Managing Medicare Compliance

ZIMMET HEALTHCARE
SERVICES GROUP, LLC

Reimbursement, Compliance & Planning Solutions for Post-Acute Care

Agenda

- Medicare program & SNF update
- Different auditors and strategies
- ZHSG audits
- Common audit findings
  - MD certifications
  - Denial notices
  - COTOs
  - UB-04s
  - Medicare Advantage

Your New Health Care System

President

Homeland Security Department

Social Security Administration

Office of Personnel Management

PCORI

Justice Department

Interagency Working Group on Health Care Quality

Labor Department

IPAB

Medicare Part A Trust Fund

Medicare Part B Trust Fund

CLASS Independence Fund

CLASS Program

CLASS Independence Benefit Plan

CDC

NIH

Public Health Service

Secretary
Health & Human Services

Treasury Department

IRS

Congress

GAO

Elder Justice Coordinating Council

AHRQ

US Preventive Services Task Force

HHS Inspector General

Essential Health Benefits Package

States

NAIC

Health Care Choice Competition

Employer Health Flex

UI Discrimination

Health Insurance CO-OP

CO-OP Advisory Board

Government Health Benefit Exchanges

Insurance Mandates

Employer Mandate

Individual Mandate for Health

CMS

CMS Actuary

Federal Coordinated Health Care Office

Medicaid/ CHIP

State Medicaid Agencies

Health Industry

Medicare

Health Insurance Companies

Employers

Individuals

Physicians

Patients

New Government

- Rationing Potential
- Involvement in Health Insurance Market
- Other Expansions
- Represents Bundles of Additional Entities
- Mandates
- Taxes & Monetary Fees/ Penalties/Cuts
- Trust Fund (Rationing Potential)
- Other New Trust Funds/ Monetary Benefits

Expanded Government

- Government with Expanded Authority/ Responsibility
- Government Financial Entity with New Inflows/ Outflows
- State/Territory with Expanded Authority/ Responsibility

Private

- Private Entity with New Mandates/ Regulations/ Responsibilities
- Unchanged Private Entity
- Special Interest Provisions

New Relationships

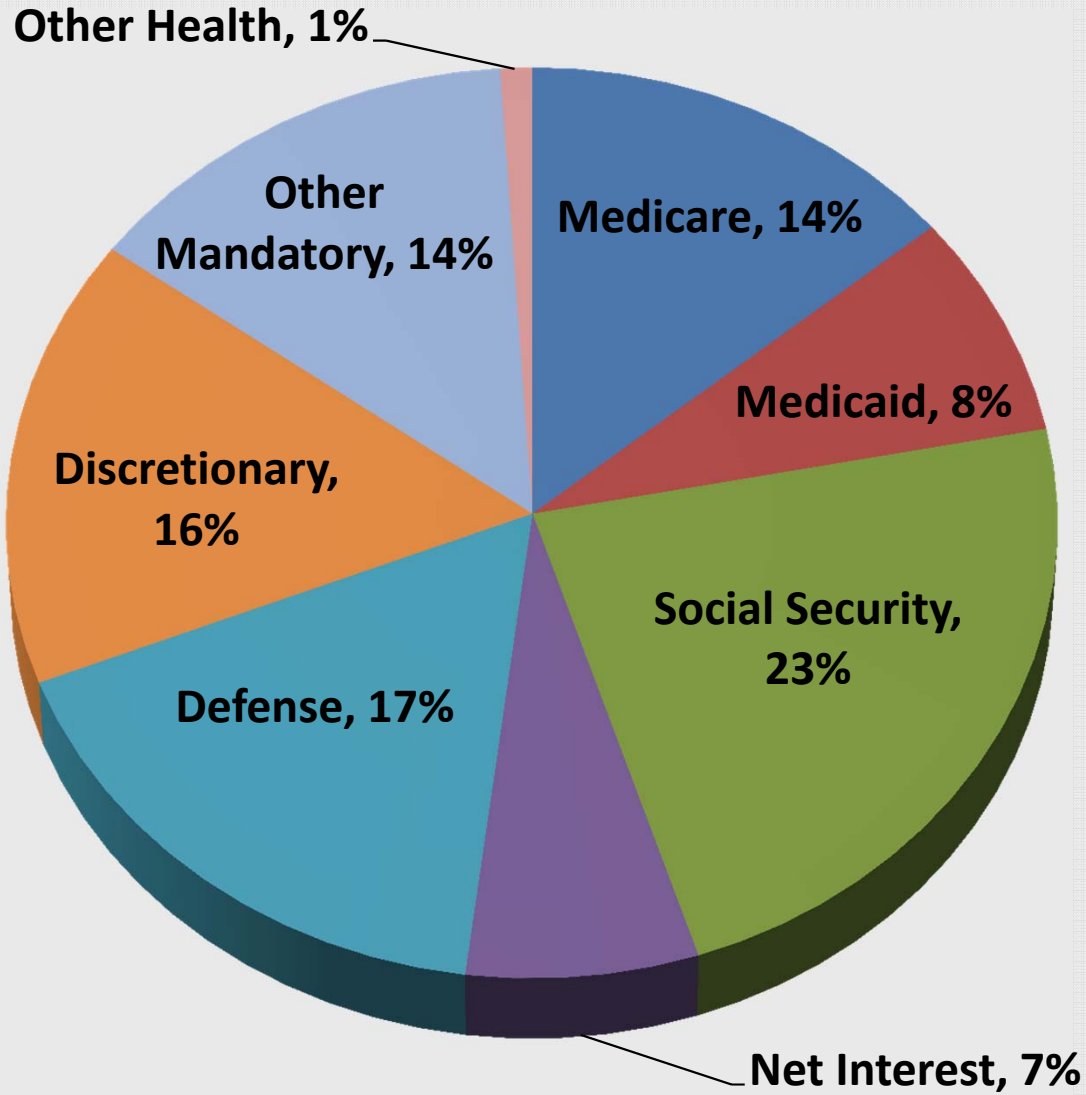
- Regulations/ Requirements/Mandates
- Reporting Requirements
- Oversight
- Money Flows
- Consultation/Advisory/ Info Sharing
- Structural Connections (Includes Existing)

