Denials Management:
Developing an Effective Denials and Appeals Management System to Reduce Lost Revenue

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Disclosure

- Ellen R. Strunk: No relevant financial relationship exists
- Jaclyn Warshauer : No relevant financial relationship exists

Objectives

1. Describe the life cycle of the claim and how to use this information to guide appeals
2. Explain the elements to include in an effective appeal letter
3. Describe methods for tracking and analyzing denial and appeal trends
4. Describe current trends in payer denials and how to keep ahead of the next trends

Why the fuss?

- Protection of beneficiaries
- Protection of the Medicare Trust Fund
- OIG Workplan
- GAO Reports
- Program Integrity

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Medicare Program Integrity

- The CMS strives in every case to pay the right amount to a legitimate provider, for covered, correctly coded and correctly billed services, provided to an eligible beneficiary. *MBPM 100-8: Chapter 1*
- The Affordable Care Act gave the Secretary of Health & Human Services increased authority to set up programs to detect and identify overpayments, as well as prosecute those who commit fraud and abuse.

Data Analysis

- Identify areas that pose the greatest risk
  - Services which may be non-covered
  - Services not correctly coded
  - Services that may have low $$ values, but are billed in multiple increments
  - "Grey" areas in coverage guidelines such as SNF, HHA and Outpatient Therapy
- Identify patterns of use:
  - Increases in utilization over time
  - Overutilization of new codes when they are first valued
  - Schemes to inappropriately maximize reimbursement

Scope of Program Integrity Issues

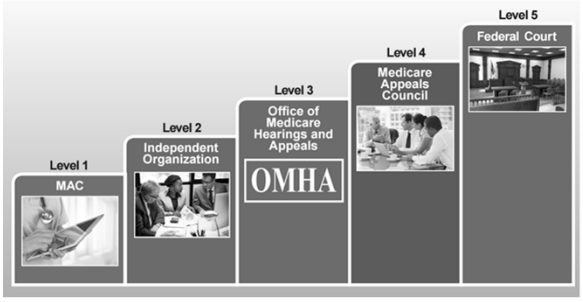
- Waste alone may account for 30% of overall healthcare costs
- Institute of Medicine estimates the US healthcare system loses about $765 billion/yr, including from fraud
- Overall….few providers will abuse or defraud the system, but nearly all contribute to waste

SOURCE: Fisher, Bynum, Skinner (2009). Slowing the Growth of Health Care Costs – Lessons From Regional Variation, NEJM, 360(9): 849-852; Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press, 2012.

What is the downstream effect?

- To the profession:
  - Current therapists may reconsider being a part of the profession
  - Prospective students may reconsider entering the profession
  - Recommendation of therapy services constrained
- To the patient
  - Improper care
  - Waste of benefit
- To society
  - Drain on public funds

The World of Appeals



Key Definitions

- **Claim:** the actual services provided during the service period
- **TOB:** Type of Bill
- **DOS:** Date of Service
- **ADR:** Additional Documentation Request
- **Appeal:** the process used to exercise a provider's right to challenge the decision of non-payment
- **Appellant:** the person or entity filing an appeal
- **Party:** A person or entity with a right to appeal an initial determination or subsequent appeal decision

Key Definitions

- **Automated Review:** System edits are used to check claims for improper coding or other anomalies
- **Complex Review**: Individuals examine a claim and its documentation to determine whether the service was covered and/or reasonable & necessary
- **Pre-Pay:** a type of probe or review that occurs prior to the claim ever being paid
- **Post-Pay:** a type of probe or review that occurs after the claim has been paid

Key Definitions

- **Provider-specific**: identification of specific inappropriate and/or inaccurate billing associated with a specific provider
  - Ex: ABC Rehab identified as having utilization of 97110 that was 2.5 times peers
- **Service-specific:** identification of inappropriate and/or inaccurate billing associated with a specific service
  - Ex: 97110 utilization increased 175%

Key Definitions

- **Redetermination:** the first level of appeal after the initial determination on a claim
- **Reconsideration:** the second level of appeal is triggered when the provider disagrees with the Redetermination. It is a new|independent review of that decision.
- **ALJ:** Administrative Law Judge: the third level of appeal is triggered when the provider disagrees with the Reconsideration.
  - It provides an opportunity to explain your position via video, telephone, or in person

Key Definitions

- **Amount in Controversy (AIC):** The threshold dollar amount remaining in dispute that is required for a Level 3 and Level 5 appeal
  - 2017: $160 for Level 3; $1,560 for Level 5
- **Determination**: the decision to pay in full, pay in part or deny (in total) the claim amount
- **Escalation:** a request to move an appeal to the next higher level because the adjudicator was not able to make a decision within a specified time (Level 2/↑)

	Type of Review	Purpose of Review
MAC: Medicare Administrative Contractors	Each entity has their own Medical Review Unit for Medicare A, B, Home Health, Hospice, and/or DME	Support the Medicare Integrity Program, which is to (1) pay claims correctly; (2) reduce the claims payment error rate
RA: Recovery Auditors (*previously called RAC's*)	Medicare A&B, Home Health, Hospice, DME	Identify and correct improper payments through identification of overpayments and underpayments; under contract through 2018

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	Type of Review	Purpose of Review
Comprehensive Error Rate Testing (CERT)	Medicare MACs, carriers, DMERCs	Calculate and monitor accuracy of payments
Payment Error Rate Measurement (PERM)	Medicaid and CHIP	Reviews fee-for-service claims, managed care payments {and eligibility}
Supplemental Medical Review Contractors (SMRC)	Assist CMS in lowering the improper payment rates and increase efficiencies in medical reviews	Conduct medical reviews on Medicare Part A, B, DME providers

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	Type of Review	Purpose of Review
Zone Program tegrity Contractor (ZPIC)	Audits arise from data analysis, complaints and/or referrals	To identify, investigate and explore potential fraud, waste and abuse
rogram Safeguard Contractor (PSC)	Investigate, perform data analysis and refer cases to law enforcement	To identify, investigate and explore potential fraud, waste and abuse
dicare-Medicaid Data Match (Medi-Medi) programs	Participation by entities is optional	Enables PSCs and other entities to analyze billing trends across programs
Medicaid Integrity ontractors (MICs)	Audit, Review, Educate	Ensure paid claims were for covered services, properly documented, and billed

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	Type of Review	Purpose of Review
Unified Program Integrity Contractor (UPIC)	Fraud, waste, abuse detection, deterrence and prevention activities	The UPIC will be responsible for combining and integrating the functions of current entities into one entity
Office of the Inspector General (OIG)	All areas of health care industry	To identify fraud, waste and abuse; publish annual workplan; reports

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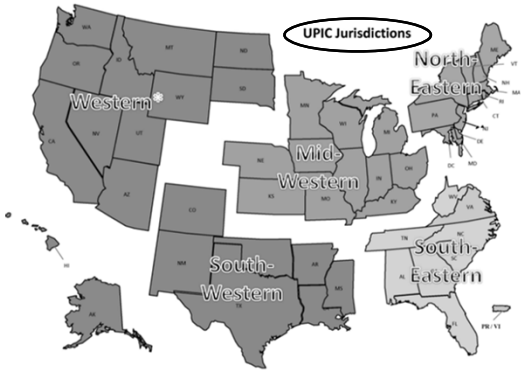


https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#upic

Medicare MACs

MAC	Probes Listed on Website
Noridian – JF (AK, WA, OR, ID, MT, WY, ND, SD, AZ, UT)	Targeted Probe & Educate w/ Extrapolation Pilot (Facilities and Private Practice)
Novitas – JH (AR, CO, LA, MS, NM, OK, TX)	IRF: LE Joint Replacement and LE Fractures SNF: RU "Upcoming Focus of Provider Specific Reviews": IRF, SNF, PT in Facilities
Novitas – JL (DE, DC, MD, NJ, PA)	IRF: LE Joint Replacement and LE Fractures

Medicare MACs

MAC	Probes Listed on Website
Palmetto (Part A/B for NC, SC, VA, WV)	IRF: LE Fractures SNF: RU HH: Claims with BG** and CH** HIPPS Codes, 2CHK*
WPS – J5 (IA, KS, MO, NE, and former Mutual of Omaha)	(Historically has looked at High $$ claims, Part B Therapy (edit 50TPT) and SNF (50SNF) – has new website that has very little information currently.)
WPS – J8 (IN, MN)	(Historically has looked at High $$ claims, Part B Therapy (edit 50TPT) and SNF (50SNF) – has new website that has very little information currently.)

