FREE WEBINAR

Netsmart

Claim Reviews: A Survivor's Guide

Prepare NOW for Medicare Claim Audits

Tues, July 11 | 1:30 PM CT

Your Speaker

Alicia Cantinieri

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 th*
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Transmittal 12015 issued May 04, 2023, is being rescinded and replaced by Transmittal 12032, dated May 10, 2023, to designate the CR type as Confidential.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.

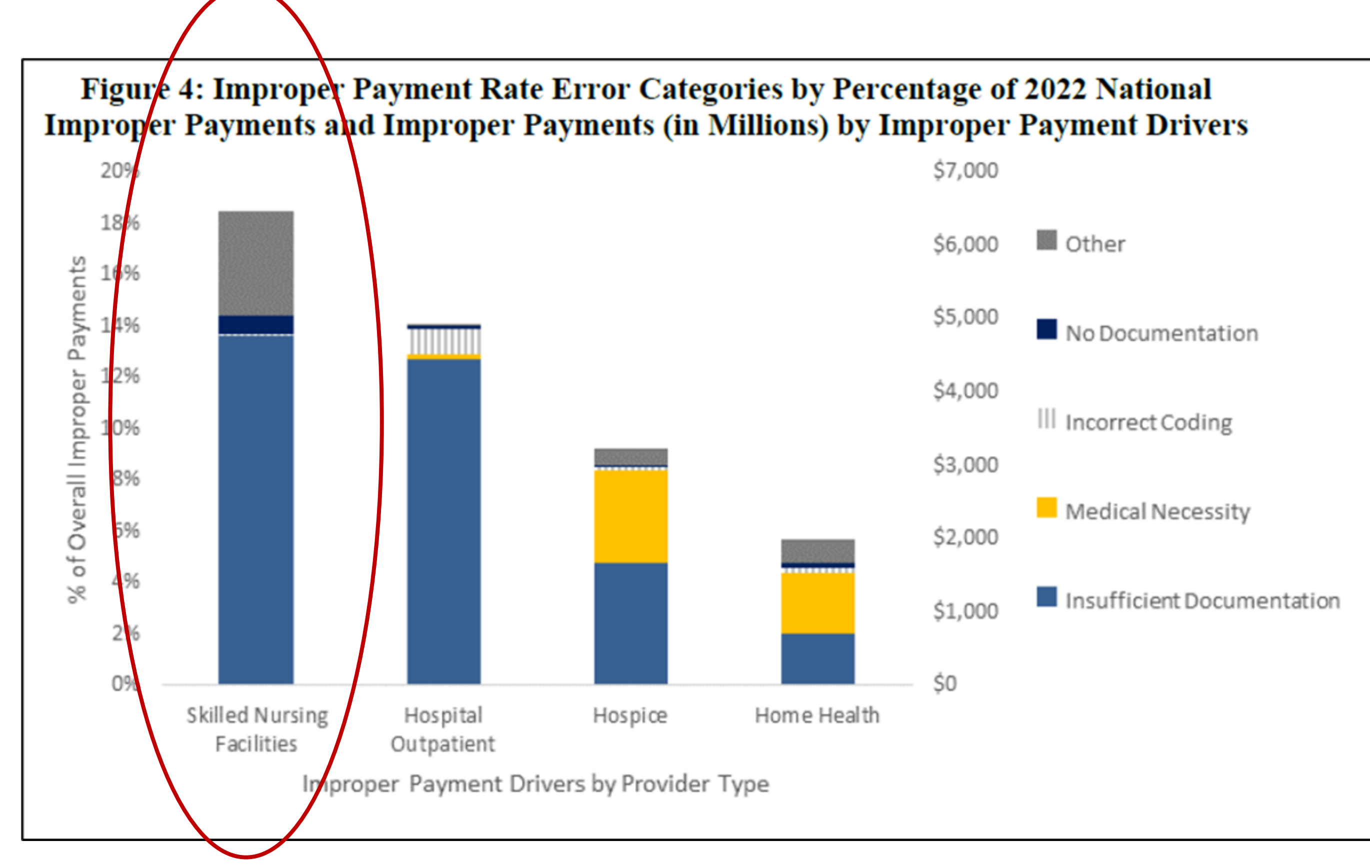
EFFECTIVE DATE: June 5, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 5, 2023