ACO: Accountable Care Organization
AHRQ: Agency for Healthcare Research and Quality
CDC: Centers for Disease Control & Prevention
CHIP: Children's Health Insurance Program
CLASS: Community Living Assistance Services & Supports
CMS: Centers for Medicare & Medicaid Services
CO-OP: Consumer Operated & Oriented Program
DFE: Fee-for-Service
FMS: Flexible Spending Arrangement
GAO: Government Accountability Office
HCERA: Health Care & Education Reconciliation Act
HHS: Health & Human Services Department
HRA: Health Savings Account
IPAB: Independent Payment Advisory Board
IRS: Internal Revenue Service
MA-PD: Medicare Advantage Prescription Drug
MMPAC: Medicare Payment Advisory Commission
MSAC: Medical Care Risk Corridors
SHCOBE: Exercise Auditors located Office Regional Systems
MCRA: Multiple Employer Welfare Arrangement
NAIC: National Association of Insurance Commissioners
NIH: National Institutes of Health
PCORI: Patient-Centered Outcomes Research Institute
PHS: Prospective Payment System

Patient Protection & Affordable Care Act, P.L. 111-148; Health Care & Education Reconciliation Act, P.L. 111-152

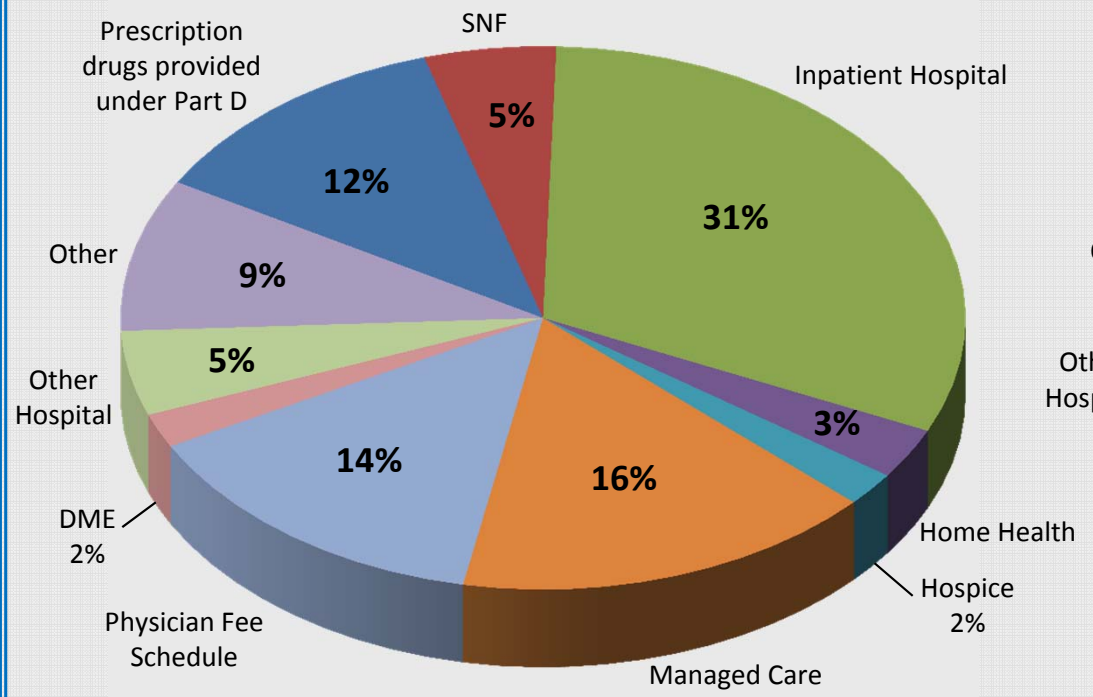
Prepared by: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Senior House Republican
Senator Sam Brownback, Ranking Member

Federal Spending Breakdown (2014)

