Centrex REHAB an integrated therapy network

Succeeding When Appealing Medicare Denials – The Art of the Defense

Matthew Mesiboy, PT, GCS

MNAPTA –APRIL 23, 2016



## Succeeding when Appealing Medicare Denials – The Art of the Defense

- No financial disclosures



## Succeeding when Appealing Medicare Denials – The Art of the Defense

**Objectives** –

1) Clinicians will Identify and learn about Medicare policy as it relates to the provision of physical therapy services.
2) Clinicians will learn about and be able to identify the 5 levels of Medicare appeal.
3) Clinicians will understand the current political and legislative environmental factors contributing to heightened Medicare auditing.



## Succeeding when Appealing Medicare Denials – The Art of the Defense

**Objectives** –

4) Clinicians will learn what assertions the various Medicare contractors are making when determining that therapy services are considered medically unnecessary.
5) Clinicians will learn how to compose a succinct and effective appeal letter for denied therapy services
6) Clinicians will Identify the key components of the alternative payment system and how that will assist in combating fraud and abuse

## Succeeding when Appealing Medicare Denials – The Art of the Defense

- Several Positions APTANJ
- HPA section Past Payment & Practice Chair
- APTA Alternative Payment System Task Force
- APTA Public Policy and Advocacy Committee (PPAC)
- Director Regulatory Affairs Fox for multistate private practice
- Centrex Rehab - Clinical Physical Therapy Specialist
- Linked In https://www.linkedin.com/in/matthew-mesibov-a025528?trk=hp-identity-photo



## Succeeding when Appealing Medicare Denials – The Art of the Defense






## Succeeding when Appealing Medicare Denials – The Art of the Defense

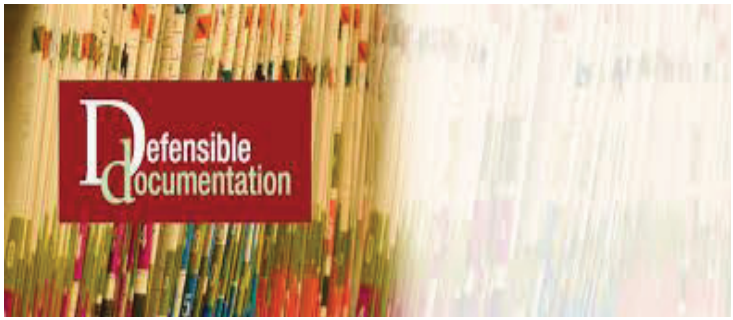
https://www.youtube.com/watch?v=VHP5wTq0IAQ



## Succeeding when Appealing Medicare Denials – **The Art of the Defense**

- Winning - Collaborating
  1. Personal Philosophy - Attitude of I can defend our services
  2. Personal Integrity – I can admit when the auditor was correct
  3. Teach – Feedback to your clinical staff so they learn

# Succeeding when Appealing Medicare Denials – The Art of the Defense






# Succeeding when Appealing Medicare Denials – The Art of the Defense

## Purpose of Documentation

1. **Evaluation** – Medically necessary services
2. **Treatment Encounter Notes** –
   - Skilled Care
   - Support billed cpt codes and time
3. **Progress Report** – Justify continued care
4. **Reevaluation** – Significant change in status
5. **Recertification** – Extend episode with justification for continued care
6. **Discharge** – Summary of medically necessary services



# Succeeding when Appealing Medicare Denials – The Art of the Defense

## Medically Necessary Services

1. Medicare Benefit Policy Manual Chapter 15, sections 220, 230 (starts approx. p 151 )

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

2. NGS LCD (Limited Coverage Determination Policy)
   - PT/OT

   https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33631



# Succeeding when Appealing Medicare Denials – The Art of the Defense

## NGS LCD (Limited Coverage Determination Policy)

- 97110 , 97112, 97140 - Documentation must clearly support the need for continued therapeutic exercise greater than 12-18 visits.
- 97530 - Documentation must clearly support the need for continued therapeutic activity treatment beyond 10-12 visits.

# Succeeding when Appealing Medicare Denials – The Art of the Defense

- Multitude of contractors looking at documentation

| Contractor | Claim Types | Claim Selection | Claim Volume | Purpose of Review |
|---|---|---|---|---|
| CERT | All Claim Types Medicare | Random | Small | Measure improper payment rates |
| PERM | All Claim types for Medicaid | Random | Small | Measure improper payment rates |
| MAC (medical review department) | All claim types with Medicare fee for service | Targeted | Depends on this issue and amount of improper payments | Prevent improper payments Provider Education |
| RA (formerly RAC) | All claim types with Medicare fee for service (Will begin reviewing Medicaid claims) | Targeted | Size depends of the magnitude of improper payments | Detect past improper payment find program vulnerabilities |
| ZPIC | All claim types with Medicare fee for service Medi- Medi in some states | Targeted based on potential fraud, waste, and abuse | Size depends of the magnitude of potential fraud and abuse | Identify fraud, waste, and abuse |

www.apta.org



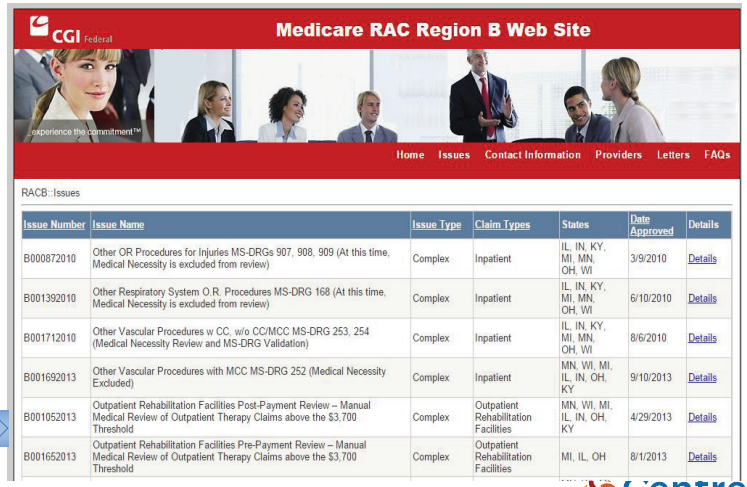
# Succeeding when Appealing Medicare Denials – The Art of the Defense