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



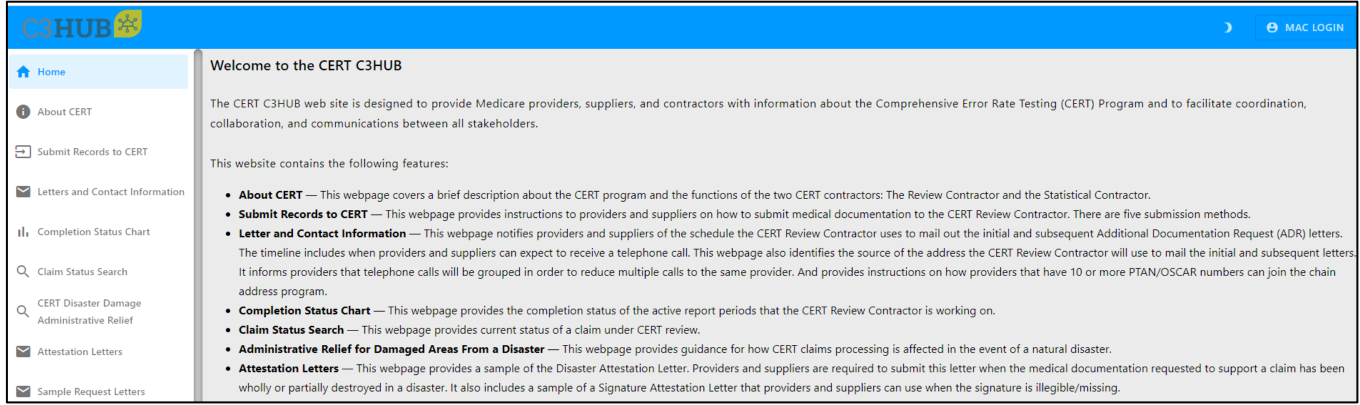
https://www.cms.gov/files/document/2022-medicare-fee-service-supplemental-improper-payment-data.pdf

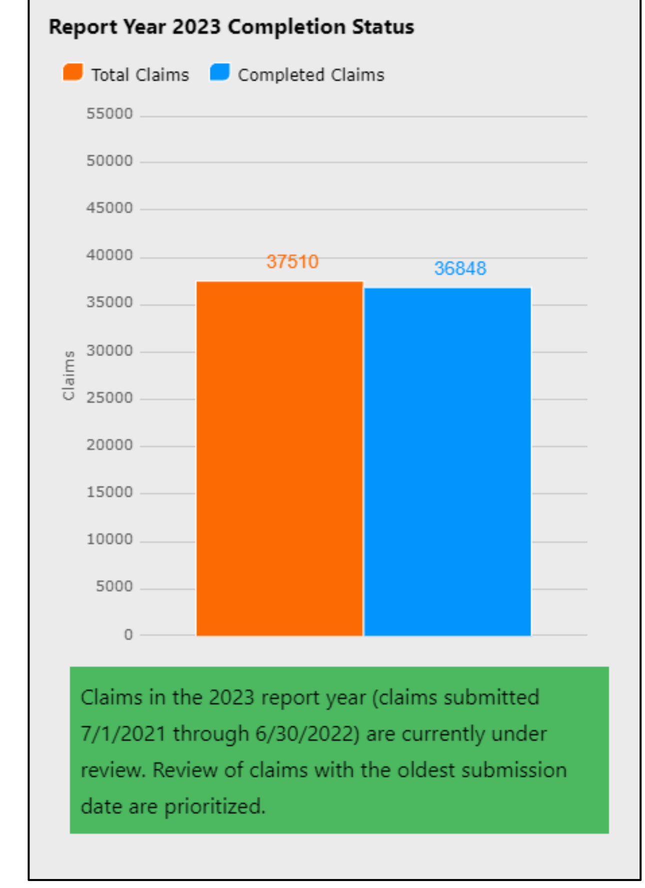
Comprehensive Error Rate Testing

- 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





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

JF Noridian
J6 NGS
JK NGS
JE Noridian
J8 WPS
JL Novitas
J5 WPS
J15 CGS
JM Palmetto
JH Novitas
JJ Palmetto
JF
JN FCSO