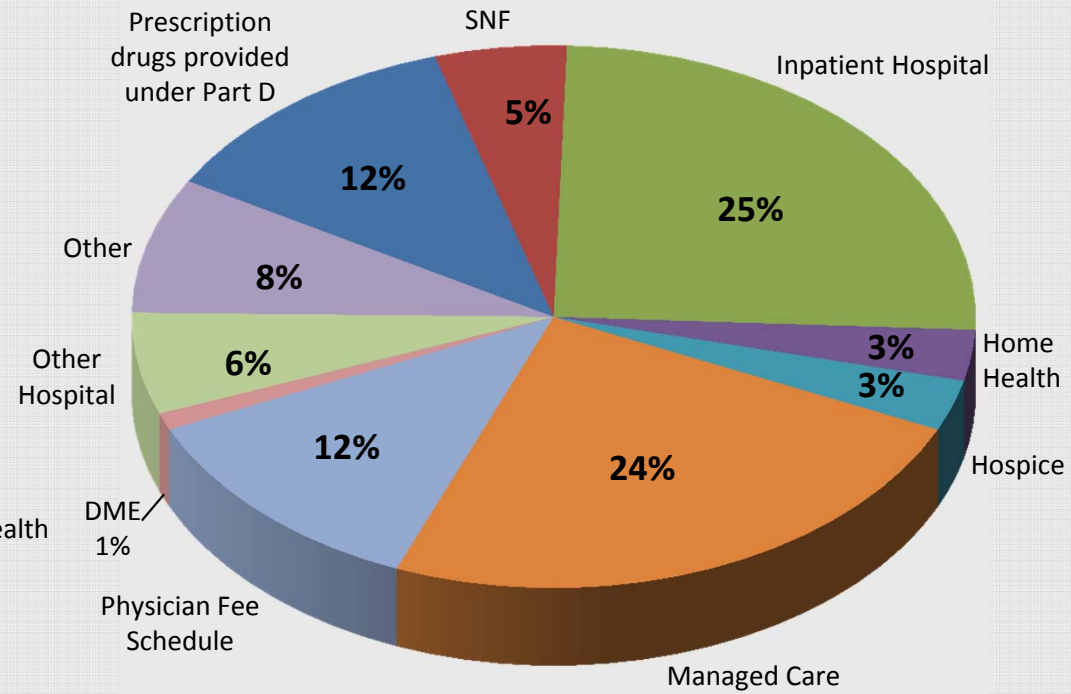


Medicare Spending Concentration

Total Spending 2006 = $401 Billion

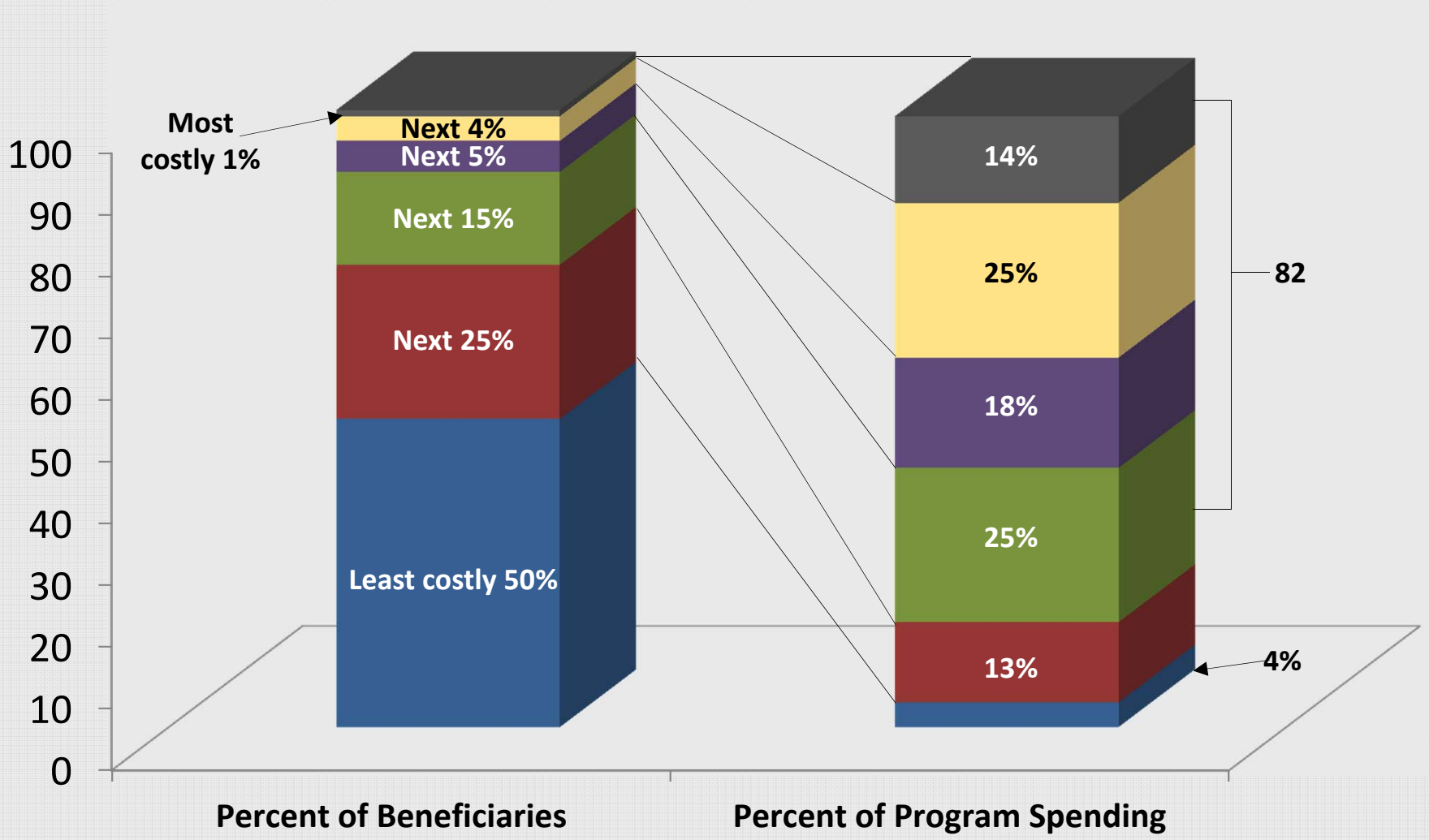


Total Spending 2012 = $562 Billion



Source: MedPac

2010 FFS Program Spending

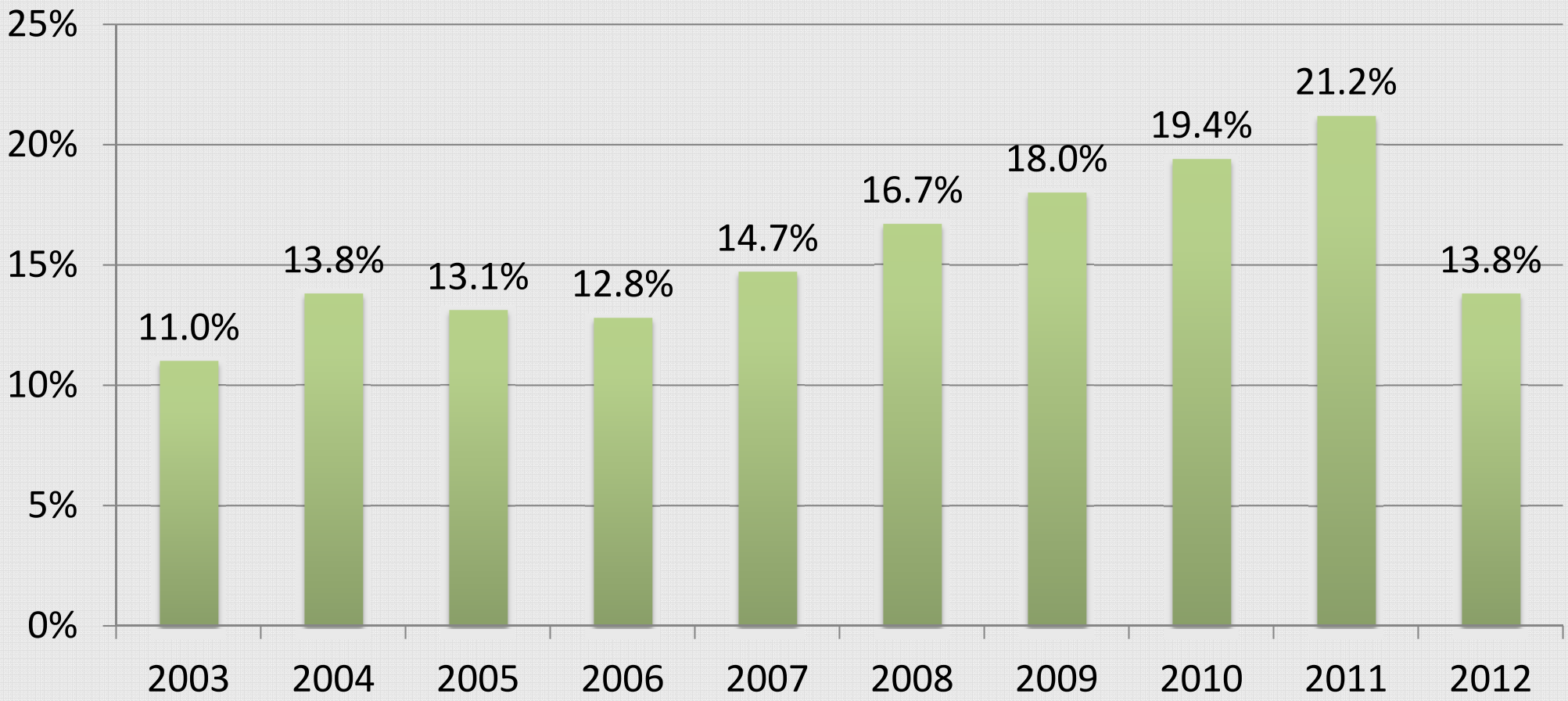


Source: MedPac

Transaction Activity

- LTC was only healthcare sector to experience increase in transaction activity (up 20% from 2012)
- Healthcare reform has initiated a shift from nursing homes to at-home managed care and community care
- ACA encourages care coordination and population health management
- Operators have changed their business model
- Increase in mergers and acquisitions to broaden the scope of services offered and reduce costs

SNF Medicare Margins Remain High



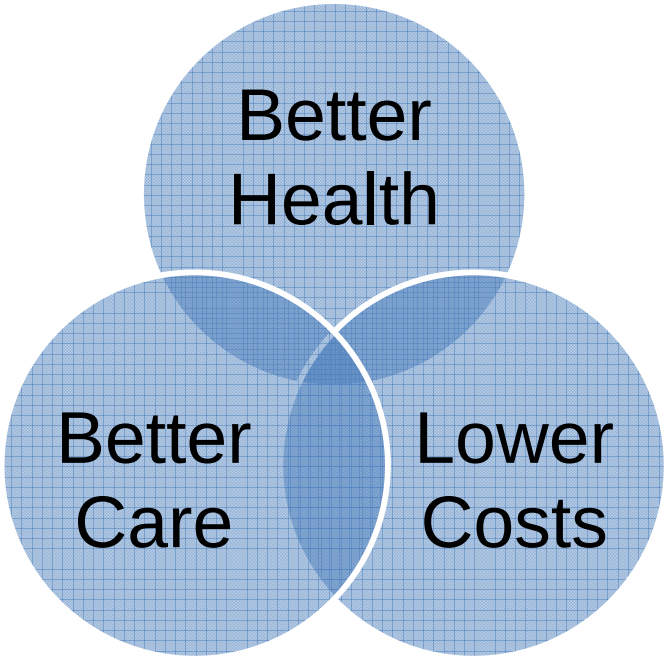
Above is for Freestanding SNFs

For profit 2012 margin = 16.1%; NFP = 5.4%

