improper payment, the MAC will adjust the individual claim payment, as appropriate, in addition to providing education, including their explanation for denial or adjustment of payment.

EFFECTIVE DATE: June 5, 2023

**Unless otherwise specified, the effective date is the date of service.*

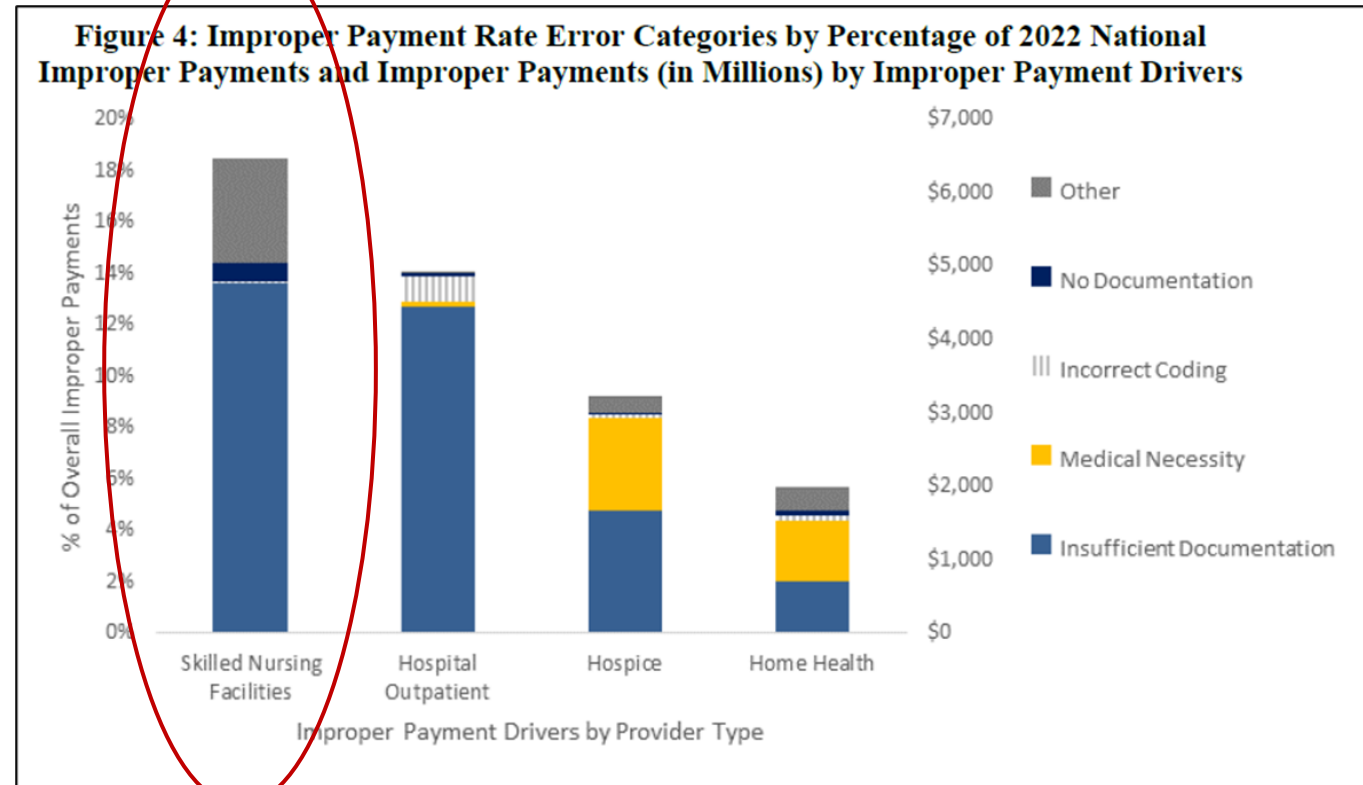
IMPLEMENTATION DATE: June 5, 2023

Highlights of the Memo

- All Medicare Area Contractors (MACs) have been instructed to select 5 claims from each SNF in their jurisdiction
- This directive is focused on Part A PDPM claims to “increase comprehension of correct billing practices”
- MACs will complete one round of probe and educate for each provider instead of the potential 3 rounds as per the traditional Target Probe and Educate (TPE) program
- Provider education will be based on the identified errors
- Prepayment review

Why Did CMS Decide to Do This Now?

- The Comprehensive Error Rate Testing (CERT) program projected an improper payment rate of 15.1% in 2022, up from 7.79% in 2021
- SNF errors are the number one driver in the overall rate
- May be in part due to the change from RUG-IV to PDPM