**OUR FOCUS**


www.clinicient.com



# Succeeding when Appealing Medicare Denials – The Art of the Defense

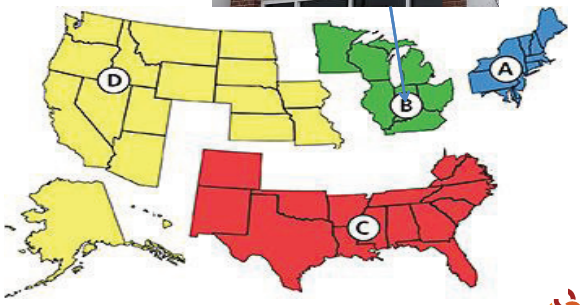



| Issue Number | Issue Name | Issue Type | Claim Types | States | Date Approved | Details |
|---|---|---|---|---|---|---|
| B000872010 | Other OR Procedures for Injuries MS-DRGs 907, 908, 909 (At this time, Medical Necessity is excluded from review) | Complex | Inpatient | IL, IN, KY, MI, MN, OH, WI | 3/9/2010 | Details |
| B001392010 | Other Respiratory System O.R. Procedures MS-DRG 168 (At this time, Medical Necessity is excluded from review) | Complex | Inpatient | IL, IN, KY, MI, MN, OH, WI | 6/10/2010 | Details |
| B001712010 | Other Vascular Procedures w CC, w/o CC/MCC MS-DRG 253, 254 (Medical Necessity Review and MS-DRG Validation) | Complex | Inpatient | IL, IN, KY, MI, MN, OH, WI | 8/6/2010 | Details |
| B001692013 | Other Vascular Procedures with MCC MS-DRG 252 (Medical Necessity Excluded) | Complex | Inpatient | MN, WI, MI, IL, IN, OH, KY | 9/10/2013 | Details |
| B001052013 | Outpatient Rehabilitation Facilities Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold | Complex | Outpatient Rehabilitation Facilities | MN, WI, MI, IL, IN, OH, KY | 4/29/2013 | Details |
| B001652013 | Outpatient Rehabilitation Facilities Pre-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold | Complex | Outpatient Rehabilitation Facilities | MI, IL, OH | 8/1/2013 | Details |

https://racb.cgi.com/issues.aspx



# Succeeding when Appealing Medicare Denials – The Art of the Defense


www.aha.org

# Succeeding when Appealing Medicare Denials – The Art of the Defense


Medicare Fee-for-Service Recovery Audit Program
April 2013

| | Recovery Audit National Program | | | | |
|---|---|---|---|---|---|
| | FY 2010 Oct 2009-Sept 2010 | FY 2011 Oct 2010– Sept 2011 | FY 2012 Oct 2011– Sept 2012 | FY 2013 Oct 2012– March 2013 | Total National Program |
| Overpayments Collected | $75.4M | $797.4M | $2,291.3M | $1,371.3M | $4.5B |
| Underpay-ments Returned | $16.9M | $141.9M | $109.4M | $65.4M | $333.6M |
| Total Corrections | $92.3M | $939.3M | $2,400.7M | $1,436.7M | $4.8B |

**Top Issue per Recovery Auditor** (January 2013 – March 2013)



# Medicare/RAC Appeals

Medicare B Threshold Documentation Review

Entities involved (Initially):

- CMS (Center for Medicare and Medicaid Services)
- Medicare Administrative Contractor (MAC)
- Recovery Audit Contractor (RAC or RA)

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# Medicare/RAC Appeals

Recovery Audit Contractor (RAC or RA)

- Reviews the documentation
- CMS must approve anything they are auditing for
- CMS has approved threshold reviews ($3700)
  - ➢ **Looking at therapy Cap also???**
- CGI is RAC for Minnesota

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# Medicare/RAC Appeals

Recovery Audit Contractor (RAC or RA)

- **1st ADR:** can only request documentation for 1 claim
- **2nd ADR:** can request up to 10% of total eligible[1] claims
- **3rd ADR:** up to 25% of remaining eligible claims
- **4th ADR:** up to 50% of remaining eligible claims
- **5th ADR:** up to 100% of remaining eligible claims

([1] Total number of claims over the $3700 Threshold that were paid March 1, 2014 through December 31, 2014)

https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/recent_updates.html

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# Medicare/RAC Appeals

- Contact Information

| Contractor | Telephone # | Hours | Website |
|---|---|---|---|
| CGI (Recovery Auditor) | 877-316-RACB (7222) | Not listed | http://racb.cgi.com. |
| NGS (National Government Services) | 877-702-0990 | 8:00 am – 4:00 pm (Closed Thursdays for training) | https://www.ngsmedicare.com |



# Medicare/RAC Appeals

- Medicare (CMS) - 5 levels of appeal
  1. **Redetermination** (MAC: response time 60 days)
  2. **Reconsideration** (a Qualified Independent Contractor (QIC: response time 60 days)
  3. **Administrative Law Judge** (ALJ) – currently at least a 2 year back log; Minimum $ amount necessary (updated annually- currently $150)
  4. **Review by the Appeals Council** within the Departmental Appeals Board in the Department of Health and Human Services
  5. **Judicial review** in federal district court (effective 1/1/16 - $1,500)



# Medicare/RAC Appeals

- RAC or RA(Recovery Audit Contractor) –
  - **Letter #1: Additional Documentation Request letter (ADR** – see example handout)
    - A dated letter from RAC requesting documentation for review
    - **Documentation due 45 days from date on letter**



# Medicare/RAC Appeals - ADR

# Medicare/RAC Appeals - ADR

**Required:**

- PT/OT/SLP Plan of Care, including Therapy Frequency and Duration.
- Initial Evaluation/Re-evaluation including Plan of Care Signed by Ordering Physician or Practitioner
- PT/OT/SLP Therapy Progress Notes, including Discharge Summary (Progress Reports), daily notes, flow sheets.
- Wound Care Progress Notes, if applicable
- CMS 1500/UB-04/CPT/HCPCS Procedure Codes Submitted
- Specific Skilled Procedures and Modalities
- Attendance/Treatment Records for this Claim Period – Must Include Total Timed Code Treatment Minutes, Total Treatment Time and Identify Each
- Physician/Non-Physician Practitioner (NPP) certification of Plan of Care for Claim Period Including Justification when the Certification is Delayed More Than 30 days.