CMS Action Plan

Using Penalties to Improve Quality and Reduce Costs

- Improve the individual experience of care
- Improve the health of populations
- Reduce the per capita cost of care for populations

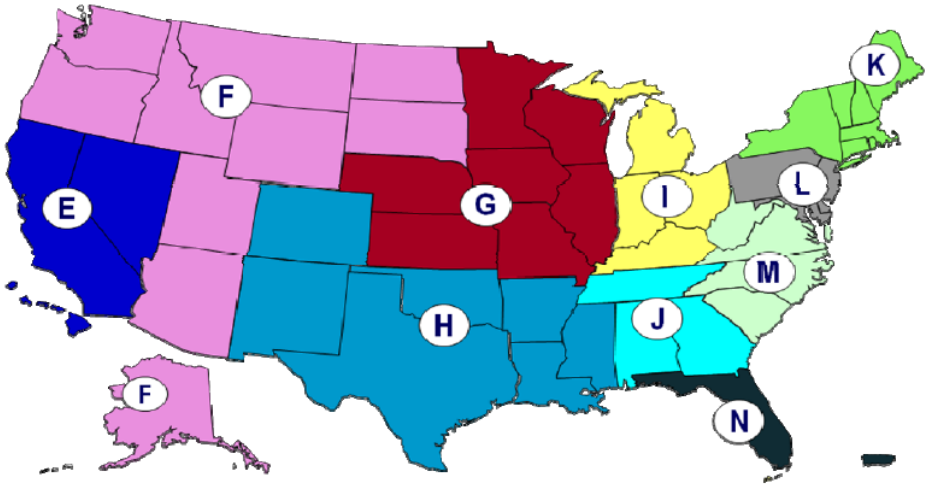


Meet Your Auditors

- MAC
- CERT
- OIG
- ZPIC
- RA (RAC)

Medicare Administrative Contractor (MAC)

- FKA "FI"
- **Most likely to use data analysis**
- Targets top performers
- NJ is in Jurisdiction L (Novitas Solutions) w/ DE, PA, MD, and DC



Comprehensive Error Rate Testing (CERT)

- Medical review to check the accuracy of payment by the MAC
- Claim is independently reviewed and can be denied
- Denials cannot be deemed “fraud” by the CERT
- Produces an error rate
- Lawmakers have urged CMS to use information from the CERT to provide guidance for different auditors (to reduce duplicative investigations)

Office of Inspector General (OIG)