https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

UPIC

SMRC

RAC

CERT

MAC Pre-Pay

TPE

MAC Post-Pay
Routine Probe

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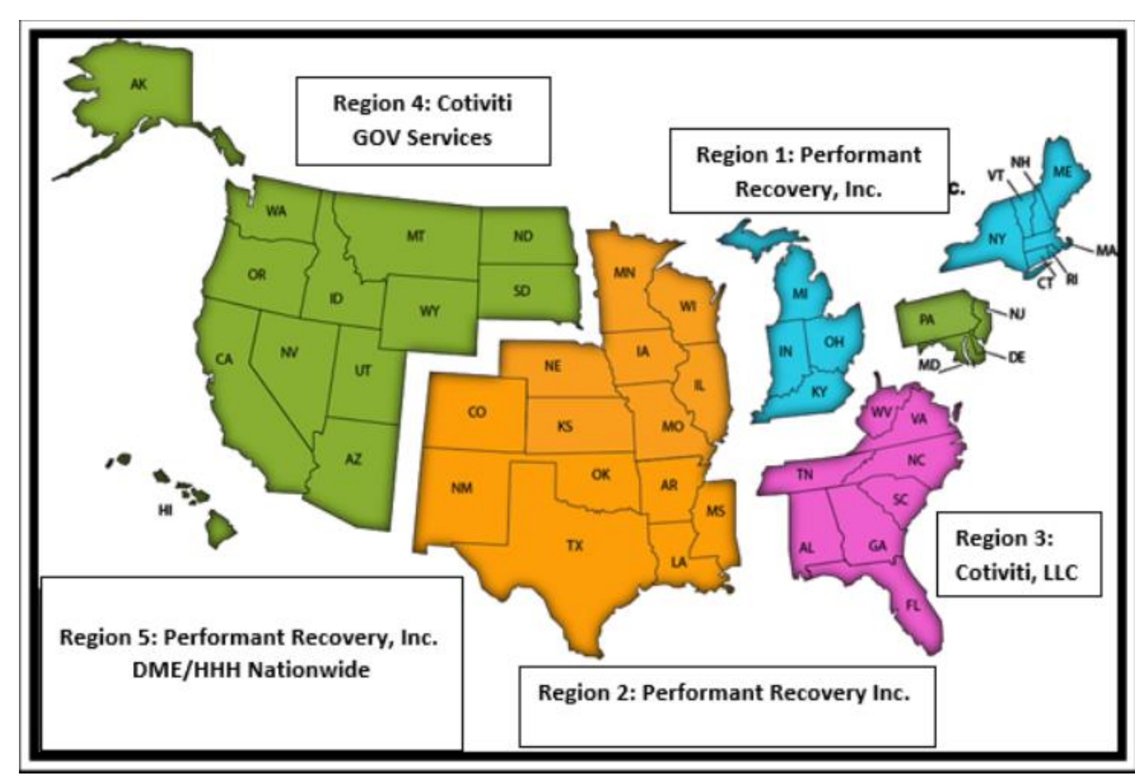
Recovery Audit Contractor (RAC)

- 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 (UPIC)

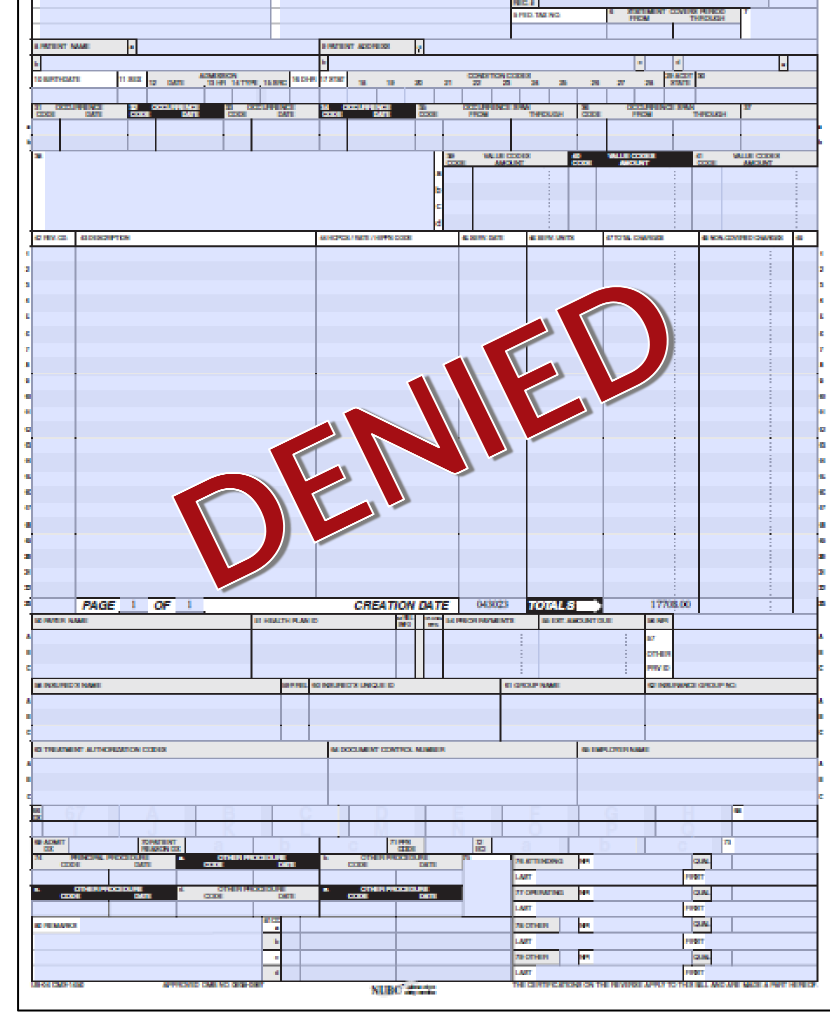
- Identifies potentially fraudulent Medicare providers
- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid – Medicare payment suspension
- Identify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