Comprehensive Error Rate Testing

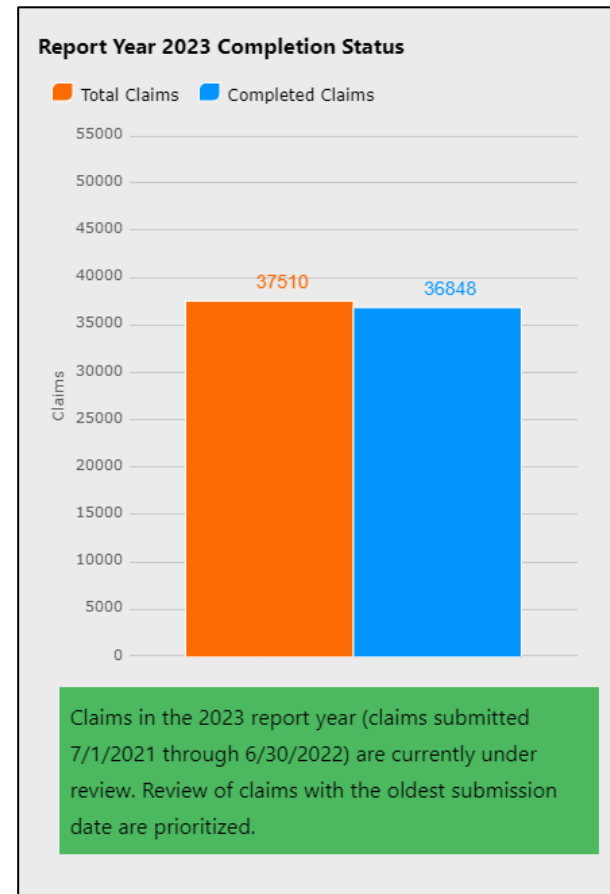
- Implemented to measure improper payments in the Medicare FFS program
- Categories of Errors
 1. No Documentation
 2. Insufficient Documentation
 3. Medical Necessity
 4. Incorrect Coding
 5. Other

CERT Information

- CERT C3HUB
 - Provides information about the CERT program to Medicare providers, suppliers, and contractors
 - Sample Request Letters – e.g., Part A & B
 - Record Submission
 - Claim Status Information
 - CERT Review Completion Status Chart

The screenshot shows the CERT C3HUB website. The header includes the C3HUB logo and a 'MAC LOGIN' button. A navigation menu on the left lists: Home, About CERT, Submit Records to CERT, Letters and Contact Information, Completion Status Chart, Claim Status Search, CERT Disaster Damage Administrative Relief, Attestation Letters, and Sample Request Letters. The main content area is titled 'Welcome to the CERT C3HUB' and contains a description of the site's purpose and a list of features:

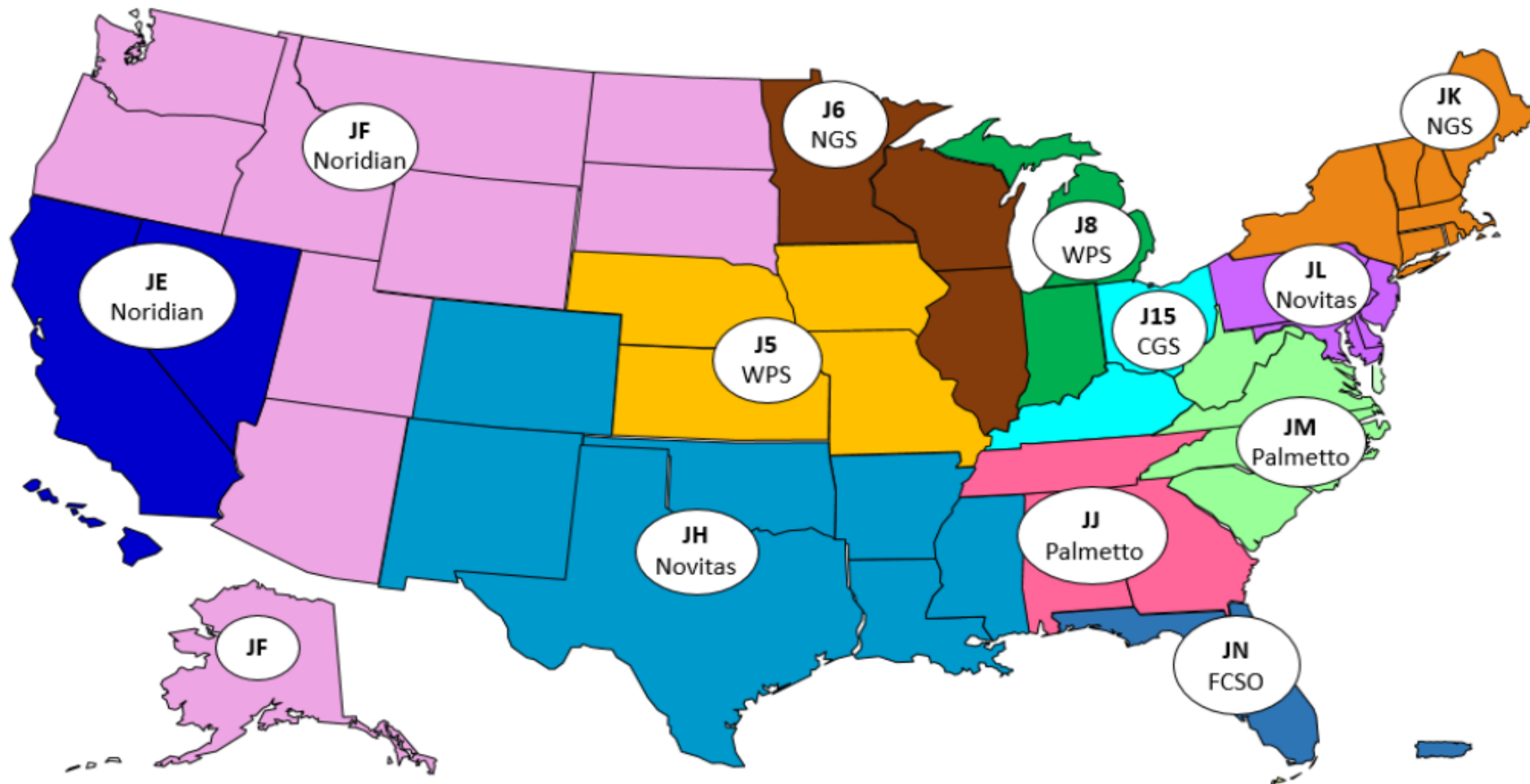
- **About CERT** — This webpage covers a brief description about the CERT program and the functions of the two CERT contractors: The Review Contractor and the Statistical Contractor.
- **Submit Records to CERT** — This webpage provides instructions to providers and suppliers on how to submit medical documentation to the CERT Review Contractor. There are five submission methods.
- **Letter and Contact Information** — This webpage notifies providers and suppliers of the schedule the CERT Review Contractor uses to mail out the initial and subsequent Additional Documentation Request (ADR) letters. The timeline includes when providers and suppliers can expect to receive a telephone call. This webpage also identifies the source of the address the CERT Review Contractor will use to mail the initial and subsequent letters. It informs providers that telephone calls will be grouped in order to reduce multiple calls to the same provider. And provides instructions on how providers that have 10 or more PTAN/OSCAR numbers can join the chain address program.
- **Completion Status Chart** — This webpage provides the completion status of the active report periods that the CERT Review Contractor is working on.
- **Claim Status Search** — This webpage provides current status of a claim under CERT review.
- **Administrative Relief for Damaged Areas From a Disaster** — This webpage provides guidance for how CERT claims processing is affected in the event of a natural disaster.
- **Attestation Letters** — This webpage provides a sample of the Disaster Attestation Letter. Providers and suppliers are required to submit this letter when the medical documentation requested to support a claim has been wholly or partially destroyed in a disaster. It also includes a sample of a Signature Attestation Letter that providers and suppliers can use when the signature is illegible/missing.