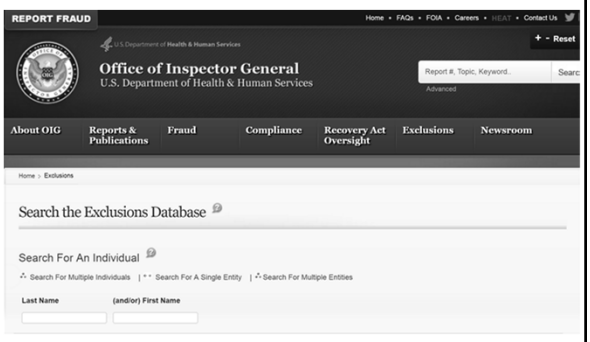
Life Cycle of a Claim

Patient information obtained → Permissions and Consents →

What should be considered?

- Full name; copy of insurance cards and DL
- Primary Care Physician; Referring MD if indicated
- Query for other services the patient may be receiving
- Financial Consent
- Assignment of Benefit
- Consent to Treat
- Medicare Secondary Payer form
- Appointment of Representative (Form CMS-1696)
- And…….

OIG Exclusions Database



Life Cycle of a Claim

Insurance validated

LCDs; NCDs; Contracts; Payer Policies

Life Cycle of a Claim

Therapist provides a service → Therapist documents → Therapist chooses codes

Life Cycle of a Claim

Codes are sent to biller → Biller submits claim → Claim goes through edits

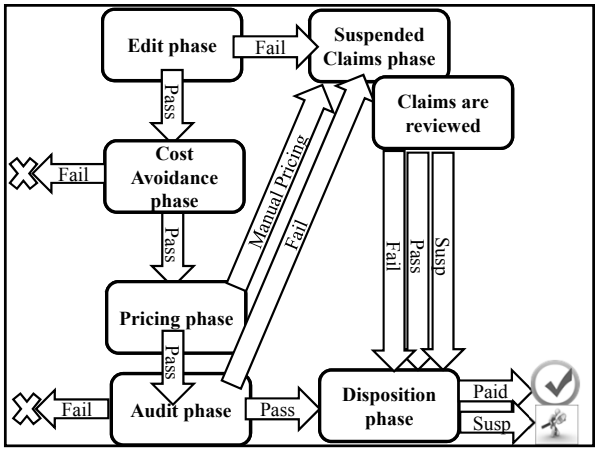
FISS and DDE

- FISS = Fiscal Intermediary Standard System
  - The standard Medicare claims processing system
- DDE = Direct Data Entry
  - Allows for: Entering, correcting, canceling transactions
  - Checking beneficiary eligibility
  - Inquiring status of claims

Life Cycle of a Claim

Validation against provider contracts, benefit plans

Validation against beneficiary eligibility, service codes, diagnosis codes



Status/Location Codes

P	**Processed/Paid, but….Partial or Full**
R	**Rejected**
D	**Denied**
S	**Suspended – no action is required by you UNLESS S-B6001 for ADR**
T	**Returned to Provider (RTP) It needs attention by you!**
I	**Inactivated**

Status/Location Codes

- Examples

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RTP: Returned to Provider

- Status/Location: T B9997
- Claim is considered "unprocessable"
- Provider should correct the claim
  - A new receipt date will be placed on the claim, which changes the dates for processing the claim
- Those that are not addressed are inactivated every 60 days.
  - Provider will have to submit a new claim

Why would I get a RTP?

- Dates mismatch
  - Ex: From/Thru dates on inpatient and SNF claim do not match
  - Dates overlap with another provider claim
- Billing NPI is the same as the attending MD NPI
- HCPC code billed is not allowed on the TOB submitted
- Claim has not been filed timely

Keys to Successful Claims

- Patient Information
- ICD-10 Codes
- Service Codes
- Dates of Service
- Modifiers
- Occurrence Codes
- All Field Locators appropriate (see handout)
- Payer Policies

- And….Documentation, Certifications

Tips for Responding to an ADR

aegis therapies 2017 Rehab Resources & Consulting, Inc.