**Optional:**

- Physician Orders
- Nursing/interdisciplinary progress notes



# Medicare/RAC Appeals

**Additional Documentation Request Report**

Good Cause for Issue:Skilled Nursing Facility Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold

| Ref. | HIC / Patient Name | Dates of Service / Date of Birth | Medical Record # | Patient Control # | Claim Reference # | RAC Case Id |
|---|---|---|---|---|---|---|
| | | | | | | |

HIC #



# Medicare/RAC Appeals

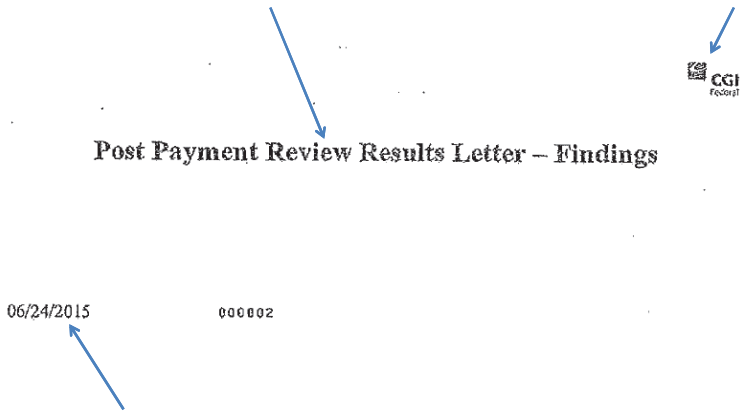
- RAC (Recovery Audit Contractor)-
  - **Response to ADR-**
    - Provide all supportive documentation
    - Timely Response



# Medicare/RAC Appeals

- RAC (Recovery Audit Contractor) –
  - **Letter # 2: Post Payment Review Results Letter – Findings** (see example handout) -
    - Comes from RA
    - Provides results of review based on submitted therapy documentation from ADR
    - Informs to wait on Demand Letter before provider should take action
    - In the "Billed Revcd" column **0420 is PT**; **0430 is OT**; **0440 is ST**
    - **Multiple patients / months in letter**

# Medicare/RAC Appeals – PPR Findings (Letter Head)






# Medicare/RAC Appeals – PPR

- Findings Paragraph

Based on the medical documentation reviewed for the selected claim(s), CGI found that some of the services you submitted were not reasonable and necessary as required by §1861 of the Act, or did not meet the Medicare coverage requirements as required in §1862 of the Act. *Additional information such as specific details on which coverage/medical necessity/coding payment policy and/or article violated is identified on the attached spreadsheet listed by claim detail.*



# Medicare/RAC Appeals – PPR

- Findings Summary

"OP or "NF"

**Review Results Findings**

| Beneficiary Name | HIC | Claim # | Medical Record # | Patient Control # |
|---|---|---|---|---|
| | | | | |

Audit Information

| DATE OF SERVICE | CPT/HCPCS | BILLED REVCD | BILLED UNITS | ALLOWED UNITS | REVIEW STATUS CODE |
|---|---|---|---|---|---|
| 9/1/2013 | 97003 | 0430 | 1 | 0 | OP |
| 9/1/2013 | 97140 | 0430 | 2 | 0 | OP |
| 9/1/2013 | G8987 | 0430 | 1 | 0 | OP |
| 9/1/2013 | G8988 | 0430 | 1 | 0 | OP |
| 9/2/2013 | 97530 | 0430 | 2 | 0 | OP |
| 9/3/2013 | 97001 | 0420 | 1 | 0 | OP |
| 9/3/2013 | 97112 | 0420 | 2 | 0 | OP |
| 9/3/2013 | 97116 | 0420 | 1 | 0 | OP |
| 9/3/2013 | 97535 | 0430 | 4 | 0 | OP |
| 9/3/2013 | G8978 | 0420 | 1 | 0 | OP |
| 9/3/2013 | G8979 | 0420 | 1 | 0 | OP |
| 9/4/2013 | 92506 | 0440 | 1 | 0 | OP |



# Medicare/RAC Appeals – PPR

- Additional Information

| | | | | | |
|---|---|---|---|---|---|
| 12/31/2013 | 97535 | 0430 | 1 | 0 | OP |

Additional Information

The review of the medical record does not show sufficient documentation supporting the services provided and the medical necessity for the therapy amount, frequency and duration for the services provided. This patient is referred to physical therapy (PT) and occupational therapy (OT) due to generalized weakness and inability to walk, right groin/knee pain and difficulty in performing self-care activities. Prior therapy was provided although there is no documentation of the outcome or specific dates as required and noted in LCD regarding this prior therapy. Documentation states the patient does not walk except with PT with standby assist and walker. Right knee and groin pain is rated 7/10. She requires moderate assistance for transfers and gait and maximum assistance for dressing and toileting. Treatment plan was therapy 5 times per week. Treatment more than two or three times a week is expected to be a rare occurrence and requires documentation to support this intensity. The evaluation did not include a specific, objective measurement of the patient's level of function prior to their current functional decline. Prior level is critical to establish the baseline data necessary for assessing the expected rehabilitation potential, setting realistic goals and measuring progress as outlined in the LCD. With no prior level of function established, the clinician has no baseline from which to make a determination that a decline has occurred. To that extent, the submitted documentation did not indicate a significant decline in the beneficiary's functional mobility status to support the therapy services provided. The documentation did not support that the services provided during the date(s) in review were such that the service could only be safely and effectively performed by a therapist. Additional documentation is needed regarding why a clinician was required to provide the care and what medical complexity existed that other providers could not provide the care. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Documentation for an exception should indicate how the patients' medical complexity directly and significantly affects the treatment for a therapy condition and the medical necessity for ongoing skilled care. Services that exceed those typically billed should be carefully documented. Refer to CMS Manual regarding medical necessity and requirements for ongoing skilled care. In summary, the medical record does not show sufficient documentation supporting the services provided and medical necessity for the therapy provided from 12-14-2013 through 12-31-2014.

Review Status Code Descriptions:

# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertions #1, 2

- The review of the medical record does not show sufficient documentation supporting the services provided and the medical necessity for the therapy amount, frequency, and duration of the services provided.
- Treatment more than 2 -3x per week is expected to be a rare occurrence and requires documentation to support this intensity



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion #1, 2

- **Group Break Out-**
  - Individually or as a team, how would you refute/appeal these assertions ? 5 minutes



# Medicare/RAC Appeals – PPR

•Additional Information – Refute/Appeal # 1, 2

- **Group Feedback –** medical necessity and frequency/duration



# Medicare/RAC Appeals – PPR

•Additional Information – Refute/Appeal #1, 2

- Eval – Medical Necessity Established
- Frequency/Duration – **Use EBP**
  - American College of Sports Medicine (ACSM) recommendations for optimal aging (2014)
  - Applying Exercise Prescription Principles Across The Health Care Continuum For the Older Adult With Multiple Chronic Conditions (American Physical Therapy Association's (APTA) Combined Sections Meeting 2015 )

# Medicare/RAC Appeals – PPR

•Additional Information – Refute/Appeal #1, 2

- Resistance, flexibility, balance exercises are to be performed 2+ days per week
- Cardio at a frequency of 5 days per week
- Academy of Geriatric Physical Therapy of APTA agrees with ACSM in the Academy's Exercise Recommendations for Older Adults, however, it further notes frequencies with ranges up to 7 days/week for aerobic capacity (i.e. "cardio"), flexibility and balance.