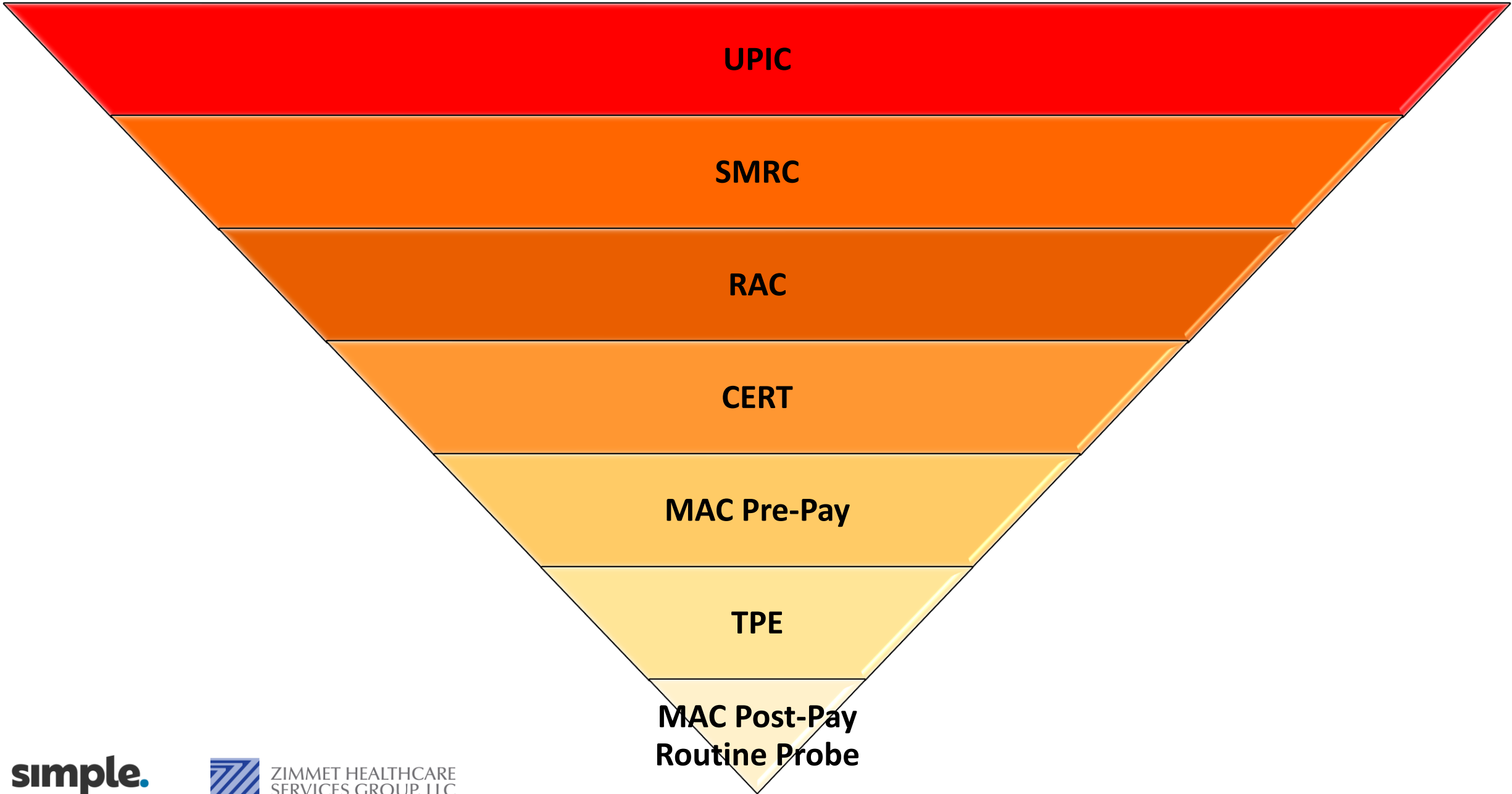


Medicare Area Contractors (MAC)