Deciphering an ADR

```
REPORT: 001              MEDICARE PART A 15004       PVDR NO____: XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DEVELOPMENT REQUEST   BILL TYPE: XXX
 CASE ID: 15004XXXXXXXXXXXXXXXXXPR
                  A GOOD AGENCY
                  123 MAIN STREET

                  ANYTOWN            IA 50010 1234

 WE HAVE RECEIVED THIS CLAIM RECORD AND FOUND THAT ADDITIONAL DEVELOPMENT
 WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED.  TO ASSIST YOU IN
 PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE
 AFFECTED CLAIM RECORD (SEE BELOW) FOR YOUR REVIEW.  PLEASE REFER TO THE
 ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODES. SOLICITED LETTERS
 CAN BE ANY ADR LETTERS AT CONTRACTORS' DISCRETION, AND NOT SOLEY FOR
                  CGS J15 MAC
                  J15 - HHH CORRESPONDENCE
                  P O BOX 20014
                  NASHVILLE          TN 37202
 PATIENT CNTRL NBR:                    DUE DATE: MM/DD/CCYY
 MEDICAL REC NO:                  DCN:  XXXXXXXXXXXXXXR
 HIC: XXXXXXXXXA    PATIENT NAME: JOSEPHINE       PATIENT
 FROM DATE: 12/01/20YY  THRU DATE: 12/31/20YY  OPR/MED ANALYST:
 TOTAL CHARGES:    5000.00     ORIG REQ DT: 01/10/20YY  CLM RCPT DT: 01/08/20YY

      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Deciphering an ADR

- **Requestor**
  - Medicare Medical Review Entities may include the CMS logo
    - Don't assume that this means the ADR is coming from your MAC
- **Date ADR generated**
  - This starts the count for timely submission
- **Patient's name**
  - Pre-pay: Single patient
  - Post-pay: Could be multiple patients

Deciphering an ADR

- The claim **Date of Service**
- **Reason for Selection**
  - Pre-pay: ADR Reason Code
    - Billers can look up the definition of the ADR Reason Code in the Reason Code Inquiry Screen of FISS
  - Post-pay: Letter will describe reason for selection
- List of the **recommended medical record documents** to submit
- **The Review Entity's address**

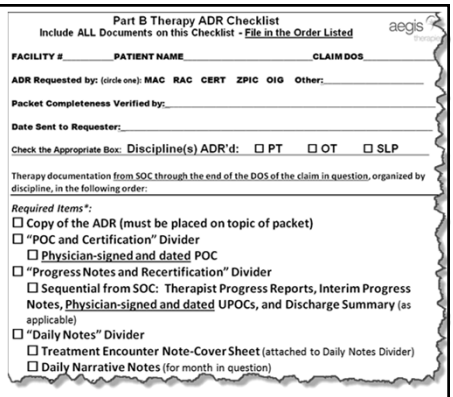
Get Paid the First Time

- **Avoid denials for late submission or insufficient information!**
- **4 very important considerations when compiling an ADR Packet:**
  - Legible
  - Complete
  - Logical Order
  - Timely

ADR Documentation List

- **Not an all inclusive list**
- Sometimes these are generic and some items might not apply to your setting
- Do not limit to documentation written during the DOS – include documentation from prior to the DOS…and sometimes after
- **Copy of ADR must be placed on top of the related medical record packet**

Checklist Example



Part B Therapy ADR Checklist
Include ALL Documents on this Checklist - File in the Order Listed

FACILITY #_____ PATIENT NAME_____ CLAIM DOS_____

ADR Requested by: (circle one): MAC RAC CERT ZPIC OIG Other:_____

Packet Completeness Verified by:_____

Date Sent to Requester:_____

Check the Appropriate Box: Discipline(s) ADR'd: ☐ PT ☐ OT ☐ SLP

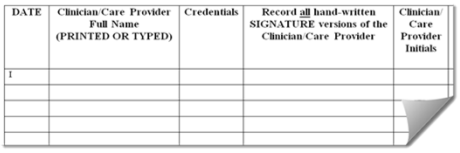
Therapy documentation from SOC through the end of the DOS of the claim in question, organized by discipline, in the following order:

Required Items:*

☐ Copy of the ADR (must be placed on topic of packet)
☐ "POC and Certification" Divider
  ☐ Physician-signed and dated POC
☐ "Progress Notes and Recertification" Divider
  ☐ Sequential from SOC: Therapist Progress Reports, Interim Progress Notes, Physician-signed and dated UPOCs, and Discharge Summary (as applicable)
☐ "Daily Notes" Divider
  ☐ Treatment Encounter Note-Cover Sheet (attached to Daily Notes Divider)
  ☐ Daily Narrative Notes (for month in question)

Signature Logs

- If there are any hand written signatures in the medical record submitted a signature log is required
  - Be sure to have the therapist include all iterations of their signature on the log



DATE	Clinician/Care Provider Full Name (PRINTED OR TYPED)	Credentials	Record all hand-written SIGNATURE versions of the Clinician/Care Provider	Clinician/ Care Provider Initials
1				

Communicate

- **Assemble a team that will be involved in gathering and verifying the ADR packet**
  - Designate a point person to coordinate the effort
  - Give a checklist to each team member of the documents they are to gather
    - Be specific… "Physician signed clarification order that covers (ENTER: specific dates)"
  - Communicate hard deadlines that give enough cushion for the verification process of the packet prior to the submission deadline

Legible and Organized

- Ensure every page is legible
- Assemble each discipline's documentation in logical order so it reads like a book
- **Each ADR DOS must have a separate packet**
- Most payors do not want staples. Some don't want paper clips, either. Check ADR and/or payor's website for how to separate multiple ADR packets

Timeliness of Submission

- **Timeliness is critical**
  - Deadline varies by Medical Review Entity
    - The ADR will give the deadline info
  - Automatic denial for late ADRs
    - For the Medicare MAC, that's day 46
- **Before submitting make an <u>exact</u> copy of the packet**
  - Can reference if the payor indicated that docs were missing
  - Can be used for appeals

Submission Methods

- **Many payors have multiple ways to submit**
  - Paper, fax, CD/DVD, esMD
  - Check the ADR and/or their website for options
- If mailing: certified mail or signature confirmation
- If faxing: maintain fax confirmation
- Some payors have time of day limits for accepting the packet
  - E.g., packet received after 5:00 on deadline considered late and claim denied

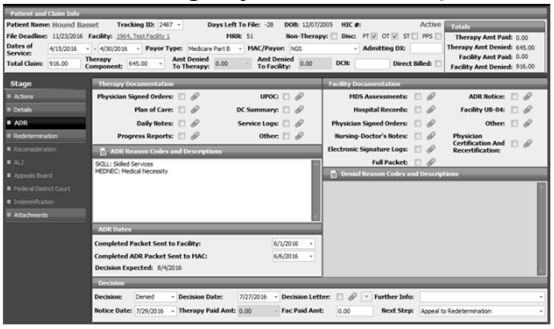
Tracking Log

ADR LEVEL	EACH APPEAL LEVEL
• Payor/Review Entity • Date of ADR • Patient name • Service under review • DOS • $$ at risk • Date ADR packet submitted • Outcome	• Denial Notice Date • Services Denied • Denied $$ • Denial Reason • Plan (e.g., appeal or not) • Date appeal packet submitted • Outcome

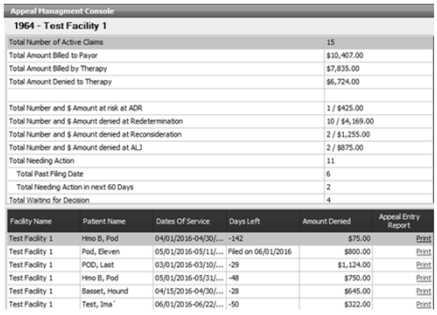
B	C	D	E	F	G	H	I
Date received packet	Facility	Patient LAST name	Patient FIRST name	MI	Medicare Number	Discipline affected	Date of ADR denial
11/15/2010	A		Kathy			ST	10/5/2010
7/20/2011	A		Rosemary			ST	7/20/2011
3/16/2011	A		Thomas			OT	3/8/2011
4/18/2011	A		Thomas			ST	4/7/2011
1/14/2011	A		Bonnie			ST	1/7/2011
8/12/2010	A		Argie			ST	7/13/2010
8/18/2011	A		Roy			ST	8/10/2011
1/29/2013	C		Nannie	B		ST	1/16/2013
10/18/2011	C		Devenna			ST	10/14/2011
8/21/2012	C		Joe			OT	7/17/2012
ck'd 2.25	D		Otis			ST	1/28/2013
ck'd 2.25	D		Otis			ST	1/28/2013

J	K	L	M
Dates of Service	$	Date Redeter is due (120)	Comments
9/2 - 9/15/10	$39.14	2/2/2011	to SH 11/22/10
6/3 to 6/30/11	$150.00	11/17/2011	I unit 92507; to SH 8/4
2/27/2011	$300.00	7/6/2011	4 u 97530; to SH 3/19
3/2 to 3/8/11	$750.00	8/5/2011	Per BOM 4/7; asked 4/11; To SH 5/2/11
12/7-12/10/10	$1,200.00	5/7/2011	Denial of 97532 related to dx; to SH 1/18
6/1-6/29/10	$300.00	11/13/2010	2 u 97532; to SH 8/14
7/20/2011	$63.38	12/8/2011	to SH 9/10; 1 u92507
12/7-12/31/12	$2,400.00	5/16/2013	97532 due to dx; sent 2/4/13
9/22 - 9/29/11	$643.98	2/11/2012	due to dx; total denial ; to SH 11/7
6/1- 6/7/12	$1,125.00	11/14/2012	530, 535, 542; Asked 7/30/12; To SH 8/27
10/1-10/10/12	$1,050.00	5/28/2013	Cap denial