UPIC 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



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

Rank	State	Score
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

SALT SCORE 63

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

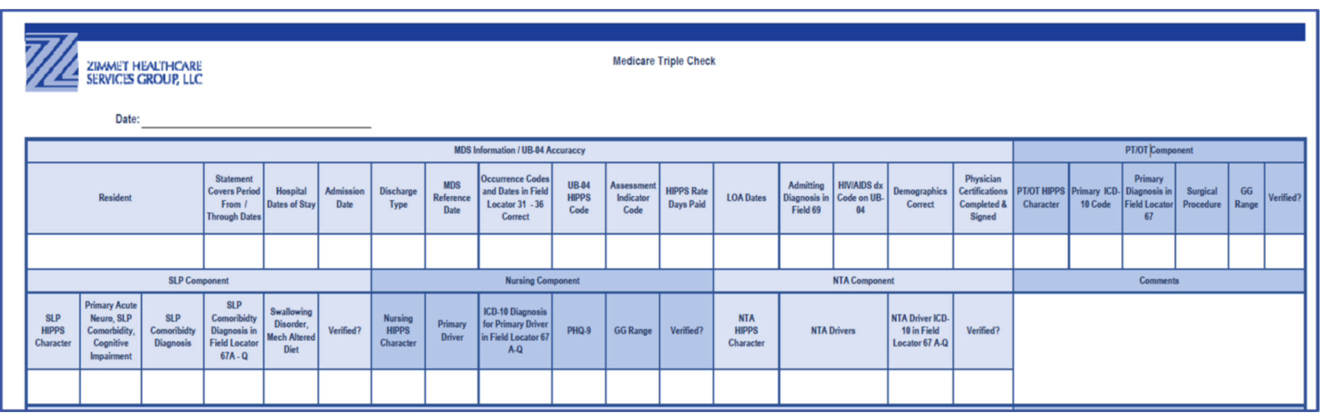
SALT SCORE 21

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



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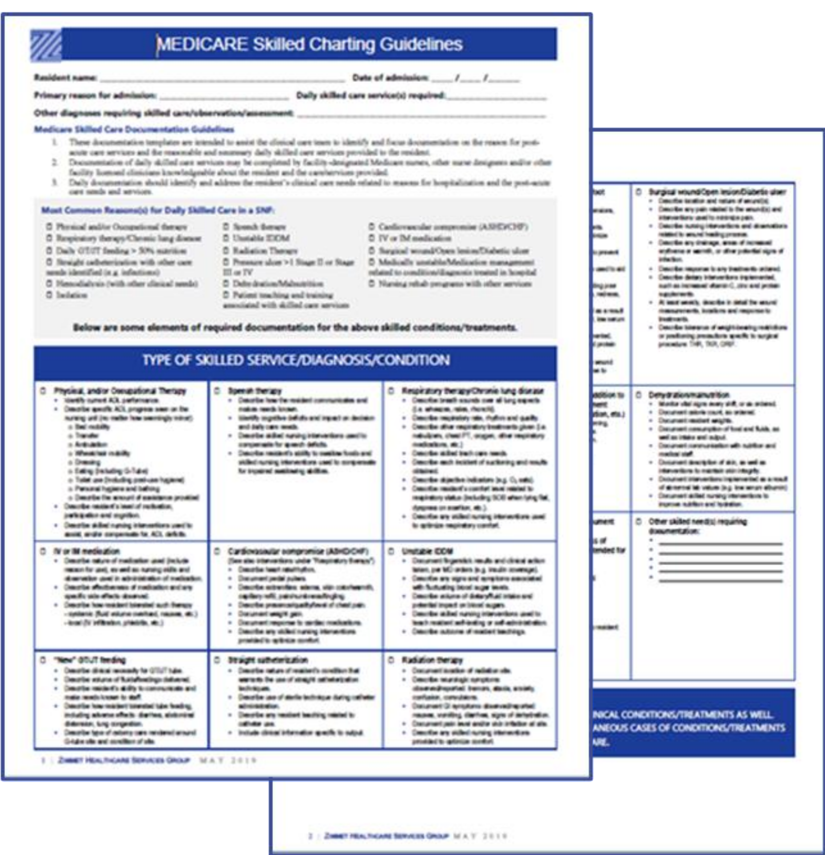
Medicare Triple Check