- Private health insurers that have been awarded a geographic jurisdiction to process Medicare Part A, B, and DME claims for traditional Medicare Fee-For-Service (FFS) beneficiaries
- Process Medicare FFS claims
- Handle redetermination requests (1st stage appeal process)
- Respond to provider inquiries
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims

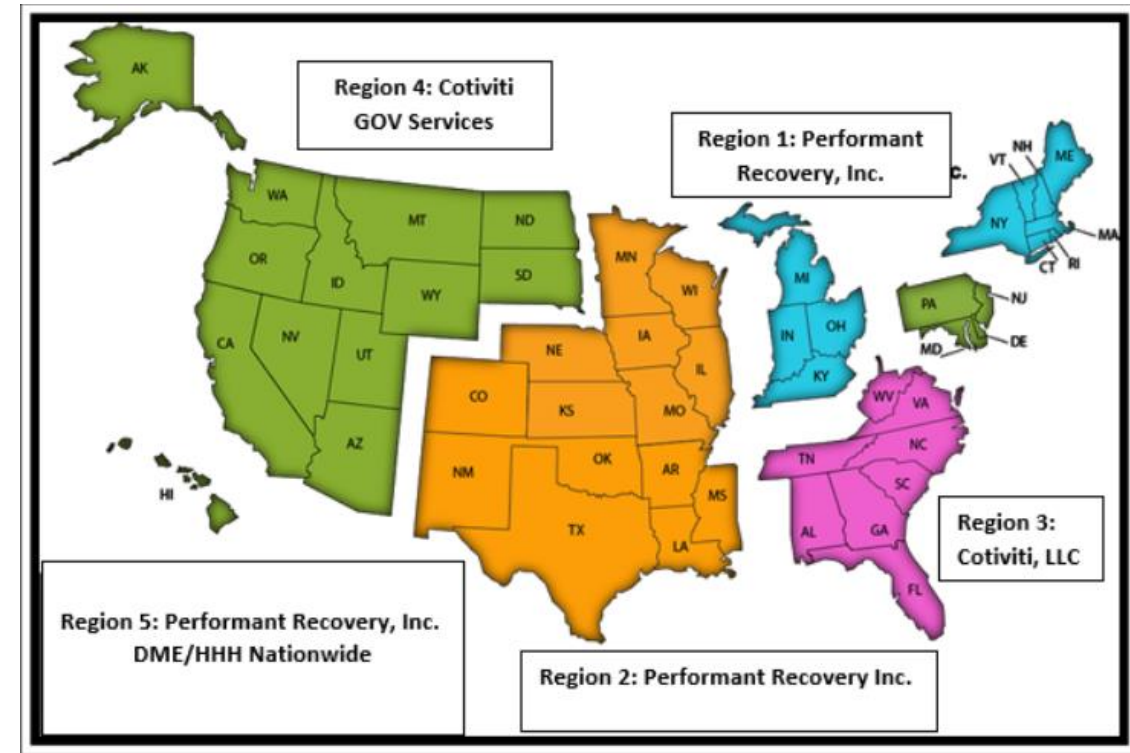
A/B MAC Jurisdictions





Recovery Audit Contractor (RAC)

- Mission is to identify and correct Medicare improper payments
- RAC may look back up to 3 years from the claim paid date to review claims
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over or underpayment



<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program>

Supplemental Medical Review Contractor (SMRC)

- Use data mining (e.g., profiling of providers, services, or beneficiary utilization) for aberrant patterns
- As directed by CMS
- Perform medical review
- Perform extrapolation
- Make interagency referrals (e.g., to the UPIC)
- Refer to the MAC for recoupment and appeals

01-088 SNF PDPM Notification of Medical Review

- Conducted by Noridian Health Care Solutions, LLC as the Supplemental Medicare Review Contractor (SMRC)
- In response to the 2021 Medicare Fee-for-Service Supplemental Improper Payment Data projected improper payment estimated at \$2.7 billion in SNF billing
- Data analysis done by CMS and the SMRC “identified a possible vulnerability in the maximization of payments by a drop in therapy utilization and/or the manipulation of other combinations of care.”
- Post-payment review of FFS Part A with dates of service between January 1 – December 31, 2020



Unified Program Integrity Contractor (UPIIC)

- Identifies potentially fraudulent Medicare providers
- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid – Medicare payment suspension
- Identify any improper payments that are to be recouped by MACs

UPIIC Process

- Perform data analysis
- Request medical records and documentation – 15 to 30 days to submit!
- Conduct interviews & onsite visits
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold/Suspend Medicare payments
- Refer cases to law enforcement
- Identify recoupment situations and refer to the MACs for the recoupment and appeals