# Medicare/RAC Appeals – PPR

EBP Therapy & Research Resources

PTNow

http://www.ptnow.org/Default.aspx



# Medicare/RAC Appeals – PPR

EBP Therapy & Research Resources

Foundation for Physical Therapy | Funding Research to Optimize Movement and Health

http://www.foundation4pt.org/



# Medicare/RAC Appeals – PPR

EBP Therapy & Research Resources

CoHSTAR

Center on Health Services Training and Research

"We fully expect the research to change the face of physical therapy and ultimately to improve patient outcomes."
- Paul Rockar Jr., PT, DPT, MS; Former President, APTA

http://www.bu.edu/cohstar/

# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 3, 4

- Prior therapy is provided although there is no documentation provided
- The evaluation did not include in specific, objective measurement of the patient's function, prior to their current functional decline



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 3, 4

- **Group Breakout**
  - Individually or as a team, how would you refute these assertions? 10 minutes



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 3, 4

- **Group Feedback**
  - Prior therapy is provided although there is no documentation provided
  - The evaluation did not include in specific, objective measurement of the patient's function, prior to their current functional decline



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 3, 4

- **Matt's Feedback**
  - **Integrity –** acknowledge if accurate
  - **Winning/Collaborative Attitude** – Explain and include prior outcome of therapy (e.g. past d/c report)

# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 5

- Documentation for an exception should indicate how the patient's medical complexity directly and significantly affects the treatment for a therapy condition and the medical necessity for ongoing skilled care. Services that exceed those typically billed should be carefully documented.



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 5

- **Group Breakout – "Documentation for an exception"**
  - Individually or as a team, how would you refute this assertion? 5 minutes



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 5

- **Group Feedback - "Documentation for an Exception"**
  - How the patient's medical complexity directly and significantly affects the treatment for a therapy condition and the medical necessity for ongoing skilled care.



# Medicare/RAC Appeals – PPR

•Additional Information – RA Assertion # 5

- **Matt's Feedback**
  - Do you require clinical staff document a statement as to why the cap has been exceeded?
  - **Progress Reports –** Justify continued care
  - **Encounter Notes –** Skilled care, support for ongoing care, adjustment of treatment for new findings

# Medicare/RAC Appeals

Recovery Audit Contractor (RAC or RA)

- Decision Tree:

RAC finds overpayment "OP"

**Discussion Period with RAC (CGI)**
➢For simple things (e.g. documentation not received)
➢Submit Discussion form with documentation (community)

**Appeal to Medicare Contractor (NGS)**
➢For disagreement with RAC findings
➢Send in Appeal (Clinical Team)



# Medicare/RAC Appeals

- RAC (Recovery Audit Contractor) –
  - ➢**Letter # 3: MAC Rebuttal/Demand Letter** (see example handout)-
    - Dated letter which comes from MAC
    - Opening paragraph states $ amount owed
    - Provides "Rebuttal" and "Appeal" options
      - ➢**Rebuttal** – **15 days** to act on (does not stop recoupment)
      - ➢ **Redetermination Appeal – 30 days** to act on (stops recoupment) – Max 120 days but get it in sooner!!!



# Medicare/RAC Appeals

- Demand Letter

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE
Part A Intermediary

Letter Number: 1

Date: 06/12/2015

FIRST REQUEST

RE : Claims Accounts Receivable - MMA 935
Provider Name:
Provider Number:
Outstanding Balance: $1,556.89

Dear Sir/Madam,

This is to inform you that you have received a Medicare payment in error which has resulted in an overpayment of $1,556.89. This amount is subject to Section 935(f)(2) of the Medicare Modernization Act (MMA) (Section 1893(f)(2) of the Social Security Act), Limitation on Recoupment. The purpose of our letter is to request that this amount be repaid to our office. The attached listing explains how this happened.



# Medicare/RAC Appeals

- RAC (Recovery Audit Contractor) –
  - ➢**Response to Post Payment Review Letter**
    - Review dates of "OP" and RA summary
    - Review therapy documentation
    - Build appeal letter with direct response to RA assertions
    - Wait for Demand letter before sending to NGS

# Medicare/RAC Appeals

- Demand Letter – Rebuttal Options

**Rebuttal Process:**

Under our existing regulations 42 CFR section 405.374, Providers and other Suppliers will have 15 days from the date of this demand letter to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence stating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. If you have reason to believe the withhold should not occur on **07/22/2015**, you must notify this office before **06/26/2015**. We will review your documentation. Our office will advise you of our decision in 15 days from receipt of your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment before a rebuttal response has been rendered.

The rebuttal statement does not cease recoupment activities consistent with section 935 of the MMA.



# Medicare/RAC Appeals

- Demand Letter –
  - 2 initial points to stop recoupment
    - I. **Redetermination** 30 days of Demand Letter stop recoupment (120 days to appeal)
    - II. **Reconsideration** Appeal – 60 days to stop recoupment (180 days to appeal)



# Medicare/RAC Appeals

- Demand Letter – Beneficiary Information

Invoice Number: 2

| Claim No. | Beneficiary Name | HIC No. | Service Date From | Service Date To | Amount Overpaid | Paid Date | Provider No. |
|---|---|---|---|---|---|---|---|
| | | | 02/01/2014 | 02/14/2014 | $1,556.89 | 03/18/2014 | |

Reason for Overpayment: This claim was adjusted due to a Recovery Audit Contractor (RAC) Review.