- General oversight specific to trends
- Report to Congress

Zone Program Integrity Contractor (ZPIC)

- Fraud and abuse arm of Medicare program
- Not a simple medical review to validate coverage and payment
- Looking for reasons to deny claims and pursue fraud allegations
- Recent increase in onsite audit visits
- Least likely to use data analysis to target claims
- **ZPICs have prior knowledge of the Facility and billing practices prior to arriving**
- **Error rates can be extrapolated to the entire billing universe**

ZPIC

- Finding reasons to deny claims based on technical and clinical reasons (both pre- and post-pay)
  - Incomplete or incorrectly signed and dated certifications, orders, plans of care
  - Missing treatment records, progress notes
  - Inadequate PLOF on rehab documentation
  - Medically unnecessary services or level of service

Recovery Auditors (RAs)

- ALJ backlog (500,000 claims as of September 2014)
- Current suspension aside from the **Part B therapy caps (pre-payment review)** and **automated system denials** pending new auditor contracts
- New RAs were supposed to be announced this October, but…

Data Analysis to Target Claims

Based on anecdotal data from our experiences with clients

- RUA RUGs –are (“R”) you (“U”) a (“A”) target?)
- RU “anything” over 60 days
- Therapy revenue codes w/ an illogical number of therapy units billed
- 3-day (only) QHS followed by “RV” or “RU” RUG group

Data Analysis to Target Claims

- Illogical start of care dates (occurrence code "11") in relationship to the month billed
- Psych or depression codes on claims w/ Rehab RUGs
- ST utilization w/ no aphasia or dysphagia diagnosis codes
- Lower-18 RUG groups
- Claims w/ 042 diagnosis

Data Analysis to Target Claims

Use your PEPPER

- High Rehab RUG capture compared to peers
- High overall reimbursement compared to peers
- High ALOS
- **Obvious change in billing patterns**

In the News

- OIG investigation of the 2011 claims from an Illinois PT resulted in a denial of 99 claims out of 100 examined
  - $634,837 in inappropriate payments
  - Documentation failures (plans of care, treatment notes, progress notes, medical necessity, MD certifications)
  - **No compliance plan that included appropriate reimbursement auditing**

In the News

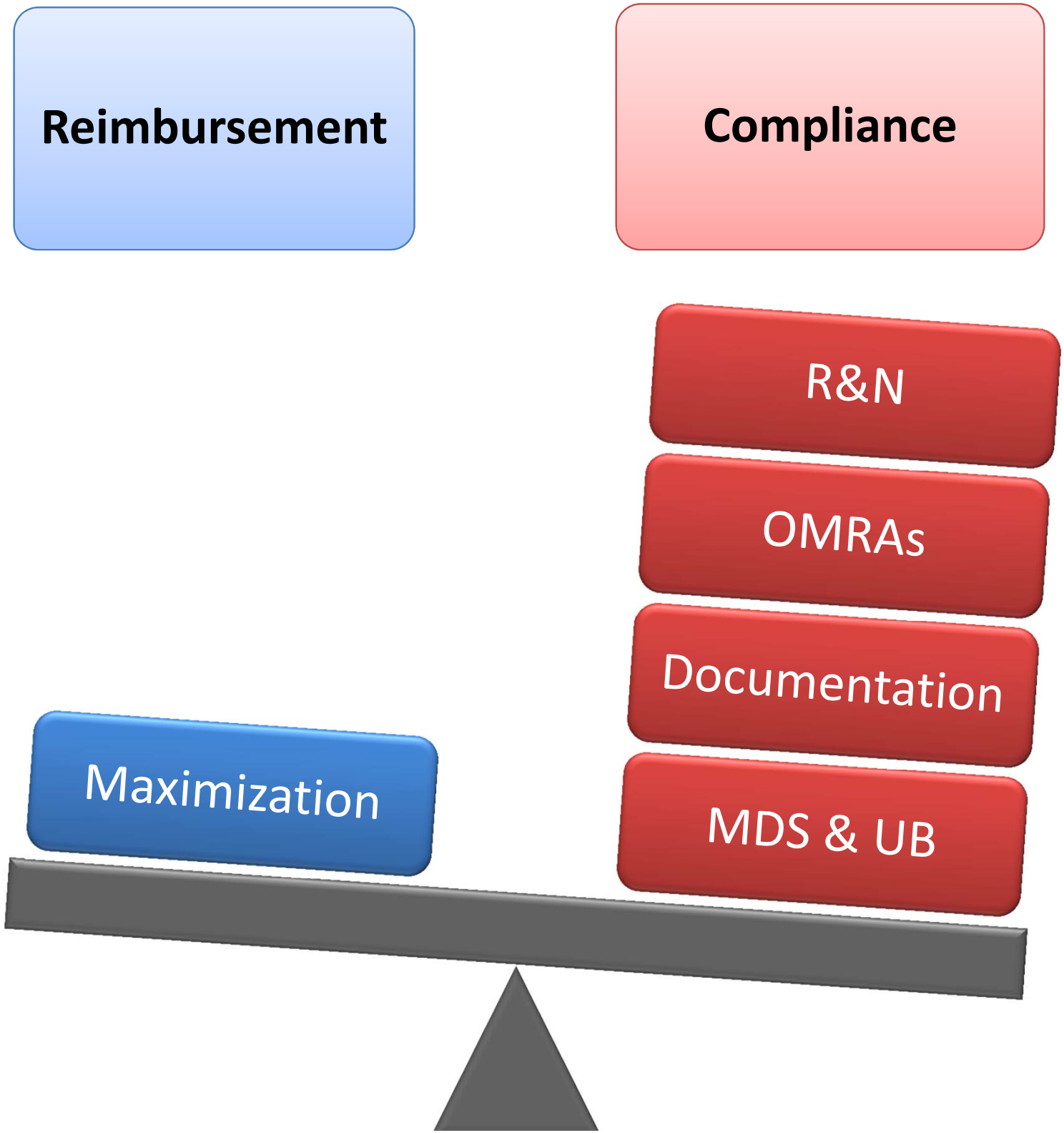
- DOJ investigations found that 2 SNF management companies failed to prevent its contracted therapy company from providing unnecessary therapy in order to increase its reimbursement
  - Billing RU at high levels
  - $3.75 million and $1.3 million settlements
  - Targeted levels regardless of clinical need
  - Rounding treatment minutes (as opposed to exact reporting)
  - SNF is responsible for oversight of its therapy dept.