11/15/12-11/20/12	$300.00	5/28/2013	Cap denial

Tracking System Example



Tracking System Example



Appeal Managment Console

1964 - Test Facility 1

Total Number of Active Claims	15
Total Amount Billed to Payor	$10,407.00
Total Amount Billed by Therapy	$7,835.00
Total Amount Denied to Therapy	$6,724.00
Total Number and $ Amount at risk at ADR	1 / $425.00
Total Number and $ Amount denied at Redetermination	10 / $4,169.00
Total Number and $ Amount denied at Reconsideration	2 / $1,255.00
Total Number and $ Amount denied at ALJ	2 / $875.00
Total Needing Action	11
Total Past Filing Date	6
Total Needing Action in next 60 Days	2
Total Waiting for Decision	4

Facility Name	Patient Name	Dates Of Service	Days Left	Amount Denied	Appeal Entry Report
Test Facility 1	Hmo B., Pod	04/01/2016-04/30/...	-142	$75.00	Print
Test Facility 1	Pod, Eleven	05/01/2016-05/11/...	Filed on 06/01/2016	$800.00	Print
Test Facility 1	POD, Last	03/01/2016-03/10/...	-29	$1,124.00	Print
Test Facility 1	Hmo B., Pod	05/01/2016-05/31/...	-48	$750.00	Print
Test Facility 1	Basset, Hound	04/15/2016-04/30/...	-28	$645.00	Print
Test Facility 1	Test, Ima`	06/01/2016-06/22/...	-50	$322.00	Print

What if the ADR deadline is missed?

- **Medicare: Automatic denial**
  - FISS Denial Reason Code: 56900
    - Remittance Advice Remark Code: M127 (Missing patient medical record documentation)
  - Submit a request for a Reopening
    - Check payor's website for instructions
  - The Reopening should be submitted to Medical Review with a cover letter indicating it is a reopening request and must be received within **120 days** from the denial date

Wait for Results

- **Time frames**
  - Not all review entities have prescribed decision time frames
    - E.g., Post-pay ZPIC, SMRC, CERT

Review Entity	Decision Time Frame
Pre-pay MAC	30 days to make decision and enter decision into FISS
Post-pay MAC	60 days to make decision and mail the results
RAC (post-pay)	30 days to make decision and contact the provider
Pre-pay ZPIC	60 days to make decision and notify the MAC

ADR Results Communication

- **Results: Paid, Partially Paid, Denied**
- **If paid, might not be notified**
  - Check Status Location in billing system
- **Pre-pay: Results Letters and Remit Advice**
  - Some payors have gone away from issuing ADR Result Letters
    - Results in FISS/DDE
- **Post-pay: Results Letter and Demand Letter (if denied)**

OUCH!! You Got a Denial!

Now What?!?

Two Routes to a Denial

- **Result of ADR Review**
  - The medical records were requested and sent in
  - The medical reviewer's decision was to deny some or all of the services
  - "Complex Medical Review"
- **Automated Denial**
  - No medical records submitted
  - The payor's computer software detects possible improper payments and will generate the denials

Can't Proceed with Managing Denials without…

- **Understanding the specific denial**
  - **WHAT** was actually billed (in the biller's system)
  - **WHAT** was actually denied
    - **WHAT** service
      - Discipline
      - CPT Code
      - RUG level
      - HHRG level
    - **WHAT** date
  - **WHY** it was denied

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Gathering Denial Info

- **Denial is result of an ADR**
  - Results Letter
  - Remittance Advice (RA)
  - FISS
    - Pre-pay ADR
- **Automated Denial**
  - Remittance Advice
  - FISS

Denied Services in FISS

- **Status Location**
  - P B9997: Partially Paid claim
    - NOTE: This Status Location is also used for a fully PAID claim
  - D B9997: Fully denied
- **Determine the specific discipline, CPT code(s) and date(s) denied**
  - Shown as non-covered lines
- **Determine the Denial Reason Code**
  - Each line could have a different reason for denial

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Denial Reason Codes

- **Denial Reason Codes**
  - Represent the cause of denial for the specific revenue code line
  - If medically denied, this code will typically start with a "5"
    - "Medically denied" – based on medical necessity
      - Automated Review: missing ICD code from payor's LCD/NCD
      - Complex Review: denied by a medical reviewer upon review of the medical records

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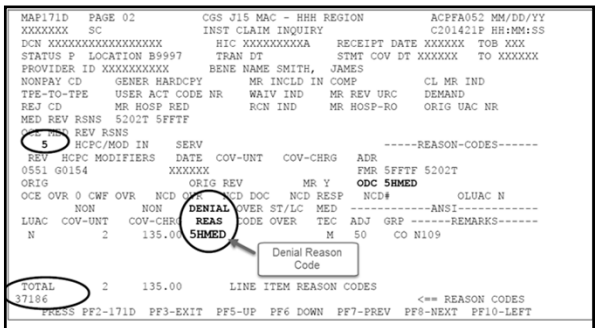

- **5HMED: Medical Necessity of services not supported**

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Common Automated Denial Reason Codes

Denial Reason Code	Explanation
56900	ADR documentation not received timely
W7019 W7020	CCI edit that is not allowed, even with modifier -59 present
W7039 W7040	CCI edit that would be allowed if a modifier -59 was present
55A00*	Claim denied for not having a covered ICD code from the applicable LCD/NCD *some payors use a different Denial Reason Code such as 52NCD or 5LPDN
V8022	Over the Therapy Cap without a KX

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Possible Routes to Obtain Payment after an Automated Denial

- Must determine first if there are grounds to obtain payment
  - No Grounds: Denial of units > 1 for Service Based Codes
- Facility to re-submit claim with correction
  - It is often suggested to try the claim resubmission route first and if that doesn't work, then appeal to redetermination
- Appeal to Redetermination

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Medical Review Denial Reason Codes

- **Payor specific**
  - Medical Review departments can make up their own Denial Reason Codes
- The explanation of the Denial Reason Code can be looked up
  - Reason Code Inquiry Screen in FISS
- Some medical reviewers will add denial reason information in the Remarks Page (Page 4) in FISS

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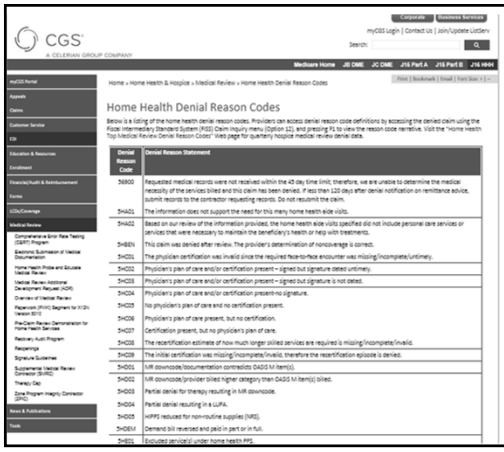


CGS has **over 60** HH Denial Reason Codes

68

Seek FISS Denial Information from the Biller

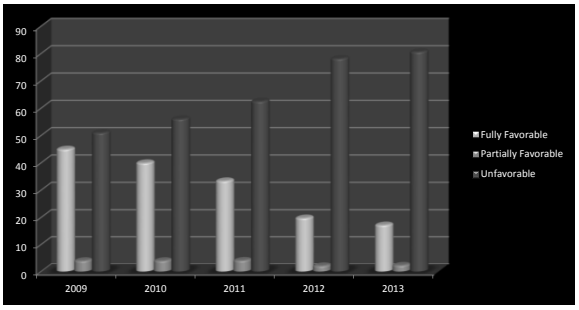
See HANDOUT: Gathering Denial Information in FISS

- ***Can I see the claim?***
  - Verify that the claim matches your therapy billing records
- ***Which lines were noncovered?***
  - FISS Page 02
- ***What is the Denial Reason Code for that noncovered line?***
  - Put cursor on noncovered line and press F2
- ***What does that Denial Reason Code mean?***
  - Check via Reason Code Inquiry Screen (Press F1)
- ***Did the reviewer write any comments on the Remarks Page (Page 04)?***

Appealing a Denial

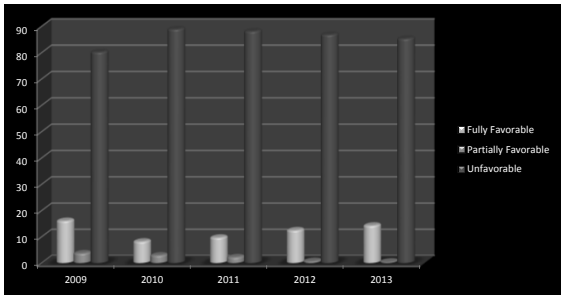
But First, Let's Look at Medicare Statistics for Appeal Results

Medicare Redetermination Results 2009-2013



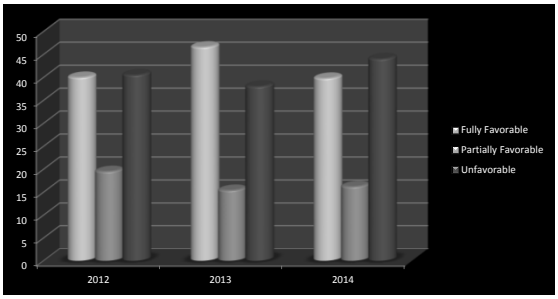
71

Medicare Reconsideration Results 2009 - 2013



72

Medicare ALJ Results 2012-2014



73

Appealing a Denial

- If you get a denial from any of the Medicare medical review entities, you follow the "normal" appeal process

MAC
RA
ZPIC
CERT
SMRC

Begin the appeal at the **Redetermination*** Level at the MAC

*Some allow a Discussion Period first

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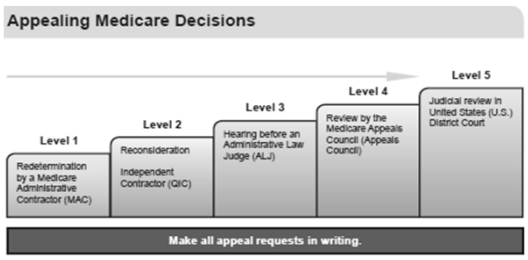
Discussion Period

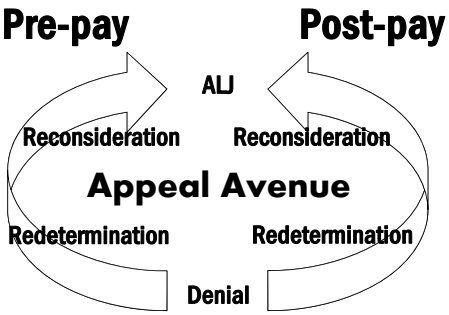
- **When the review entity allows a Discussion Period**
  - Allows provider time to submit additional information/doc
  - Do not submit appeal while in a requested Discussion Period