# Medicare/RAC Appeals – PPR

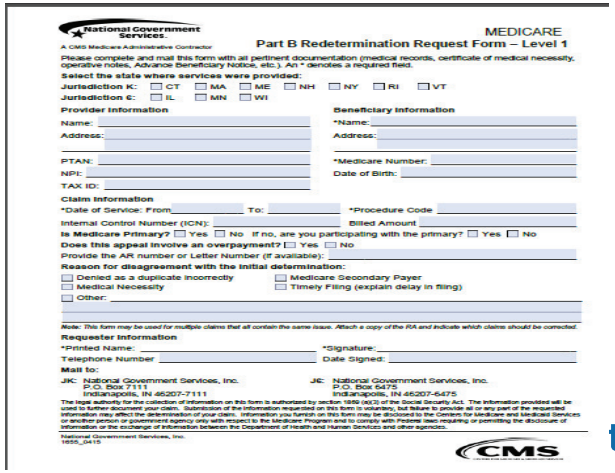
- Appeal Redeterm Example – **Open & Review**

Dear Sir/Madam,
This is a physical therapy services Redetermination appeal supportive letter for the Recovery Auditor (RA) overpayment findings of (Insert Name) – HIC # (Insert #). The dates of physical therapy overpayments are 4/1/2014 – 4/8/2014.
Review of the RA findings of overpayment related to physical therapy services includes the following assertions to which I wish to appeal (RA assertion in bold).

1) **Review of medical record does not show sufficient documentation supporting the services provided and the medical necessity for the therapy amount, frequency and duration for services provided. Treatment more than two to three times a week is expected to be a rare occurrence and per the CMS manual, treatment frequency of greater than three times per week requires documentation to support this intensity** – According to the initial evaluation of 2/28/14, this is the case of a 72 year old gentleman who was hospitalized 2/1 -27/14 due to an infection of the total knee replacement and removal of eschar along with placement of a wound vac. Compared to the patient's prior level of function which includes supervised assist for bed mobility, transfers and ambulation with a standard walker for 100', the patient was found to require moderate assist for bed mobility, contact guard from an elevated surface (i.e. not a standard

# Medicare/RAC Appeals – PPR

## Redetermination Form – Accompanies Appeal



National Government Services.
A CMS Medicare Administrative Contractor

MEDICARE
**Part B Redetermination Request Form – Level 1**

Please complete and mail this form with all pertinent documentation (medical records, certificate of medical necessity, operative notes, Advance Beneficiary Notice, etc.). An * denotes a required field.

**Select the state where services were provided:**

Jurisdiction K: ☐ CT ☐ MA ☐ ME ☐ NH ☐ NY ☐ RI ☐ VT
Jurisdiction C: ☐ IL ☐ MN ☐ WI

**Provider Information**
Name:
Address:
PTAN:
NPI:
TAX ID:

**Beneficiary Information**
*Name:
Address:
*Medicare Number:
Date of Birth:

**Claim Information**
*Date of Service: From: To: *Procedure Code
Internal Control Number (ICN): Billed Amount
Is Medicare Primary? ☐ Yes ☐ No If no, are you participating with the primary? ☐ Yes ☐ No
Does this appeal involve an overpayment? ☐ Yes ☐ No
Provide the AR number or Letter Number (if available):

**Reason for disagreement with the initial determination:**
☐ Denied as a duplicate incorrectly ☐ Medicare Secondary Payer
☐ Medical Necessity ☐ Timely Filing (explain delay in filing)
☐ Other:

*Note: This form may be used for multiple claims that all contain the same issue. Attach a copy of the RA and indicate which claims should be corrected.*

**Requester Information**
*Printed Name: *Signature:
Telephone Number Date Signed:

**Mail to:**
JK: National Government Services, Inc. P.O. Box 7111 Indianapolis, IN 46207-7111
JE: National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46207-6475

The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your claim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the Centers for Medicare and Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

National Government Services, Inc.
10/05_0415

CMS

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# Medicare/RAC Appeals

- Demand Letter – Beneficiary Information
  - ➢Safeguards Through out the Process
    - Correct ID #s
    - Beneficiary Information

Centrex REHAB



# Medicare/RAC Appeals

- RAC (Recovery Audit Contractor) –
  - ➢**Letter # 4: MAC Receipt of Redetermination Appeal** (see example handout)-
    - Dated letter which comes from MAC
    - Opening paragraph confirms receipt of request for redetermination from the Qualified Independent Contractor (QIC)
    - The Account Receivable number is how you identify who the patient this is in reference to (same number on Post Payment Review Findings letter which has the patient name as well)

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# Medicare/RAC Appeals

- **MAC Receipt of Redetermination Appeal Letter**

8/25/2015

Provider Number

Dear Administrator,

This letter serves to notify you that we have received your request for redetermination or a notice from the Qualified Independent Contractor (QIC) regarding your request for reconsideration for the 935 Account Receivable (s) listed below. All collection processes have ceased; however, interest will continue to accrue on any outstanding unpaid balance of the overpayment as explained in our original demand letter.

| Demand Letter Date | Account Receivable Number | Status Code | Status Date |
|---|---|---|---|
| 07/30/2015 | | 935-APPEAL-REDETER | 08/24/2015 |

You will receive a notice once a decision has been made regarding your appeal.

Please refer to the original demand letter for specific claim information (HICN & Dates of Service) related to the receivable (s) listed above. If you have additional questions, please contact our office at (877) 702-0990. You may also visit us through our Web site at www.NGSMedicare.com

Centrex REHAB

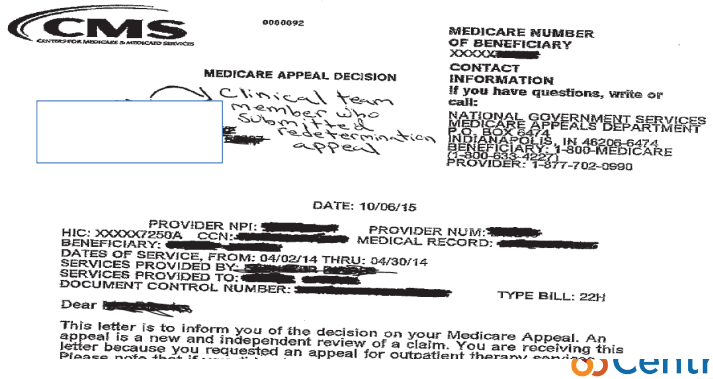
# Medicare/RAC Appeals

- **Letter # 5: MAC Decision of Redetermination Appeal Letter**
  - Dated letter which comes from MAC
  - To practice/facility within 60 days of receipt of Redetermination Appeal
  - Details the decision (can be fully in favor, partially in favor or disagree fully with appeal)
  - Letter includes a Reconsideration Appeal form (Level 2 appeal)