In the News

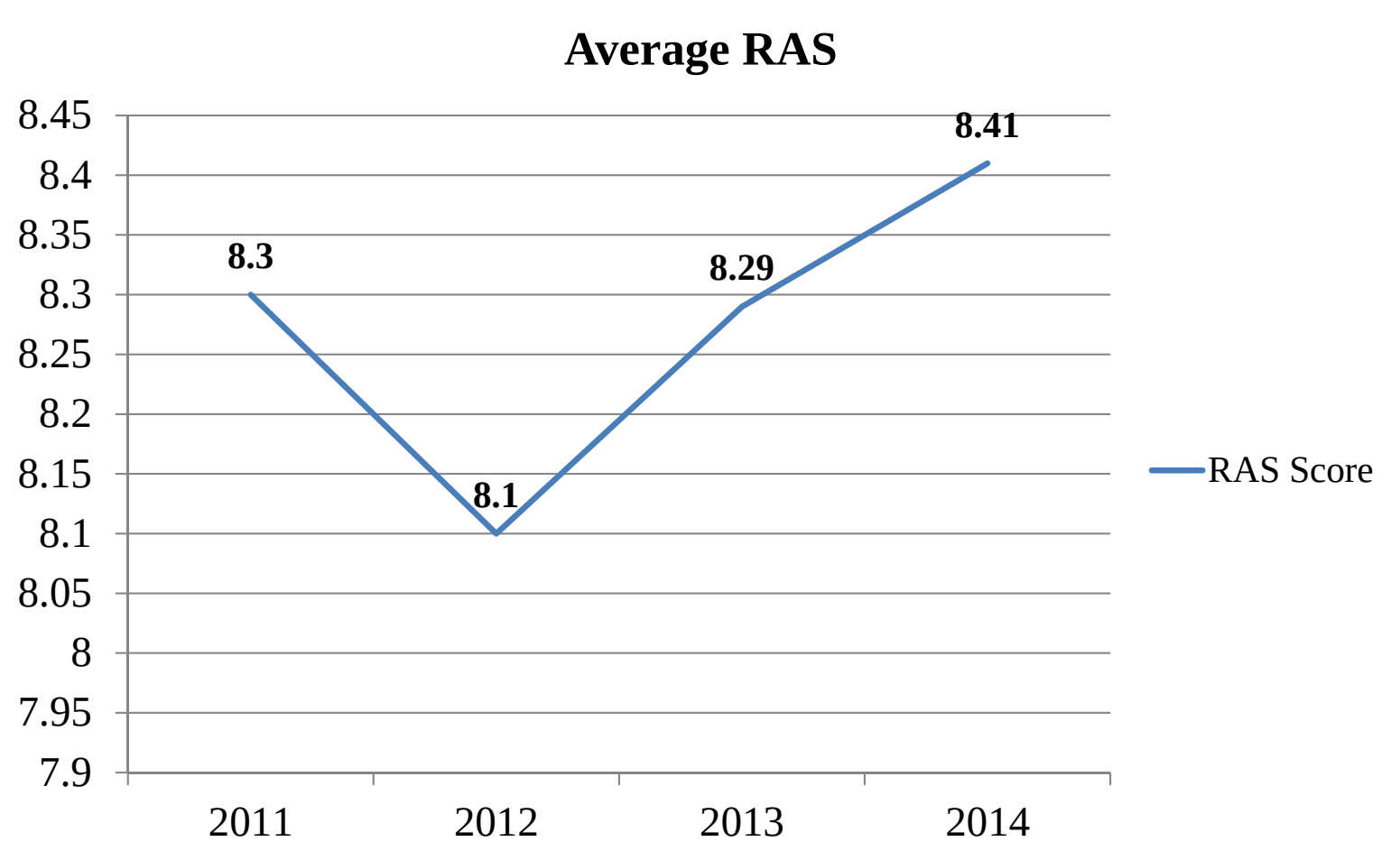
- Extendicare agrees to $38 million settlement
- 33 SNFs in 8 states
- **Whistleblower**
- Unnecessary rehab services during ARD periods
- 5-year corporate integrity agreement

ZHSG Audits

- ZHSG conducts > 400 “formal” reimbursement compliance audits per year
  - Targeted or Randomly selected (OIG RAT-STATS)
  - General or focused reviews
  - Audit components include UB-04, MDS, all supporting documentation
  - Technical requirements, MDS capture, billing administration, medical necessity


Reimbursement
Compliance
R&N
OMRAs
Documentation
MDS & UB
Maximization

Average Risk Assessment Scores



Frequent Findings

- MD certification issues
- Non-compliant cut letter issuance
- Missed COT OMRAs
- UB-04 inaccuracies
- Fragmented MA process

Physician Certifications

- MD certification required for skilled services
- Facility determines the method by which the certifications are obtained
- No required/standard form
- Certification statements may be entered on forms, notes, or other records that a MD normally signs in caring for a patient (e.g., evaluation)

Physician Certifications: Audit Focus

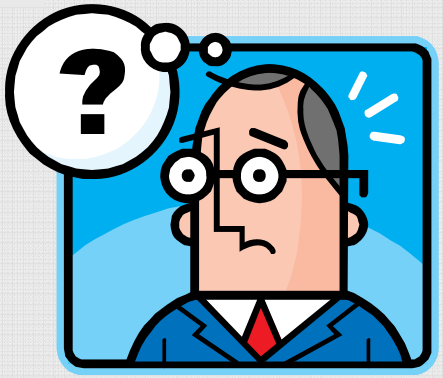
- Area of focus for ZPICs (technical denial)
- The CERT has reported improper payment rate increased from 4.8% in 2012 to 7.7% in 2013 with failure to obtain MD certifications as a major source of improper payments
- Increased audit focus going forward

Physician Certifications

Initial Certification	"Reasonable and practicable"
1st Recertification	Within 14 days from Medicare start date
2nd Recertification	Within 30 days from prior recertification
3rd Recertification	Within 30 days from prior recertification
4th Recertification	Within 30 days from prior recertification

Initial Certification

"at the time of admission, or as soon thereafter as is reasonable and practicable"



Common Errors

- 1st recertification dated day-15
- Pre-dating
- Signature and date of the signature completed by different individuals
- Incorrect instructions on the certification form
- Failure to complete anticipated length of stay and discharge plan on Briggs form (NGS is denying claims based on this)
- Insufficient reasons for skilled care

Reasons for Skilled Care

- Often insufficient (e.g., “restorative rehab,” “PT/OT”)
- Should include the medical condition that warrants the skilled care treatment (e.g., “restorative rehab for debility due to pneumonia”)

2 Common Denial Notices

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

SKILLED NURSING FACILITY'S NAME & ADDRESS
TELEPHONE NO. AND TTYTDD NO.