Common Reasons for Claim Denial

- No response to ADR or request for records
- Missing information
- Technical information
- Improper coding
- Physician's orders – medical necessity
- **Insufficient Documentation**

The image shows a detailed medical claim form, likely a UB-04, which is a standard form for submitting claims to health insurance companies. The form is filled with various fields for patient information, dates, and codes. A large, bold, red 'DENIED' stamp is prominently placed over the center of the form, indicating that the claim has been rejected. The stamp is slanted and has a drop shadow effect. The form itself contains numerous tables and sections, including fields for patient name, address, dates of service, and various medical codes. At the bottom of the form, there are fields for 'PAGE 1 OF 1', 'CREATION DATE 04/22/21', and 'TOTALS 1778.00'. The form is a grid-like structure with many small boxes and lines, typical of a complex data entry form.

How Can We Limit Negative Outcomes?

- Know your risk
- Triple Check
- Support skilled services - **DOCUMENTATION**
- Audit Response Team
 - Procedure
 - Practice



Statistical Analysis of Likely Targets (SALT)

- CORE Analytics Tool
- ZHSG reviewed ~ 96,000 Medicare Part A claims (MDS, UB-04, Documentation) in 2022; trending for 121,000 in 2023
- Informal compilation of our findings:
 - “Explicit/Implicit Omission” v. “Objective/Subjective Improper Capture”
- Omissions outpace Improper Capture events by 2 to 1

Average SNF SALT Score by State

ZHSG analytics applied to CMS LDS claim files from Q1 – Q4 2022

1	NJ	64.4
2	NY	61.3
3	MD	58.5
4	CA	57.6
5	FL	57.0
6	TN	56.2
7	NV	55.8
8	IL	54.3
9	IN	54.2
10	DE	54.1
11	TX	53.8

12	OH	53.6
13	UT	53.5
14	VA	53.3
15	WA	53.0
16	DC	52.5
17	ID	51.7
18	AZ	51.6
19	AR	51.5
20	KY	51.4
21	CT	51.3
22	HI	50.9

23	VT	50.0
24	NC	48.8
25	MA	48.7
26	NH	47.7
27	LA	47.5
28	NM	47.5
29	GA	47.4
30	SC	47.2
31	WV	47.1
32	AK	45.8
33	KS	45.4

34	WY	45.0
35	CO	45.0
36	OK	44.3
37	MI	43.7
38	PA	43.7
39	OR	43.2
40	WI	43.2
41	RI	40.8
42	MT	40.6
43	SD	40.4
44	MO	39.6

45	ME	38.9
46	NE	37.7
47	MS	37.3
48	AL	37.1
49	IA	35.6
50	MN	34.1
51	ND	31.4
52	PR	19.5

Generation Health and Rehab (Apr-2023 to Jun-2023)

PDPM Category	Target Area	SNF Capture	CORE Average	National %	National Percentile
PT/OT	Non-Ortho Surgery / Acute Neuro	18.8%	26.1%	21.7%	57.0
SLP 1	All Three	3.0%	9.3%	7.4%	23.0
SLP 2	Both	3.3%	18.9%	15.1%	16.0
Nursing	Special Care High	56.2%	46.6%	35.2%	90.0
Nursing	Extensive Services	19.7%	9.9%	8.9%	85.0
Nursing	Depression End-Split	76.0%	29.3%	20.4%	94.0
NTA	3-5 Points	42.0%	37.8%	33.5%	82.0
NTA	6-8 Points	14.7%	12.3%	9.6%	83.0
NTA	9-11 Points	6.8%	4.7%	3.8%	84.0
NTA	12+ Points	3.1%	2.3%	1.6%	60.0
N/A	PPD Rate (AWI=1)	\$702	\$663	\$632	95.0
N/A	Average Length of Stay	20.9	23.7	26.3	28.0

Millennial Care Center (Apr-2023 to Jun-2023)

PDPM Category	Target Area	SNF Capture	CORE Average	National %	National Percentile
PT/OT	Non-Ortho Surgery / Acute Neuro	9.70%	26.80%	21.9%	17.0
SLP 1	All Three	3.00%	9.40%	7.5%	22.0
SLP 2	Both	0.00%	19.00%	15.1%	1.0
Nursing	Special Care High	3.40%	49.20%	35.5%	4.0
Nursing	Extensive Services	3.00%	6.70%	10.0%	19.0
Nursing	Depression End-Split	24.50%	29.70%	21.2%	73.0
NTA	3-5 Points	14.90%	37.40%	34.1%	7.0
NTA	6-8 Points	4.30%	12.50%	9.8%	23.0
NTA	9-11 Points	0.00%	5.00%	3.8%	1.0
NTA	12+ Points	13.30%	2.50%	1.6%	97.0
N/A	PPD Rate (AWI=1)	\$582	\$660	\$643	3.0
N/A	Average Length of Stay	17.8	23.6	26.3	16.0

Triple Check

- Monthly prior to claim submission
 - Billing accuracy
 - Provides checks and balances to the entire admissions, billing, and Minimum Data Set (MDS) process
- Items to review
 - Clinical eligibility
 - UB-04 accuracy
 - MDS coding
 - Physician Certification