    - Appeal will override the Discussion Period
  - Discussion Period does not extend appeal timeframe
- **RAC**
  - Requested within 30 days of receipt of Review Results Letter
- **SMRC**
  - Written request received by SMRC within 30 days of date of Results Letter
  - Discussion Period info on Strategic Health Solution's website

– 1

Medicare Appeals



- Medicare MLN: Medicare Parts A & B Appeals Process



Pre-pay vs Post-pay

	PRE-PAY	POST-PAY	DECISION
Redetermination Due Dates	120 Days	• 120 Days unless provider seeks to Stop Recoupment of the overpayment • 30 Days from first Demand Letter if Stop Recoupment	60 Days
Reconsideration Due Dates	180 Days	• 180 Days unless provider seeks to Stop Recoupment of the overpayment • 60 Days from Medicare Redetermination Notice if Stop Recoupment • Must have participated in Stop Recoupment at Redetermination, as well	60 Days
ALJ Due Dates	60 Days	60 Days	Delayed due to volume

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Post-pay Appeal Highlights

- **When a Post-pay ADR review results in a denial**
  - 2 letters should be received
    - A letter indicating the reason for the denial
    - A Demand Letter asking for the $$ back
- **Redetermination Appeal rights don't begin until the claim is re-processed to the denial and the Demand Letter is sent**
  - So don't send in the appeal packet until then

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The OPTION to Stop Recoupment

- **935 Limitation on Recoupment**
  - This means that when an overpayment is subject to the limitation on recoupment protections, Medicare will not begin overpayment collection (or will cease collections that have started) when it receives a valid request for a redetermination (first level of appeal), or a reconsideration (second level of appeal)
  - **Applies only to Post-Pay denials**

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Stop Recoupment OPTION

- If submit a valid appeal request by the Stop Recoupment deadline
  - The overpayment recoupment stops, but not the accrual of interest
    - Interest begins to accrue on the 31st day from the date of the Demand Letter. Accruement continues until the debt is fully satisfied (paid in full or overturned at appeal)
    - Interest rate: 9.625% at the time of presentation development
- Unless a valid appeal is received, recoupment begins on:

Redetermination	Day 41	Reconsideration	Day 61

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NO Stop Recoupment OPTION when Appealing to ALJ

- If the claim remains denied after the Reconsideration Appeal, the "normal" ALJ appeal process applies
  - There is no Stop Recoupment process when appealing to the ALJ
  - Medicare will recoup the denied dollars and the interest accrued
    - If the ALJ overturns the denial, Medicare will pay the provider back

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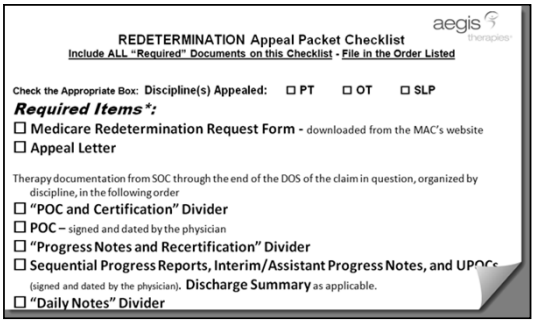
Appeal Request Forms

- **NAME and SIGNATURE must be included on forms**
- **Redetermination** Request Form
  - Many MACs have a payor-specific Redetermination Request Form on their website
    - **Need to know if you are "Part A" or "Part B"**
- **Reconsideration** Request Form
  - CMS website: Form CMS 20033
- **ALJ** Request Form
  - CMS website: Request for Medicare Hearing by an Administrative Law Judge Form (CMS 20034)

1st: Redetermination Appeals

- Conducted by the MAC
  - Different review department from the ADR reviewers
- Submission deadline counted from Remittance Advice date
- Include an Appeal Letter rebutting the denial
- Use same communication, collection, verification process as discussed in the ADR section to ensure that the appeal packet is legible, complete, organized, timely
- Many payors have gone away from sending a Medicare Redetermination Notice when the finding is fully favorable

Use an Appeal Packet Checklist



REDETERMINATION Appeal Packet Checklist

Include ALL "Required" Documents on this Checklist - File in the Order Listed

Check the Appropriate Box: Discipline(s) Appealed: ☐ PT ☐ OT ☐ SLP

Required Items*:

☐ Medicare Redetermination Request Form - downloaded from the MAC's website

☐ Appeal Letter

Therapy documentation from SOC through the end of the DOS of the claim in question, organized by discipline, in the following order

☐ "POC and Certification" Divider

☐ POC – signed and dated by the physician

☐ "Progress Notes and Recertification" Divider

☐ Sequential Progress Reports, Interim/Assistant Progress Notes, and UPOCs (signed and dated by the physician). Discharge Summary as applicable.

☐ "Daily Notes" Divider

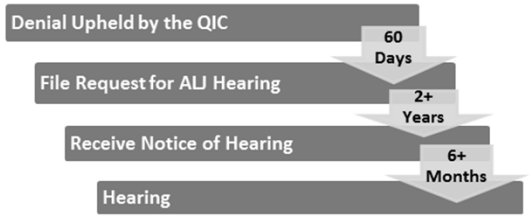
2nd: Reconsideration Appeals

- Conducted by the QIC
- Submission deadline counted from Medicare Redetermination Notice (MRN) or Remit Advice
- Include an updated Appeal Letter
- The last opportunity to submit the medical record to support your appeal
  - ALJ will use the medical record submitted to the QIC
    - Documentation not submitted at the Reconsideration Level may be excluded from consideration at the ALJ unless you demonstrate good cause for submitting the late evidence
- Should include a copy of the MRN or RA

3rd: ALJ

- Three situations when a party can request a hearing before an ALJ
  - Appealing QIC's reconsideration determination
  - Escalating because QIC failed to make decision timely
  - Asking ALJ to review QIC's dismissal of request for reconsideration
- 2017 Amount in Controversy: $160

ALJ is a **LONG** Process



ALJ Best Practice

- ALJ hearing may be years out
- Recommend that all forms, appeal packet reviews and the writing of the Position Statement Letter (appeal letter) be completed at the time of the hearing request while the patient, familiar staff, and the medical records are readily available
  - Some forms/documents will not be sent at the time of the request but should be filed until the appropriate time

Time Point 1: File Request for ALJ Hearing

- Submit the following at this stage
  - Request for Medicare Hearing by an Administrative Law Judge Form
  - Copy of the first page of the Reconsideration Results letter
  - Appointment of Representative Form (AOR)
    - As applicable
  - Transfer of Appeal Rights
    - As applicable

Time Point 1: File Request for ALJ Hearing

- **Must send a copy of the ALJ hearing request form to all other parties to the QIC reconsideration**
  - Names listed in QIC letter
  - Suggest including evidence of the mailing of this info in the ALJ packet
- Submission deadline 60 days from Reconsideration Decision Letter date

Time Point 2: Respond to Notice of Assignment / Notice of Hearing

- Notice of Assignment will come first indicating that the hearing has been assigned to a specific judge and will provide the judge's address
  - Maintain this letter for ALJ name and address
- Notice of Hearing will indicate date and time of hearing
  - Usually 6 months out

Time Point 2: Respond to Notice of Assignment / Notice of Hearing

- Complete the Response to Notice of Hearing Form and send to the Office of Medicare Hearings and Appeals (OMHA) **within 5 days** of receiving the Notice of Hearing

Time Point 2: Respond to Notice of Assignment / Notice of Hearing