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 HIPPS Code	Assessment Indicator Code	HIPPS Rate Days Paid	LOA Dates	Admitting Diagnosis in Field 69	HIV/AIDS dx Code on UB-04	Demographics Correct	Physician Certifications Completed & Signed	PT/OT HIPPS Character	Primary ICD-10 Code	Primary Diagnosis in Field Locator 67	Surgical Procedure	GG Range	Verified?

SLP Component						Nursing Component						NTA Component				Comments
SLP HIPPS Character	Primary Acute Neuro, SLP Comorbidity, Cognitive Impairment	SLP Comoribidty Diagnosis	SLP Comoribidty Diagnosis in Field Locator 67A - Q	Swallowing Disorder, Mech Altered Diet	Verified?	Nursing HIPPS Character	Primary Driver	ICD-10 Diagnosis for Primary Driver in Field Locator 67 A-Q	PHQ-9	GG Range	Verified?	NTA HIPPS Character	NTA Drivers	NTA Driver ICD-10 in Field Locator 67 A-Q	Verified?	

Documentation



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

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

- Physical and/or Occupational therapy
- Respiratory therapy/Chronic lung disease
- Daily GT/JT feeding > 50% nutrition
- Straight catheterization with other care needs identified (e.g. infections)
- Hemodialysis (with other clinical needs)
- Isolation
- Speech therapy
- Unstable IDDM
- Radiation Therapy
- Pressure ulcer >1 Stage II or Stage III or IV
- Dehydration/Malnutrition
- Patient teaching and training associated with skilled care services
- Cardiovascular compromise (ASHD/CHF)
- IV or IM medication
- Surgical wound/Open lesion/Diabetic ulcer
- Medically unstable/Medication management related to condition/diagnosis treated in hospital
- Nursing rehab programs with other services

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

TYPE OF SKILLED SERVICE/DIAGNOSIS/CONDITION

- 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

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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

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PREPARING FOR A MEDICARE AUDIT

recommended

n advance of the deadline

clude the ARD of the

s, daily contact notes

ovider is responsible for third-

etry, ophthalmology,

uested to confirm signatures

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ADR DOCUMENTATION PREPARATION CHECKLIST

Resident Name: ______
Resident Idenitifcation Number: ______
Date of Birth ______
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 face sheet including current contact information for beneficiary representative		
	Advanced Directives		
	MDS assessments (if requested)		
	Facility physician's historyand physical		
	Physician certification/recertification, 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		

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/
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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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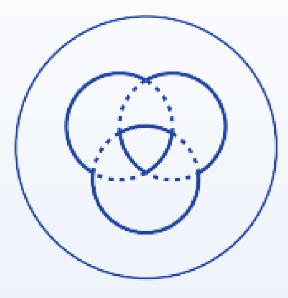
www.zhealthcare.com info@zhealthcare.com

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

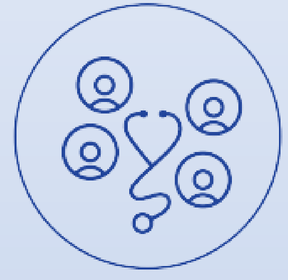
Ancillary
Innovations

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

REIMBURSEMENT

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

Request your FREE DEMO now

Questions?

Thanks for joining us!

Recording and slides will be available here