ZIMMET HEALTHCARE SERVICES GROUP, LLC															Medicare Triple Check									
Date: _____																								
MDS Information / UB-04 Accuracy															PT/OT Component									
Resident	Statement Covers Period From / Through Dates	Hospital Dates of Stay	Admission Date	Discharge Type	MDS Reference Date	Occurrence Codes and Dates in Field Locator 31 - 36 Correct	UB-04 HPPS Code	Assessment Indicator Code	HPPS Rate Days Paid	LOA Dates	Admitting Diagnosis in Field 69	HWI/MS dx Code on UB-04	Demographics Correct	Physician Certifications Completed & Signed	PT/OT HPPS Character	Primary ICD-10 Code	Primary Diagnosis in Field Locator 67	Surgical Procedure	GG Range	Verified?				
SLP Component					Nursing Component					NTA Component					Comments									
SLP HPPS Character	Primary Acute Neuro, SLP Comorbidity, Cognitive Impairment	SLP Comorbidity Diagnosis	SLP Comorbidity Diagnosis in Field Locator 67A - Q	Swallowing Disorder, Mech Altered Diet	Verified?	Nursing HPPS Character	Primary Driver	ICD-10 Diagnosis for Primary Driver in Field Locator 67 A-Q	PHQ-9	GG Range	Verified?	NTA HPPS Character	NTA Drivers	NTA Driver ICD-10 in Field Locator 67 A-Q	Verified?									

Documentation

- Medical history and physical exams
- Skilled services provided
- Detailed rationale explaining the need for skilled service
- Complexity of service
- Patient's response to skilled services
- Plan for future care based on prior results
- Other patient characteristics

MEDICARE Skilled Charting Guidelines

Resident name: _____ Date of admission: ____/____/____
 Primary reason for admission: _____ Daily skilled care service(s) required: _____
 Other diagnoses requiring skilled care/observation/assessment: _____

Medicare Skilled Care Documentation Guidelines

1. These documentation templates are intended to assist the clinical care team to identify and focus documentation on the reasons for post-acute care services and the measurable and necessary daily skilled care services provided to the resident.
2. Documentation of daily skilled care services may be completed by facility-designated Medicare nurses, other nurse designers and/or other facility licensed clinicians knowledgeable about the resident and the care/services provided.
3. Daily documentation should identify and address the resident's clinical care needs related to reasons for hospitalization and the post-acute care needs and services.

Most Common Reason(s) for Daily Skilled Care in a SNF:

<input type="checkbox"/> Physical and/or Occupational therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiovascular compromise (AHN/CHF)
<input type="checkbox"/> Respiratory therapy/Chronic lung disease	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> IV or IM medication
<input type="checkbox"/> Daily OT/ST feeding > 50% assistance	<input type="checkbox"/> Pressure ulcer > 1 Stage II or Stage III or IV	<input type="checkbox"/> Surgical wound/Open Wound/Diabetic ulcer
<input type="checkbox"/> Strength collaboration with other care needs identified in a plan of care	<input type="checkbox"/> Hemodialysis (with other clinical needs)	<input type="checkbox"/> Medically unstable/Medication management related to condition/diagnosis treated in hospital
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Patient teaching and training associated with skilled care services	<input type="checkbox"/> Nursing rehab progress with other services

Below are some elements of required documentation for the above skilled conditions/treatments.

TYPE OF SKILLED SERVICE/DIAGNOSIS/CONDITION		
<p>Physical and/or Occupational Therapy</p> <ul style="list-style-type: none"> Describe specific ACL program seen on the morning and the afternoon (specify time) Describe resident's response to therapy Describe resident's ability to perform tasks and make needs known to staff Describe how resident tolerated task loading, including adverse effects (dizziness, abnormal vital signs, lung congestion) Describe type of safety care required (round the table and transfer of table) 	<p>Speech Therapy</p> <ul style="list-style-type: none"> Describe how the resident communicates and make needs known Describe resident's ability to follow and respond to verbal and written instructions Describe resident's ability to swallow food and utilize feeding interventions used to compensate for impaired swallowing skills 	<p>Respiratory Therapy/Chronic Lung Disease</p> <ul style="list-style-type: none"> Describe breath sounds use of lung sounds (e.g. wheeze, crackles, rhales) Describe respiratory rate, rhythm and quality Describe other respiratory treatments given (e.g. nebulizers, chest PT, oxygen, other respiratory medications, etc.) Describe skilled nursing interventions used to address respiratory condition Describe resident's response to treatment Describe resident's condition level related to respiratory status (including SPO2 when using that device on resident, etc.) Describe any skilled nursing interventions used to address respiratory condition
<p>IV or IM medication</p> <ul style="list-style-type: none"> Describe when medication was given (include reason for use, as well as timing with meals, if applicable) and to what medication Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident 	<p>Cardiovascular compromise (AHN/CHF)</p> <ul style="list-style-type: none"> Describe when intervention was given (including therapy) Describe heart rhythm/abnormalities Describe resident's response to treatment Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident 	<p>Unstable CO2</p> <ul style="list-style-type: none"> Document respiratory status and clinical status (vital signs, pulse oximetry, etc.) Describe when intervention was given (including therapy) Describe resident's response to treatment Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident
<p>"One" OT/ST feeding</p> <ul style="list-style-type: none"> Describe when intervention was given (include reason for use, as well as timing with meals, if applicable) and to what medication Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident 	<p>Strength rehabilitation</p> <ul style="list-style-type: none"> Describe when intervention was given (include reason for use, as well as timing with meals, if applicable) and to what medication Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident 	<p>Radiation therapy</p> <ul style="list-style-type: none"> Document number of radiation doses Describe treatment site(s) Describe when intervention was given (including therapy) Describe resident's response to treatment Describe effectiveness of medication and any specific side effects observed Describe how resident tolerated such therapy (patient's vital signs, comfort, response, etc.) Describe any skilled nursing interventions provided to optimize resident