- Shortly after sending the Response to Notice of Hearing send the following directly to the ALJ:
  - Signed ALJ Position Statement (appeal letter)
  - Submit any medical record documentation that was not submitted or legible at the Reconsideration level along with the Filing of New Evidence form, as applicable

Time Point 3: Hearing

- **Prior to the hearing**
  - Study the medical record
  - Have regulations/citations prepared to support your case
  - Be prepared to refer to documents in the medical record (and not info in the ALJ Position Statement Letter)
  - Medical Necessity denial: be prepared to explain the complexity of the patient during the DOS in question
  - Skilled Services denial: be prepared to explain the complexity/sophistication of the treatment interventions provided

Appeal Letter Writing Tips

Scope of Medicare Appeals Review

- MLN Matters Article: SE1521 Revised
  - Effective with appeal requests on/after 4/18/16
- Limits appeal reviewers to only look at the denied lines and only for the reason the service was initially denied
  - Applies to Redetermination and Reconsideration levels
  - Does not apply to pre-pay automated denials
    - Missing KX, Missing covered ICD-10 codes, CCI edits, Missing modifier -59

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When to Write an Appeal Letter

- Appeal letters are only written if a denial of payment has occurred
- Serves as a rebuttal to the specific denial
- Therefore, you will need access to the denial information to write an effective appeal letter
  - What was denied
  - Why it was denied

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Can the same Appeal Letter be used at all levels of appeal?

- Generally, NO
  - The services denied can change at each level of appeal
    - The rebuttal must be specific to the exact services denied and the reason for denial at the most recent level
  - At the ALJ level, the appeal letter must be argued based on regulation. At this level you must ensure that the arguments are sound and include citations
    - This is because ALJs can pay the claim based on your Position Statement letter and a review of the Medical Record without holding an actual hearing
      - "Paid on Record"

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Appeal Letters Must…

- Be concise and to the point
  - Maximum length: 2-3 pages long
- **NOT re-write what is in the medical record**
  - The reviewer will also be reading the medical record
- **Fill in the gaps**
- **Connect the dots**
- **Synthesize the information**

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The Appeal Letter General Flow

1) Claim Dates of Service (DOS) at Issue
   - Typically not the therapy SOC and EOC dates
2) Purpose of the letter
3) Recap of the services denied and the reason for the denial
   - Specific to the most recent services denied and the reason for the denial
4) Explanation why the denial decision was improper
   - Incorporating regulation/policy citations in your rebuttal
     - Only use Medicare citations for Medicare and Medicare Replacement payors
     - **SEE HANDOUT: Medicare Appeal Citations**

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ALJ Position Statement Letter

To whom it may concern:

This letter is a request for reconsideration of the denial of payment for *(discipline)* services provided to *(resident's name)* from *(dates of denied services)*. The reason given for that determination was *(include the exact reason given in the QIC's denial letter)*. The following information will clarify why we believe that the services should be covered and paid according to Medicare Guidelines.

Per the QIC's decision letter, the reason for upholding the denial for *(explain why the QIC denied)* was based upon the following Medicare regulation: *(give the exact Medicare citations that the QIC used for this denial)*.

We dispute the denial for the following reasons.

Concisely explain why you believe it was denied in error, and, as appropriate, how the QIC's Medicare citations did not apply to this case. Be sure to support your defense with your own Medicare citations (see the "Medicare Citations for Use in Appeal Letters" resource.) Add your own comments that explain how the quotation applies to the services that were provided.

- **Appeal letter at the ALJ level**
- **Focus on the law / citations**
- **A convincing letter can pay off!!**

Current Trends

Current Trends

- RAC's: Will be starting up soon
- SHS: $3700 MMR and SNF Part A (Therapy OMRAs)
- IRF Medical Necessity
- SNF Medical Necessity and RUG Validations
- Outpatient Therapy Skilled Services
- Use of Modifier -59 (Automated Denial or ADR)
- Electrical Stimulation
- CPT Codes 97112, 97532
- SNF: Orders/certs not signed before patient is discharged
- Part B certs not signed before patient is discharged
- Therapy frequency is not matching order/cert
- Late certifications not accepted as valid, even with delayed cert doc
- No daily narrative notes
- No signature logs

Finally, track your denials for trends. If you get a denial…

- …look in the mirror
- Failed to convincingly support the services
- The therapists that provided the denied services must be made aware of the denial and should be involved in writing the appeal letter
- Look for opportunities to improve the documentation and clinical decision making to reduce the chance for future denials

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Thank You!

Ellen Strunk
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Jaclyn Warshauer
National Clinical Director
Aegis Therapies
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- Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015: Report to Committee on Finance in Congress
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- Department of Health Care Finance: Report on Managed Care Claims Processing - Rate of Denials. October 2015
- Fisher, Bynum, Skinner (2009). Slowing the Growth of Health Care Costs – Lessons From Regional Variation, NEJM, 360(9): 849-852; Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press, 2012.
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- Medicare Appellant Forum –Office of Medicare Hearings and Appeals (OMHA). 2/25/16
- Medicare Benefit Policy Manual. CMS website
- Medicare Direct Data Entry (DDE) Manual. FISS Overview. CMS website.
- Medicare Learning Network: Medicare Parts A & B Appeals Process. CMS website.

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- Medicare Manual System. Pub 100-4 Medicare Claims Processing. Transmittal 1104. November 3, 2006. Uniform Billing (UB-04) Implementation. CMS website.
- Office of Inspector General: US Department of Health and Human Services: The Medicare-Medicaid (Med-Medi) Data Match Program. Report OEI09-08-00370)
- Office of the Inspector General: U.S. Department of Health and Human Services: Work Plan Fiscal Year 2017
- Original Medicare Fact Sheet. CMS website.
- Skilled Nursing Facility Resident Assessment Instrument Manual, V1.14, October 2016

- ***Can I see the claim?***
  - Verify that the claim matches your therapy billing records
- ***Which lines were noncovered?***
  - FISS Page 02
- ***What is the Denial Reason Code for that noncovered line?***