# Medicare/RAC Appeals

- **Letter # 5: MAC Decision of Redetermination Appeal Letter**



CMS

MEDICARE APPEAL DECISION

Clinical team member who submitted redetermination appeal

MEDICARE NUMBER OF BENEFICIARY
XXXXX[redacted]

CONTACT INFORMATION
If you have questions, write or call:
NATIONAL GOVERNMENT SERVICES
MEDICARE APPEALS DEPARTMENT
P.O. BOX 6474
INDIANAPOLIS, IN 46206-6474
BENEFICIARY: 1-800-MEDICARE
(1-800-633-4227)
PROVIDER: 1-877-702-0990

DATE: 10/06/15

PROVIDER NPI: [redacted] PROVIDER NUM: [redacted]
HIC: XXXXX7250A CCN: [redacted] MEDICAL RECORD: [redacted]
BENEFICIARY: [redacted]
DATES OF SERVICE, FROM: 04/02/14 THRU: 04/30/14
SERVICES PROVIDED BY: [redacted]
SERVICES PROVIDED TO: [redacted]
DOCUMENT CONTROL NUMBER: [redacted]
TYPE BILL: 22H

Dear [redacted]

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for outpatient therapy servic



# Medicare/RAC Appeals

- **Letter # 5: MAC Decision of Redetermination Appeal Letter**

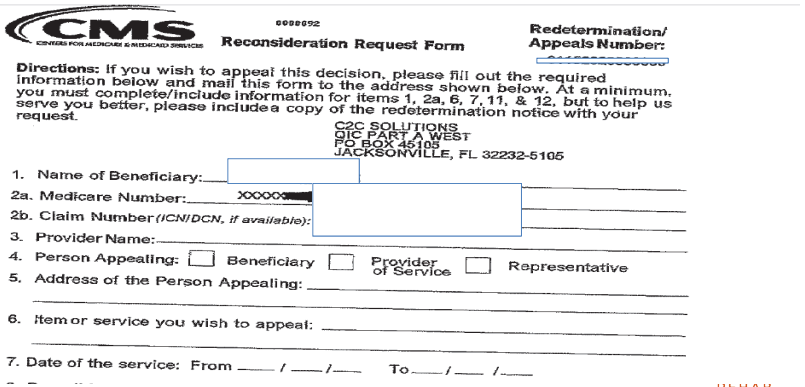
The appeal decision is unfavorable. Medicare cannot make payment for the services at issue in your appeal.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). Your appeal of this decision must be made in writing and received by the QIC within 180 days of receipt of this letter. You are presumed to have received this decision five days from the date of the letter unless there is evidence to show otherwise. However, if you do not wish to appeal this decision, you are not required to take any action.



# Medicare/RAC Appeals

- **Letter # 5: MAC Decision of Redetermination Appeal Letter – Reconsideration Form**



CMS

Reconsideration Request Form

Redetermination/ Appeals Number:

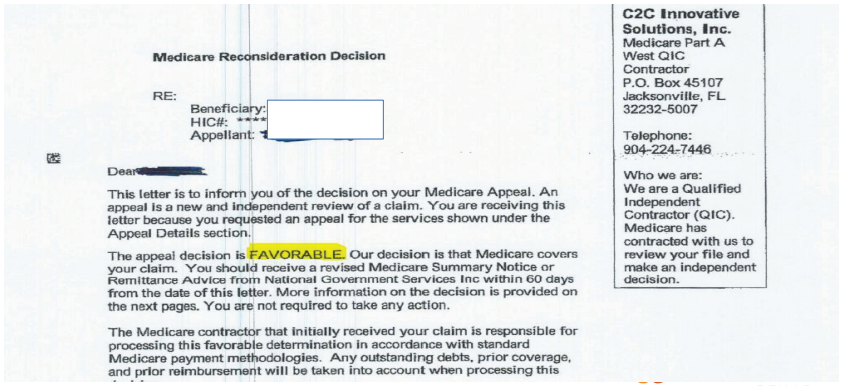
**Directions:** If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11, & 12, but to help us serve you better, please include a copy of the redetermination notice with your request.

C2C SOLUTIONS
QIC PART A WEST
PO BOX 45105
JACKSONVILLE, FL 32232-5105

1. Name of Beneficiary: [redacted]
2a. Medicare Number: XXXXX[redacted]
2b. Claim Number *(ICN/DCN, if available)*: [redacted]
3. Provider Name: [redacted]
4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative
5. Address of the Person Appealing: [redacted]
6. Item or service you wish to appeal: [redacted]
7. Date of the service: From [redacted] To [redacted]

# Medicare/RAC Appeals

- **Letter # 6: QIC Decision to Reconsideration Appeal**



**Medicare Reconsideration Decision**

RE:
Beneficiary:
HIC#: ****
Appellant:

Dear [redacted]

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for the services shown under the Appeal Details section.

The appeal decision is FAVORABLE. Our decision is that Medicare covers your claim. You should receive a revised Medicare Summary Notice or Remittance Advice from National Government Services Inc within 60 days from the date of this letter. More information on the decision is provided on the next pages. You are not required to take any action.

The Medicare contractor that initially received your claim is responsible for processing this favorable determination in accordance with standard Medicare payment methodologies. Any outstanding debts, prior coverage, and prior reimbursement will be taken into account when processing this

**C2C Innovative Solutions, Inc.**
Medicare Part A
West QIC
Contractor
P.O. Box 45107
Jacksonville, FL
32232-5007

Telephone:
904-224-7446

Who we are:
We are a Qualified Independent Contractor (QIC). Medicare has contracted with us to review your file and make an independent decision.



# Medicare/RAC Appeals

- **Appeal Levels 3 -5**
  - **3. Administrative Law Judge** (ALJ) – currently at least a 2 year back log; Minimum $ amount necessary (updated annually- currently $150)
  - **4. Review by the Appeals Council** within the Departmental Appeals Board in the Department of Health and Human Services
  - **5. Judicial review** in federal district court (effective 1/1/16 - $1,500)



# Medicare/RAC Appeals

- Appeals – What's a therapist and management team to do????