ADDITIONAL CLINICAL CONDITIONS/TREATMENTS AS WELL AS ANXIOUS CASES OF CONDITIONS/TREATMENTS ARE:

Poll #2

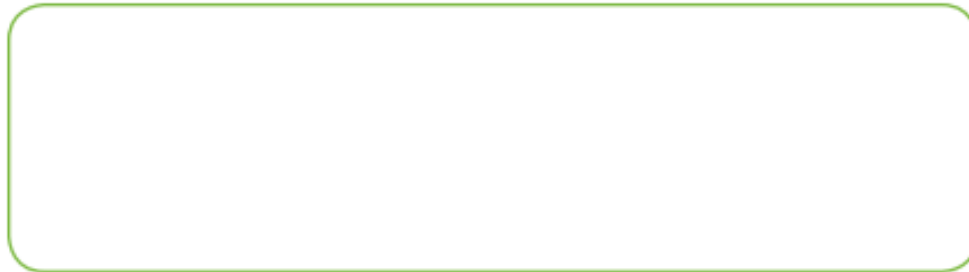


What Do I Do When, Not If, I Receive an Audit Notification?

CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
8701 Park Central Drive
Suite 400-A
Richmond, VA 23227

Important Dated Information Enclosed

Immediate Response Required
Medicare Record Request




If no addressee name is shown, forward to Medical Records Department.


Audit Request Response Plan

- Identify an ADR Coordinator
- Identify who is responsible for collecting the facility mail and what to do with any letters from CMS, MAC, UPIC, or any other entities
- Compile records for 30 days prior to ARD
- Tracking checklist with due dates and the person responsible
- Team review of each packet
- Prepare a cover letter





PREPARING FOR A MEDICARE AUDIT



ADR DOCUMENTATION PREPARATION CHECKLIST

Resident Name: _____
 Resident Identification Number: _____
 Date of Birth: _____ from: _____ thru: _____
 Service Date(s) from: _____ thru: _____

Include records for the look back period of the MDS associated with the claim period requested. This may include records outside the claim period. Records should be in chronological order. The documentation should be reviewed to ensure they are for the timeframe under review; all documents are legible, one-sided, and numbered. Keep a copy of the packet sent to the review contractor.

Person Responsible	Record Requested	Date Completed	Comments/Notes
	Copy of the claim(s): UB-04		
	Hospital Records including ED notes, history and physical, progress notes, therapy notes, consults, labs, medication administration records		
	Hospital discharge summary		
	Facility floor sheet including current contact information for beneficiary representative		
	Advanced Directives		
	MDS assessments (if requested)		
	Facility physician's history and physical		
	Physician certification/re-certification, signed and dated, including attestation, if applicable		
	Physician's order admitting resident to skilled care signed and dated		
	Facility physician's orders signed and dated		
	Physician's progress notes		
	Nurse Practitioner / Physician Assistant notes		
	Nursing admission assessment		
	Nursing progress notes		
	Medication Administration Records		
	Treatment Administration Records		
	Wound tracking records		
	Respiratory assessment and plan of care (if applicable)		
	Respiratory assessments/flow sheets (if applicable)		
	Social Service assessments and progress notes		
	Dietary assessments and progress notes		
	Recreation assessments and progress notes		
	CNA ADL documentation		
	Vital signs, height/weight records		
	MDS section GG documentation		

recommended

in advance of the deadline

include the ARD of the

s, daily contact notes

provider is responsible for third-

etry, ophthalmology,

requested to confirm signatures

Responding to Audit Requests

- Timely response is critical
- Provide all requested records
- Check the right beneficiary, right service, and right date of service
- Clear copies of both sides of the document
- Check submission requirements
- Verify that mailing address and/or fax numbers are correct



Additional Documentation Requests

- May include:
 - Hospital history and physical, transfer forms, and discharge summaries
 - Facility physician's history and physical
 - Physician's (and extenders') orders and progress notes
 - Consultant progress notes
 - Nursing assessments and progress notes
 - Rehab documentation
 - Interdisciplinary assessments and progress notes
 - MARs, TARs, flow sheets, vital sign records
 - Care plans
 - MDS to confirm signatures/credentials

What NOT to Do

- Ignore notification letters
- Fail to notify the “Chain of Command”
 - Administration
 - Corporate
 - Compliance
 - Legal
- Miss deadlines
- Send disorganized or incomplete records
- Fail to send the records in the format requested
- Send the wrong patient files
- Forget to maintain a copy of the records sent
- Fail to respond to appeal deadlines

In Summary...