  - Put cursor on noncovered line and press F2
- ***What does that Denial Reason Code mean?***
  - Check via Reason Code Inquiry Screen (Press F1)
- ***Did the reviewer write any comments on the Remarks Page (Page 04)?***

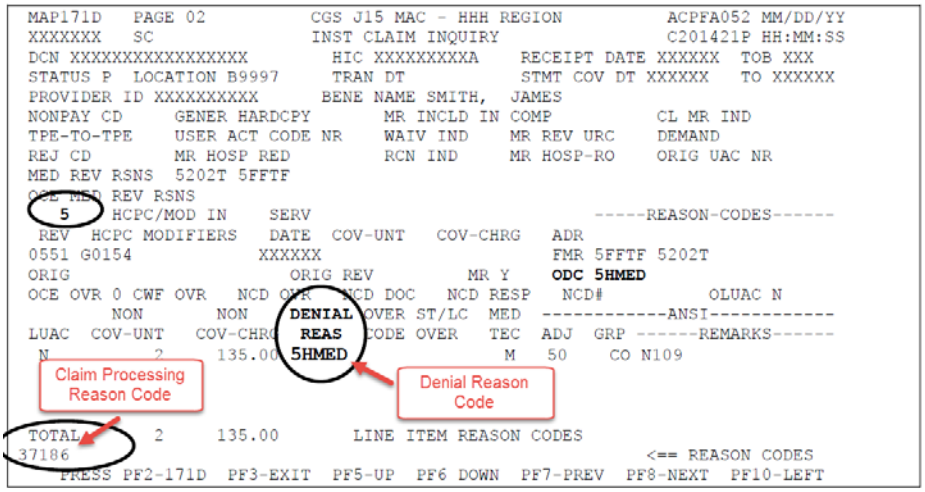
CLAIMS PROCESSING REASON CODES vs DENIAL REASON CODES

Claims Processing Reason Codes

- **When a claim has completed processing, a 5-digit reason code is applied by FISS which explains the processing outcome**
  - **Posted in the lower left corner of the claim**
- **Reason Code 37192: Claim has been approved for payment**
  - **Fully paid, OR**
  - **Partially paid: will need to review the non-covered lines to determine the line specific Denial Reason Code**
- **Fully Denied: the Claims Processing Reason Code will show the Denial Reason Code if all the lines were denied for the exact same reason**

Denial Reason Codes

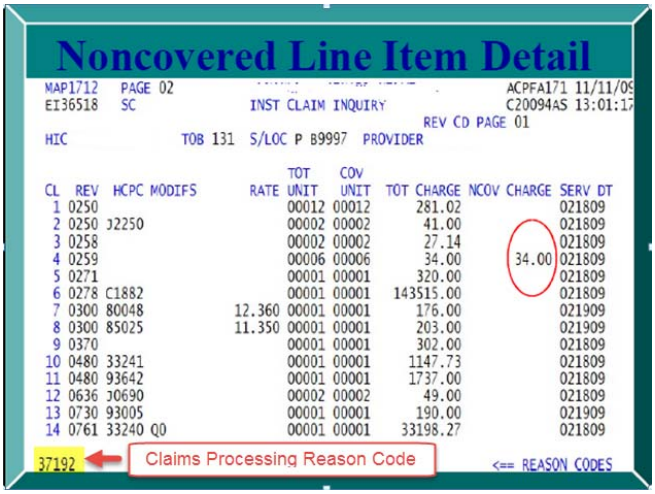
- **Represent the cause of denial for the specific revenue code line**
- **If medically denied, this code will typically start with a "5"**
  - **"Medically denied" – based on medical necessity**
    - **Automated: missing ICD code from payor's LCD/NCD**
    - **Complex: denied by a medical reviewer upon review of the medical records**



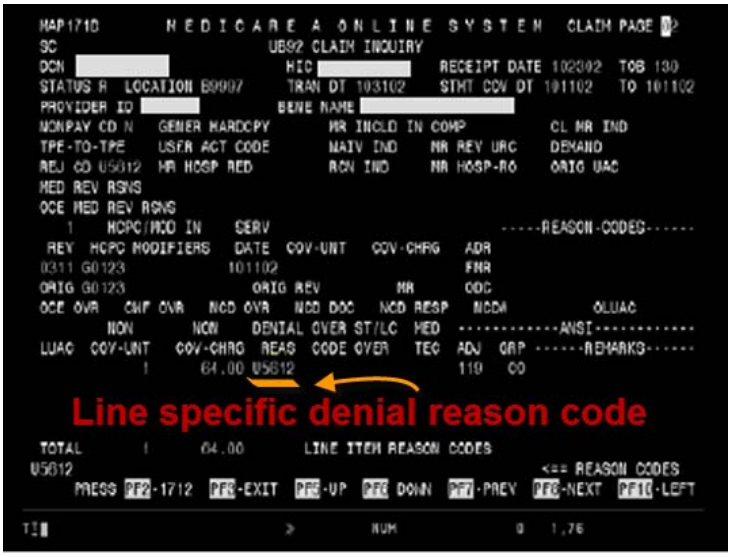
- 5HMED: Medical Necessity of services not supported
- 37186: Approved for payment

Accessing Denial Information

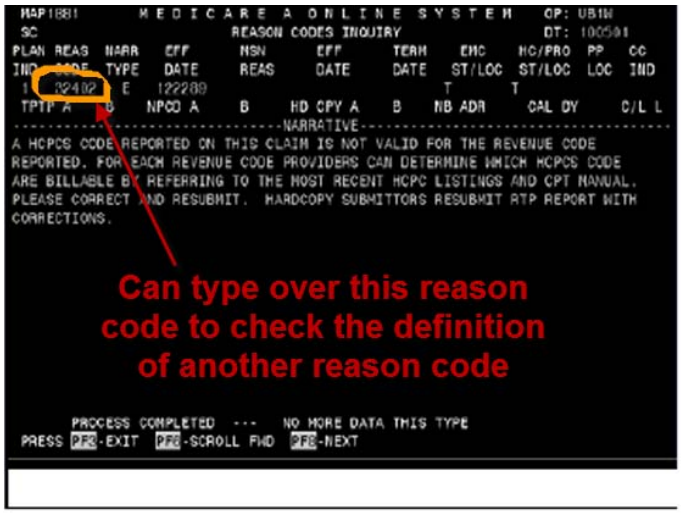
On Page 02 in FISS, the denied lines will have NCOV (noncovered) Charges.



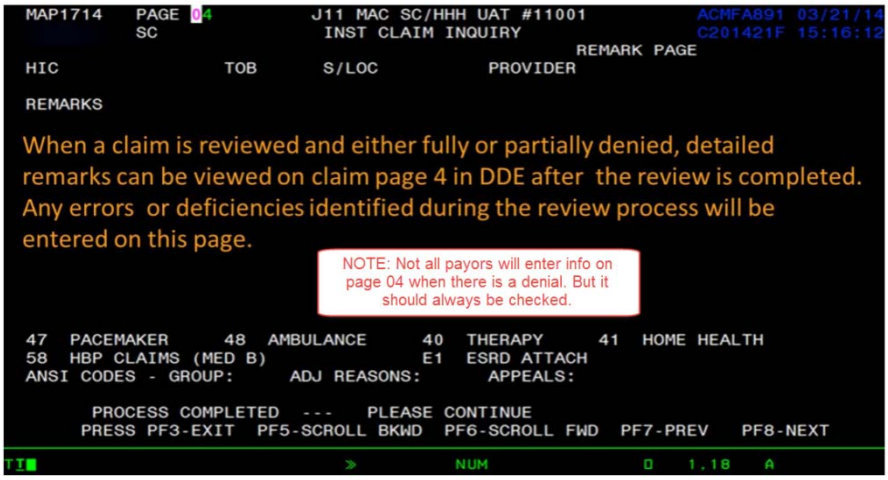
From Page 02, put the curser on a CPT line with non-covered charges and press F2. The line item detail information will display for that particular line, including the line-specific Denial Reason Code.



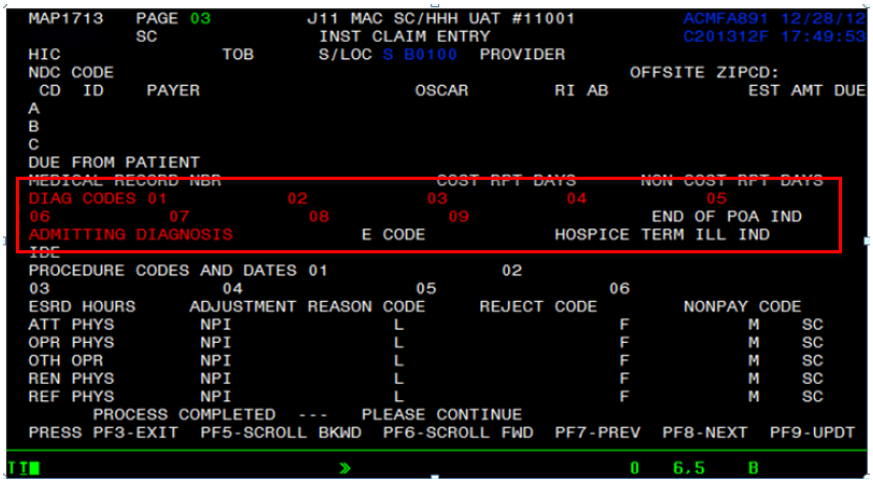
To find the explanation for the Denial Reason Code, press F1 to access the Reason Code Inquiry Screen.



Some payors/reviewers will enter denial reason information on the Remarks Page (page 04) in FISS.



If the denial was because of a missing ICD-10 code from the payor's LCD/NCD/policy and your therapy records indicate that you did have a covered ICD-10 selected, verify that the covered ICD-10 code was entered in one of the first 9 positions on Page 03 of the claim in FISS.



Medicare Citations for Use in Appeal Letters

December 2016

Quote Medicare Coverage Guidelines that support your case. Choose ONE or TWO of the quotations below. Add your own comments that explain how this quotation applies to the services that were provided.

Medicare – All Setting Citations:

The Medicare Program Integrity Manual states in chapter 6, §6.1, "Rules of thumb" in the Medical Review (MR) process are prohibited. Medicare contractors must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements, such as, lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable."

Medicare Part B Citations: (Part B includes outpatient therapy services regardless of setting: Rehabilitation Agency, SNF Part B, CORF, Hospital Part B including ER and Observation, Home Health Part B when not under a home health plan of care, therapists in private practice)

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "To be considered reasonable and necessary…the services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition".

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function)."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Factors that contribute to need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Changes in objective and sometimes to subjective measures of improvement also help establish the need for rehabilitative services."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Justification for treatment… In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable.

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Rehabilitative therapy services are skilled procedures that may include…Continued assessment and analysis during implementation of the services at regular intervals."

Medicare Part B Citations (cont):

The Medicare Benefit Policy Manual states in chapter 15, §220.3, ", "Rehabilitative therapy services are skilled procedures that may include…Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system)."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Rehabilitative therapy services are skilled procedures that may include…Instruction leading to establishment of compensatory skills."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Rehabilitative therapy services are skilled procedures that may include…Training of patient and family to augment rehabilitative treatment. Training of staff and family should be ongoing throughout treatment and instructions modified intermittently as the patient's status changes."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition or to maximize his/her functional abilities."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care".

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "A therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "Rehabilitation therapy may be needed, and improvement in a patient's condition may occur, even when a chronic, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition or to maximize his/her functional abilities."

The Medicare Benefit Policy Manual states in chapter 15, §230.1, "Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status."

The Medicare Benefit Policy Manual states in chapter 15, §230.2, "Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning."

The Medicare Benefit Policy Manual states in chapter 15, §230.3, "The speech-language pathologist employs a variety of formal and informal speech, language, and dysphagia assessment tests to ascertain the type, causal factor(s), and severity of the speech and language or swallowing disorders."

The Medicare Benefit Policy Manual states in chapter 15, §230.3, "Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment."

The Medicare Benefit Policy Manual states in chapter 15, §230.3, "Swallowing assessment and rehabilitation are highly specialized services."

Part B Maintenance Therapy

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "Skilled therapy services… may be covered in certain circumstances as maintenance therapy under a maintenance program."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Justification for treatment… In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel."

The Medicare Benefit Policy Manual states in chapter 15, §220.2, If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.

The Medicare Benefit Policy Manual states in chapter 15, §220.2, "skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program."

Part B Group Therapy:

The Medicare Benefit Policy Manual states in chapter 15, §230, "Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity."

Part B Documentation:

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary."

The Medicare Benefit Policy Manual states in chapter 15, §220.3, Limits on Requirements: Contractors shall not require more specific documentation unless other Medicare policies require it.