# Medicare/RAC Appeals

- Communication – Facility vs. small practice

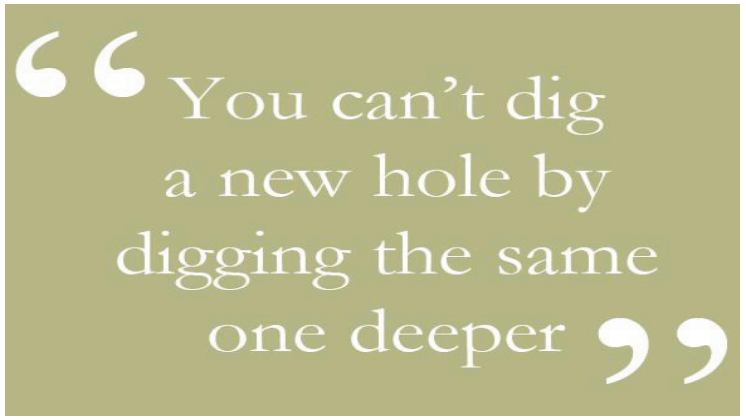
# Medicare/RAC Appeals
# "Alternative Payment System"

**A Time to Change**

https://www.youtube.com/watch?v=VrSUe_m19FY



# Medicare/RAC Appeals
# "Alternative Payment System"






# Medicare/RAC Appeals
# "Alternative Payment System"

- Alternative Payment System
  - Project Game Changer
  - Developing the APS model
  - Advocacy on Capitol Hill
  - Submissions to AMA RAC
  - January 2017 – Outpatient evaluation codes



# Medicare/RAC Appeals
# "Alternative Payment System"

•Demise of Fee-for-Service and opens the door for value-based payment.

http://hitconsultant.net/2015/05/11/death-fee-service-healthcare/


www.apta.org

# Shifting Risk in the Payment Reform Environment


Several key trends happening in how healthcare is delivered and paid for:

- Third party payment trends downward across all services and all third party payers
- Third party pay demanding greater accountability and quality
- Continued consolidation of providers, facilities and payers
- Consumers, including aging "boomers", demanding choice, access, efficiency for their medical needs



# Emerging Practice & Payment Models

ACOs

Bundled Payment

Community-Based Care Transitions

Coordinated Care/Chronic Conditions

PCMHs



# Value-Based Healthcare

**CMS:** to shift the incentives for payment from volume to value

- Demonstration of value must be communicated through documentation
- Timeline announced January, 2015:
  - 2016: 30% of FFS payments based on value and provided through alternative payment models
  - 2018: 50% of FFS payments based on value and provided under alternative models that base payments on quality of care

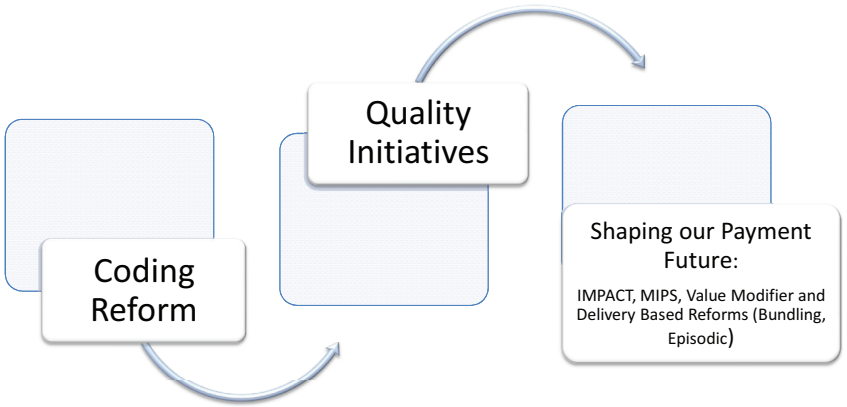
http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

**Health Care Transformation Task Force:** Commercial payers to shift 75% of operations to contracts designed to improve quality and lower costs by 2020

http://www.hcttf.org/



# PT: Pathway To Payment Reform



# Basic Concepts for Payment Reform Models

- More/different payment for redesigning care to achieve higher quality at lower cost
- Create responsibility for controlling/reducing other healthcare costs
- **Result**: Payer saves money, provider appropriately incentivized, patient benefits



# Payment Reform for Rehab Services: Timelines and Guidance

2015

- RUC-Eval codes
  - April: surveyed evaluation codes through RUC process.
  - September: presented survey results to RUC for establishment of Values to be considered by CMS for 2017 Fee schedule
- PM&R WG continues work on severity/intensity model for intervention codes.

2016

- February; reviewing progress achieved and payment environment to inform continued path forward.



# Big Picture: Key Factors in Determining Payment

A payment method based on the accurate and complete communication of the following:

- Completed Patient Assessment Instrument
- Evaluation of Clinical Presentation
- Treatment and management options planned and provided
- Demonstration of Value associated with achievement of functional outcomes



# 2017 Physical Therapy Evaluation & Reevaluation Codes

- **Evaluation Codes**
  - **Three codes:** low complexity evaluation, moderate complexity evaluation, high complexity evaluation.
  - **4 Components:**
    - Patient history and comorbidities,
    - Examination and the use of standardized tests and measures,
    - Clinical presentation, and
    - Clinical decision making.

## 2017 Physical Therapy Evaluation & Reevaluation Codes

- **Re-evaluation Code**
  - **Single Code**
  - All incorporate standardized tests and measures and patient assessment instrument or functional outcome measure.



## Overview of New Evaluation Structure: Defining Process

***Process***: Patient presentation upon evaluation includes determining their overall **severity and complexity:**

- History (medical, functional)
- Examination
  - Physical impairment
  - Impact on the patient ability to function
  - Cognition
  - Living environment



## Overview of New Evaluation Structure: Defining Process

- 3 levels of complexity:
  - Low
  - Moderate
  - High
- The level of the PT evaluation dependent on clinical decision making and the nature of the condition (severity)



## Overview of New Evaluation Structure: Defining Process

- Also part of the evaluation process:
  - Development of plan of care
  - Coordination, consultation and collaboration of care with physicians, other QHP's or agencies

## Overview of New Evaluation Structure: Defining Process

- Clinical Judgment
  - To achieve good outcomes, therapist uses clinical judgment to determine the overall severity of their complaints/condition and make appropriate decisions regarding interventions to use in treatment based on this patient assessment, at each encounter or session supported as much as possible by current best evidence.