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice:_____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance you may have. Your other insurance is:_____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at: Address:_____

Generic Notice
CMS 10123

SNF ABN
CMS 10055

Generic Notice

- Discharges home when benefit days remain
- Medicare Part A discharge, benefit days remain, and the resident remains in the Facility under a different payor source
- Part B therapy discharges

SNF ABN letter

- Upon admission, when clinical (skilled need) and/or technical (3-night QHS) requirements are not met for Med A
- Medicare Part A discharge, benefit days remain, and the resident remains in the Facility under a different payor source
- Benefits exhaust

Issuance

- Unless coverage ends abruptly, 48 hours before discharge
- Burden rests on the provider to demonstrate reasonable effort has been made to deliver the notice
- Note refusals to sign

If You Don't Issue…

- Facility could be held financially liable for any days that residents remain in the Facility following the coverage end date through day-100
- Citation during state survey

QIO

- Generic Notice appeals go to the QIO
- Went from 53 to 2 QIOs on August 1, 2014
- Backlog
- Our QIO is Livanta – update your Generic Notice to include that information

Change of Therapy OMRA

- 7-day rolling window beginning on day following ARD if therapy level changes
  - e.g.: ARD day 14, COTO review period is days 15 – 21
  - SNFs must continue to review Tx minutes every 7 days ***AFTER LAST ARD***
  - If level differs from RUG level of most recent MDS, COTO is required and payment is adjusted from 1st day of COTO observation period (up or down)
- Default rate applied for late COTO, ***PROVIDER LIABILITY*** if "missed"
- Residents in rehab RUGs ***MUST*** have 5 individual days of therapy per week or RUG will be lost

COTOs

National average is 11%...

- >11%
  - Suggestive of poorly managed rehab scheduling
  - Off-cycle COTOs add to the assessment burden

- <11%
  - Are COTOs being missed?

The COTO "loophole"

COTO is ***NOT*** required (but is allowed) if Day 7 of the observation period is also the day of SNF discharge or if ARD of a scheduled PPS assessment is set on or before Day 7 of the COT observation period

Event	DAY	RTM	Total	ARD = 13	14+COTO
ARD	1	30		RVB	RVB
	2	90		RVB	RVB
	3	90		RVB	RVB
	4	90		RVB	RVB
	5	60		RVB	RVB
	6	90		RVB	RVB
5-day	7	90	540	RVB	RVB
	8	120		RVB	RUB
	9	120		RVB	RUB
	10	30		RVB	RUB
	11	120		RVB	RUB
	12	120		RVB	RUB
14-day	13	120		RVB	RUB
14-day+COTO	14	90	720	RVB	RUB

COTO Observation Period

Total Reimbursement Impact (Bergen County) = $1,278

	Event	DAY	RTM	Total	14-Day	14+COTO
	ARD	1	30		RUB	RUB
		2	120		RUB	RUB
		3	120		RUB	RUB
		4	120		RUB	RUB
		5	120		RUB	RUB
		6	120		RUB	RUB
	5-day	7	120	750	RUB	RUB
		8	120		RUB	RVB
		9	0		RUB	RVB
COTO Observation Period		10	90		RUB	RVB
		11	90		RUB	RVB
		12	90		RUB	RVB
		13	30		RUB	RVB
COTO Unnecessary	14-day+COTO	14	90	510	RUB	RVB

Total Reimbursement Impact (Bergen County) = $1,278

May 2, 2013 SNF ODF

- Effective 5/19/13, a modification (as opposed to an inactivation) will be permitted to change the reason for assessment in MDS Section A0310C
- Modifications must be made within 14 days from identification of the error
- ARD modifications may also be made to correct clerical errors (cannot change look-back)

May 2, 2013 SNF ODF Implications

- Combine COTOs with regular PPS assessments when therapy levels increase
- Start of Therapy OMRAs/Short-Stay assessments

Item Set Code Must Remain the Same

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	ISC	Description
01	01,02,06,99	0	10,11,99	NC	Comprehensive
01	01,02,06,07	1,2,3	10,11,99	NC	Comprehensive
01	02,07	4	10,11,99	NC	Comprehensive
03	01 thru 06,99	0	10,11,99	NC	Comprehensive
03,04,05	01 thru 07	1,2,3	10,11,99	NC	Comprehensive
03,04,05	02 thru 05,07	4	10,11,99	NC	Comprehensive
04,05	01 thru 07,99	0	10,11,99	NC	Comprehensive
02,06	01 thru 06,99	0	10,11,99	NQ	Quarterly
02,06	01 thru 07	1,2,3	10,11,99	NQ	Quarterly
02,06	02 thru 05,07	4	10,11,99	NQ	Quarterly
99	01 thru 06	0,1,2,3	10,11,99	NP	PPS
99	02 thru 05	4	10,11,99	NP	PPS
99	07	1	99	NS	SOT OMRA
99	07	1	10,11	NSD	SOT OMRA and Discharge
99	07	2,3,4	99	NO	EOT, EOT-R or COT OMRA
99	07	2,3,4	10,11	NOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	10.11	ND	Discharge
99	99	0	01,12	NT	Tracking