The Medicare Benefit Policy Manual states in chapter 15, §220.3, "Treatment Note: The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting. The treatment note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the progress reports and are allowed, but not required daily.

The Medicare Benefit Policy Manual, chapter 15, §220, defines reevaluation: "RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care." In addition, section 220.3 states, "Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care."

Medicare SNF Part A:

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2.1, "Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved."

The Medicare Benefit Policy Manual, chapter 8, §30.2.2, in describing principles for skilled SNF Part A services states, "If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service."

The Medicare Benefit Policy Manual states in chapter 8, §30.4, "Such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services."

The Medicare Benefit Policy Manual states in chapter 8, §30.2.1, "Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition."

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2, "The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist."

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2, "A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient."

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2, "In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled."

The Resident Assessment Instrument (RAI) Manual states in Chapter 2, "There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment."; "The use of grace days allows clinical flexibility in setting ARDs."

The Resident Assessment Instrument (RAI) Manual states in Chapter 3, Section O, "The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide."

The Resident Assessment Instrument (RAI) Manual states in Chapter 3, Section O, "Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives more than one mode of therapy per visit."

The Resident Assessment Instrument (RAI) Manual states in Chapter 3, Section O, "In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS."

SNF Part A Maintenance:

The Medicare Benefit Policy Manual states in chapter 8, §30, "Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care."

The Medicare Benefit Policy Manual states in chapter 8, §30.4.1.2, "If the specialized knowledge and judgment of a qualified therapist are required, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are considered skilled therapy services."

The Resident Assessment Instrument (RAI) Manual states in Chapter 3, Section O, "…therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively."

SNF Part A Billed Days

The Medicare Program Integrity Manual states in chapter 6, §6.1, "Medicare expects to pay at the rate based on the most recent clinical assessment (i.e., MDS), for all covered days associated with that MDS. This means that the level of payment for each day of the SNF stay may not match exactly the level of services provided. Accordingly, the medical review process for SNF PPS bills must be consistent with the new payment process."

SNF Part A Medicare Week

The Final Rule for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012 states, "Additionally, the idea that a resident can receive the required amount of weekly therapy while still not being provided therapy for 3 consecutive days, as suggested by the commenter, assumes that there is a prescribed "Medicare therapy week". **It should be noted, however, that there is no prescribed "Medicare therapy week" that spans across any specific days."**

Home Health Part A

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist."

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety."

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2, "Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition"

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service."

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during the last visit(s) for rehabilitative/restorative treatment. The goals of a maintenance program would be to maintain the patient's current functional status or to prevent or slow further deterioration."

Home Health Part A (cont)

The Medicare Program Integrity Manual states in chapter 6, §6.2.1, "For medical review purposes, the referring /certifying physician's initial order for home health services for a patient initiates the establishment of a plan of care as part of the certification of patient eligibility for the Medicare home health benefit."

The Medicare Program Integrity Manual states in chapter 6, §6.2.1, "CMS does not require a specific form or format for the certification as long as a physician certifies that the five certification requirements, outlined in 42 CFR 424.22(a)(1) and section 6.2.1.1, are met."

Home Health Part A Maintenance:

The Medicare Benefit Policy Manual states in chapter 8, §30.2.2, "Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care."

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered."

The Medicare Benefit Policy Manual states in chapter 8, §40.2.1, "The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.

Medicare Managed Care

The Medicare Managed Care Manual states in §10.2, "MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations…that are not present in original Medicare."

Common Status/Location Codes

P B9997	Processed or paid (full or partial) billing transaction
P B7501	Post-pay MSP review
P B7505	Post-pay MSP review
R B9997	Rejected billing transaction (finalized)
R B75XX	Rejected billing transaction (suspended). It may take at least 75 days for the claim to move to a R B9997 finalized status/location
D B9997	Denied claim – All services denied Partial denials with appear in the "P" status
T B9900	Transaction will need correction, once it moves into T B9997 in the next cycle
T B9997	Billing transaction needs correction by provider Referred to as "Returned to the Provider" (RTP) status/location
S B6000	Claim will need additional information when it moves to S B6001
S B6001	Claim needs additional information from provider Referred to as "Additional Development Request" (ADR) Information must be sent by the 30th day. If Reason Code 5ADR2 is listed, additional signature documentation is requested.
S M50MR	Indicates ADR information has been received and medical review of documentation is the next step. The review process may take up to 60 days to complete.
S M5CLM	Status a claim is moved to for additional processing after the ADR documentation has been reviewed.
S MRADJ	MSP adjustment is being made – created after MSP adjustment received; awaiting completion
I B9900	Billing transaction inactivated from RTP file; waiting to purge it from FISS

Companies who assist with monitoring OIG Exclusion status

LEIE analyzer: www.leieanalyzer.com

Provider Trust: www.providertrust.com

Streamline Verify: www.streamlineverify.com

Verify Comply: www.verifycomply.com

Zebu Compliance: www.zebucompliance.com

Entities with electronic submission of medical documentation capabilities (esMD)

Medicare RAs

1. HealthDataInsights
2. Connolly
3. CGI Federal
4. Performant Recovery

DME MACs

1. CGS
2. Noridian

AB MACs

1. Cahaba
2. FCSO
3. NGS (some areas)
4. Noridian
5. Novitas 9some areas)
6. Palmetto
7. WPS