## Overview of New Evaluation Structure: Defining Process

**History:**

- Assists in supporting level of evaluation by addressing;
- Comorbidities that impact function and ability to progress through a plan of care
- Previous functional level, context of current functional abilities and
- Treatment approaches in past if applicable and other factors that may impact patients ability to progress and reach goals
- Provides rationale: Medical necessity for level of evaluation reported



## Overview of New Evaluation Structure: Defining Process

**Personal Factors:** Contextual Factors that influence how disability is experienced by the individual

- Include sex, age, coping styles, social background, education, profession, past/current experience
- Overall behavior patterns, character
- Other factors that influence how disability is experienced by the individual
- **IF NO IMPACT ON PLAN OF CARE, SHOULD NOT BE CONSIDERED WHEN SELECTING LEVEL OF SERVICE**



## Overview of New Evaluation Structure: Defining Process

- **Body Regions:** Head, neck, back, lower extremities, upper extremities, and trunk
- **Body Structures:** Structural or anatomical parts of body, such as organs, limbs and their components classified according to body systems
- **Body Systems:** Musculoskeletal, neuromuscular, cardiovascular pulmonary, and integumentary

Review of Body Systems would include.....

## Overview of New Evaluation Structure: Defining Process

- 4 primary elements that will inform your choice of the level of evaluation:
  - History
  - Examination
  - Presentation
  - Clinical Decisions Making
- Must communicate information regarding these elements and then decide what level of Evaluation to report



## Alternative Payment System

### CPT Code Revisions
### PT Evaluation- Low Complexity

| History | Examination | Presentation | Decision-Making |
|---|---|---|---|
| Problem focused, No personal factors and/or comorbidities that impact POC | Problem focused, addressing 1-2 body structures and functions, activity limitations and/or participation restrictions | Stable and/or uncomplicated characteristics | Low complexity, use of standard patient assessment instrument and/or measurable assessment of functional outcome |



## Alternative Payment System

### CPT Code Revisions
### PT Evaluation- Moderate Complexity

| History | Examination | Presentation | Decision-Making |
|---|---|---|---|
| Expanded, 1-2 personal factors and/or comorbidities that impact POC | Expanded, addressing 3 of any of the following body structures and functions, activity limitations and/or participation restrictions | Evolving with changing characteristics | Moderate complexity, use of standard patient assessment instrument and/or measurable assessment of functional outcome |



## Alternative Payment System

### CPT Code Revisions
### PT Evaluation- High Complexity

| History | Examination | Presentation | Decision-Making |
|---|---|---|---|
| comprehensive, 3 or more personal factors and/or comorbidities that impact POC | Comprehensive, addressing 4 or more of any of the following body structures and functions, activity limitations and/or participation restrictions | Unstable and unpredictable characteristics | High complexity, use of standard patient assessment instrument and/or measurable assessment of functional outcome |

## CPT Code Revisions
## PT Re-evaluation

- Single level
- Established Plan of Care
- An examination including a review of history and use of standardized tests and measures is required
- Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome

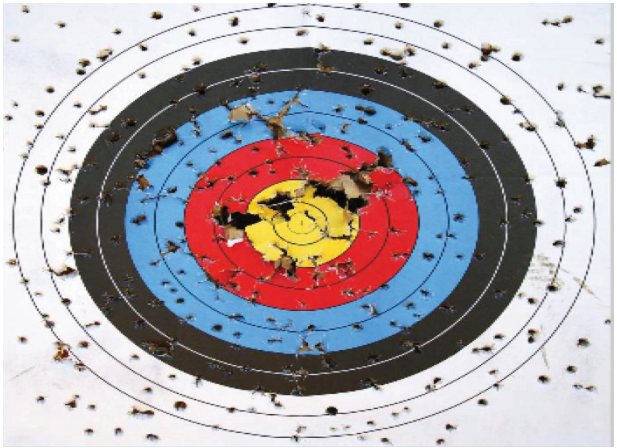


## Reporting Levels of Evaluations: Reflecting Physical Therapists Clinical Decision Making

- Reflect complexity of patient in order to better determine the management path
- Assessment tools at the front end, outcomes reported at the back end begin to differentiate how patients are managed for potential development of reformed payment model
- Address issue of variation in care



## Goal: Decrease the Variation in Care





## Payment and the RUC Process:
### Timeline for Evaluation codes

**Evaluation RUC Survey Analysis**

July 2015: Survey closed

July through August 2015: Data analysis w/ member experts

September 2015: RUC recommendations due to AMA

**Evaluation Code Launch**

October 2015: Recommendations presentation to the RUC

**July 2016: MPFS proposed rule (comment period)**

**January 2017: Potential implementation**

**Refinement of Intervention Codes**

Currently regrouping and strategizing on next steps

RUC process will impact in some way either current codes or revised codes

## Misvalued Code List (CMS)

- **Potentially Misvalued Codes**
  - 97032 – Electrical Stimulation
  - 97116 – Gait Training
  - 97035 – Ultrasound
  - 97140 – Manual Therapy
  - 97110 – Therapeutic Exercise
  - 97530 – Therapeutic Activities
  - 97112 – Neuromuscular Reed.
  - 97535 – Self-Care/Home Mgmt.
  - 97113 – Aquatic Therapy
  - G0283 – E-Stim Other Than Wound



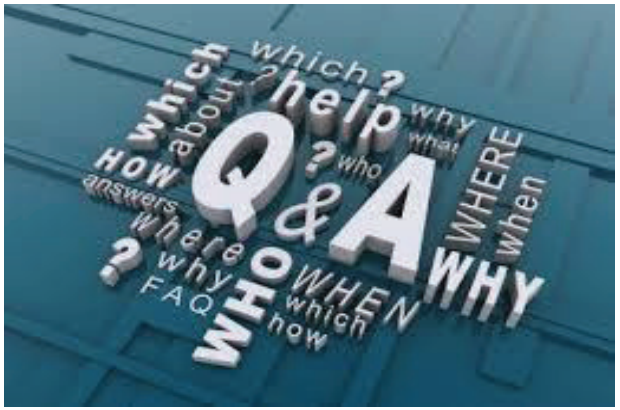
## Succeeding when Appealing Medicare Denials – The Art of the Defense

- Resources

1) Medicare Parts A & B Appeals Process, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf
2) Medicare Overpayments, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/overpaymentbrochure508-09.pdf
3) Recovery Audit Contractors Claims Review Process and Medicare Appeals Process, http://www.rycan.com/Documents/RACFlowChart.pdf
4) Alternative Payment System (APTA), http://www.apta.org/PaymentReform/
5) Center for Integrity In Practice (APTA; Includes a free 0.2 CEU webinar), http://integrity.apta.org/home.aspx?navID=10737435752



## Succeeding when Appealing Medicare Denials – The Art of the Defense






## Succeeding when Appealing Medicare Denials – The Art of the Defense

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mmesibov@centrexrehab.com