The EOT Trap

- When the EOT OMRA is always set on Day 3 after therapy ends, one of every seven occurrences will likely result in missed COTO
  - When EOT ARD is the last day of a COTO observation period, EOT obviates need for COTO (more $)
  - When Day 3 falls on the day after the last day of a COTO observation person, the COTO has been missed
- ARDs should never be based on “standing” policy
- Communication between nursing & therapy

COTO Observation Period

1	2	3	4	5	6	7	8	9
Tx	Tx	Tx	Tx	Tx		EOTO		
RVB	RVB	RVB	RVB	RVB	Non-R	Non-R	Non-R	Non-R

EOTO referenced on day 7 of COTO observation period obviated need for COTO

1	2	3	4	5	6	7	8	9
Tx	Tx	Tx	Tx	Tx			EOTO	
PROVIDER LIABLE					Non-R	Non-R	Non-R	Non-R

EOTO requirement does NOT eliminate the need for the COTO

Common Error

- Therapy utilization miscoded (e.g., E-Stim Unattended minutes are counted) on prior MDS, resulting in a RUG score change
- Facility thinks they are providing treatment at the correct RUG level the next 7 days
- In actuality, COTO is missed
- Why is this important?

Missed COTOs

Resident still on Medicare Part A

- Set an ARD w/ the current date to get default instead of provider liability
- If multiple COTOs missed – complete different COTOs using today's date
- Constant monitoring of COTO periods

Missed COTOs

If resident is no longer on Medicare Part A

- Provider liability applies
- Cannot bill the beneficiary for denied services NOR can they bill the supplemental insurer or the next insurer (e.g., Medicaid)

How to Bill Missed COTOs

- MDS correction not permitted; must be adjusted via the UB-04
- Occurrence code “77” w/ the corresponding dates of the missed COTO should be indicated in Field 35 of the UB-04

Final Rule FY 2015

- Rule prior to October 1, 2014: COTOs are not permitted to establish Rehab RUGs (exclusive of the “maximizer” rule)
- As per final rule (effective 10/1/14): COTOs may be completed to capture a Rehab RUG when the prior MDS captures a non-rehab RUG (resident did not qualify for a Rehab RUG, e.g., 4 days/120 mins) under “limited circumstances”

“Limited Circumstances”

- The resident must have qualified for a RUG-IV therapy group on a prior MDS during their current Med A stay
- Therapy did not end from day-1 of the 1st COTO observation period (that classified the resident in the non therapy RUG group) until the ARD of the COTO (that reclassified the resident into the therapy RUG group)

Example

- Day-30: RUB30
- Day-37: 4 days/115 minutes of rehab provided (complete COTO)
- Day-44: Rehab goes back up to RU
- COTO is allowed to be completed on day-44

External Audit Activity (UB-04)

- Insufficient primary codes
  - Therapy claims w/ psych/depression diagnoses
  - Where is the disconnect coming from – clinical or billing?
  - Clinical staff has the responsibility to validate clinical documentation and the MDS
  - Billing staff has the responsibility to match the MDS to the claim that is submitted to Medicare
- ST claims with no diagnosis to support treatment (absence of aphasia/dysphagia codes)
- Claims w/ AIDS diagnosis

Outcomes Data

- What do your claims say about you?
- How does your data compare to benchmarks (RUG levels, ADLs, LOS, types of assessments, discharge destinations)?
- **ACOs, Managed Care, and Bundling will expect data**
- Accurate UB-04s will deliver the data – the problem is that there are so many inaccuracies (incorrect primary, outdated codes) that data generation activities are inaccurate

AIDS Diagnosis

- Diagnosis code 042
- 128% per diem adjusted payment rate
- Must be on the claim to receive adjusted rate
- MD must document the AIDS diagnosis every 60 days to support coding
- HIV+ does <u>not</u> count

ICD-10

Delayed!!!

ICD-9 vs. ICD-10

ICD-9	ICD-10
3-5 characters	3-7 characters
Approx. 13,000 codes	Approx. 68,000 codes
1st digit alpha or numeric; digits 2-5 numeric	1st digit alpha; digits 2 and 3 numeric; digits 4-7 alpha or numeric

Prepping for ICD-10

- Develop an implementation strategy
- Communicate with your billing service – ask about their compliance plan
- Providers who perform billing in-house should rely on pertinent team members to coordinate ICD-10 transition efforts (medical coding, clinical, IT, and finance staff)

ZHSG Audit Findings (UB-04)

- Inappropriate primary dx codes
- Codes omitted based on MDS assessments and clinical documentation
- Duplicated codes
- Rehab “V57.XX” codes as secondary
- Outdated codes
- Incorrect LOA coding

Leave of Absence

- Any time residents do not meet the midnight census, they are considered to be on LOA
- **LOA alters the MDS reference windows for regularly scheduled assessments (but <u>not</u> COTOs or EOTOs)!**
- Must "restart" the Medicare cycle if the resident is formally admitted to the hospital or out of the Facility for >24 hours

Medicare Advantage

- Growing rapidly (30% of all Medicare beneficiaries nationwide)
- Increase of over 10% in the past 2 years
- Transition from FFS program to private insurance program
- On average less than 80% of FFS rates
- Administrative costs

ZHSG MA Audit Findings

- Outdated rate structures
- Rate inconsistencies (contracted, approved, billed, and paid)
- Inefficiencies in the provision of therapy
- Failure to receive timely prior authorization
- No case management/prior authorization on rate exclusions
- Denials are not appealed

Managing Managed Care

- Operations: from admission to discharge
- Protocols
- Administrative policies and procedures
- Billing
- Audit

Final Thoughts

- Review systems of processing information
  - Who is in charge of what?
- Constantly monitor therapy logs to avoid significant overbilling and missed OMRAs
  - Minimal oversight can prevent systemic overbilling
- Ensure UB-04s are accurate and complete to minimize rejections
  - UB-04s are often ignored, yet are the primary source for audit initiation
  - Who is looking at your UB-04s?

Final Thoughts

- Implement a process for internal and external auditing to strengthen compliance
  - Use data to identify potential areas of weakness
  - Identify issues before they become systemic
  - Satisfy corporate compliance program mandated by the ACA
- Strengthen your Managed Care process
- Never assume you won't be audited; always provide exceptional care