- Add SALT!
- Leverage your data to identify and mitigate risk areas
- Conduct internal audits
- Use an objective third-party auditor
- Benchmark/analyze your data
- DOCUMENT, DOCUMENT, DOCUMENT
- Have an Audit Response Team



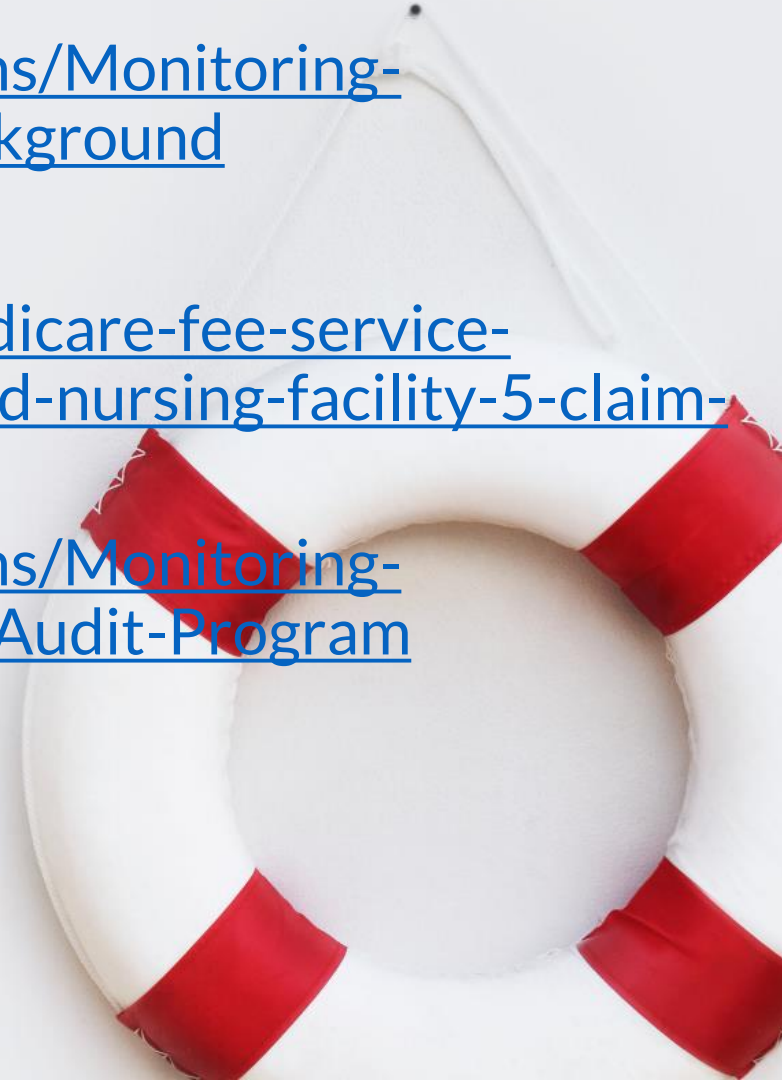
References & Resources

- <https://www.cms.gov/files/document/r12037otn.pdf>
- <https://www.cms.gov/files/document/r12015otn.pdf>
- <https://www.cms.gov/files/document/mm13164-skilled-nursing-facility-probe-and-educate-review.pdf>
- <https://www.cms.gov/files/document/2022-medicare-fee-service-supplemental-improper-payment-data.pdf>
- <https://noridiansmrc.com/>
- <https://noridiansmrc.com/current-projects/01-088/>
- <https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf>
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf>



References & Resources

- <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC>
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background>
- <https://c3hub.certrc.cms.gov/>
- <https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/medical-review-and-education/skilled-nursing-facility-5-claim-probe-and-educate-review>
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program>
- eCapIntel data: <https://ecapintel.com/home>





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INTERVENTIONAL-REIMBURSEMENT:
Outsourced MDS & HMO Authorization



SNF INDUSTRY & PROVIDER ANALYTICS



ConsulTech: Innovation @ the eXchange of Consulting & Technology



Transaction Advisory
Asset Monitoring



Compliance
Auditing



Clinical
Reimbursement



Full-Spectrum
Cost Reporting



Ancillary
Innovations

Innovative Solutions for the Post-Acute Care Industry



Regulatory
Support



Quality Innovations –
Five-Star Management



Litigation Support –
Expert Witness



Managed Care /
ISNP Rationalization



Strategy &
Analytics

ROARING

REIMBURSEMENT



ZIMMET HEALTHCARE SERVICES GROUP, LLC



AUGUST 9-10, 2023
UNCASVILLE, CONNECTICUT



CORE Analytics for SNF claims

Unlock more with Simple + CORE

- Improve reimbursement with real-time claims analytics
- Connect the power of MDS data to claims insights
- Thousands of real-time logic tests improve claims accuracy/outcomes
- Data is current to last month billed (no delay of 6-9 months)
- Most clients achieve average 8:1 return on investment or better

CORE
analytics

FINANCIAL

PT/OT

SPEECH THERAPY

NURSING

NON-THERAPY ANCILLARY

END-SPLIT

Medicare

CORE Free Group Regional Comparison

*CORE represents the average distribution of the PDPM element measured based on claims submitted to our proprietary database.



Request your **FREE DEMO** now

Questions?

simple.
a Netsmart solution



ZIMMET HEALTHCARE
SERVICES GROUP, LLC



Thanks for joining us!

[Recording and slides will be available here](#)

