Home Health Audits: ADR/RA/ZPIC

PRESEN TED BY:
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RA - Common Questions?

- What is a RA?
- What does a RA do?
- What are the providers’ options?
- What can providers do to get ready?
Contract Issues with RAs

- **January 14, 2015** – Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract. Questions regarding the protest may be directed to the GAO. CMS will post updates on this website, as appropriate.

- **December 30, 2014** – CMS has awarded the Region 5 Recovery Audit contract to Connolly, LLC. The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission through the identification and correction of improper payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and home health/hospice (HH/H) claims submitted under Title XVIII of the Social Security Act (the Act). The Recovery Auditor will review all applicable claims types through the appropriate review methods and work with CMS and the DME and HH/H MACs to adjust claims to recoup overpayments and pay underpayments.

- **November 4, 2014** – Procurement Update: The new contracts for Recovery Auditor Regions 1, 2, and 4 remain under a pre-award protest, which is expected to continue into late summer of 2015. However, the procurement process continues for Region 3 (Part A / Part B claim reviews), which includes Florida, Tennessee, Alabama, Georgia, West Virginia, Virginia, North Carolina and South Carolina; and, for Region 5, which will be the national contract for DMEPOS and Home Health & Hospice claim reviews. The CMS remains hopeful that these two new contracts will be awarded before the end of this year.

RA Scope of Work

- The RAs are tasked with detecting and correcting **PAST** improper payments so that CMS and Carriers/MACs can implement actions that will prevent future improper payments:
  - **Providers** can avoid submitting claims that do not comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** and future Medicare beneficiaries are protected
RA Scope of Work

- RAs review claims on a post-payment basis
- RAs use the same Medicare policies as Carriers and MACs: NCDs, LCDs and CMS Manuals
- Two types of review:
  Automated (no medical record needed)
  Complex (medical record required)
- RAs will be able to look back three years from the date the claim was paid

The Collection Process

- Same as for Carrier and MAC identified overpayments (except the demand letter comes from the RA)
  - Carriers, and MACs issue Remittance Advice - Remark Code N432: Adjustment Based on Recovery Audit
- Carrier/MAC recoups by offset unless provider has submitted a check or a valid appeal
What is Different?

- Demand letter is issued by the RA
- RA will offer an opportunity for the provider to discuss the improper payment determination with the RA (this is outside the normal appeal process)
- Issues reviewed by the RA will be approved by CMS prior to widespread review
- Approved issues are posted to RA website before widespread review

What are Providers’ Options?

If you agree with the RAs determination:
- Pay by check
- Allow recoupment from future payments
- Request or apply for extended payment plan

If you disagree with the RA’s determination:
- **APPEAL**

Appeal Timeframes

Ensure Accuracy

- Each RA employs:
  - Certified coders – Nurses – Therapists - A physician: CMD
- CMS’ New Issue Review Board provides greater oversight
- RA Validation Contractor provides annual accuracy scores for each RA
- If a RA loses at any level of appeal, the RA must return its contingency fee!!

2015 RA Improvements

- CMS will establish ADR limits based on a provider’s compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits. The ADR limits will be adjusted as provider’s denial rate decreases, ensuring the provider that complies with Medicare rules has less Recovery Audit reviews.
- Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. This provides more immediate feedback to the provider on the outcome of their reviews.
- Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.
2015 RA Improvements

- Recovery Auditors will not receive a contingency fee until after the second level of appeal is exhausted. Previously, Recovery Auditors were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare’s statutes, coverage determinations, regulations and manuals.
  - Note: if claims are overturned on appeal, providers are paid interest calculated from the date of recoupment. For more information please visit.
- Recovery Auditors will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to do so will result in CMS placing the Recovery Auditor on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions.

Zone Program Integrity Contractors (ZPIC)

- Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:
  - Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
  - Conducting investigations in accordance with the priorities established by CPI’s Fraud Prevention System;
  - Performing medical review, as appropriate;
  - Performing data analysis in coordination with CPI’s Fraud Prevention System;
  - Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
  - Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.
Zone Program Integrity Contractors (ZPIC)

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.

Additional Development Requests

- Request for medical records
- Information request for ADR obtained through either DDE system
- Have limited time period to respond – 30 days
- This is a prepayment review which occurs at the point of billing
Top 10 ADR Denials - PGBA

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># Claims</th>
<th>% Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>997</td>
<td>49.9</td>
</tr>
<tr>
<td>2</td>
<td>56900</td>
<td>Auto Deny - Requested Records not Submitted</td>
<td>413</td>
<td>20.7</td>
</tr>
<tr>
<td>3</td>
<td>5F041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>159</td>
<td>8.0</td>
</tr>
<tr>
<td>4</td>
<td>5A041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>122</td>
<td>6.1</td>
</tr>
<tr>
<td>5</td>
<td>5F012</td>
<td>Physician's Plan of Care and/or Certification Present - Signed but Not Dated</td>
<td>73</td>
<td>3.7</td>
</tr>
<tr>
<td>6</td>
<td>5FN0A</td>
<td>Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted</td>
<td>67</td>
<td>3.4</td>
</tr>
<tr>
<td>7</td>
<td>5F011</td>
<td>Physician's Plan of Care and/or Certification Present - No Signature</td>
<td>49</td>
<td>2.5</td>
</tr>
<tr>
<td>8</td>
<td>5CHG3</td>
<td>MR HIPPS Code Change Due to Partial Denial of Therapy</td>
<td>48</td>
<td>2.4</td>
</tr>
<tr>
<td>9</td>
<td>5CHG1</td>
<td>MR HIPPS Code Change/Doc Contradicts MO Item(s)</td>
<td>47</td>
<td>2.4</td>
</tr>
<tr>
<td>10</td>
<td>5F023</td>
<td>No Plan of Care or Certification</td>
<td>25</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Therapy Auto Edit - PGBA

- Home Health Insurance Prospective Payment System (HIPPS) Codes 2CGK* and 1BGP* in Four Regions Medical Review Results
  - Current codes PGBA is focused on is 2CGL* & 2BGL*
  - The J11 Medical Review Department performed a service-specific prepay targeted medical review on claims for 2CGK* and 1BGP* (variable last digit of HIPPS codes).

2CGK* - Midwest Results

<table>
<thead>
<tr>
<th>Percent of Total Denials</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.2%</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
<tr>
<td>25.2%</td>
<td>5A041</td>
<td>Info Provided Does Not Support Medical Necessity for This Service</td>
</tr>
<tr>
<td>25.2%</td>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>22.2%</td>
<td>5FN0A</td>
<td>Appropriate OASIS Not Submitted</td>
</tr>
</tbody>
</table>
**1BGP* - Southwest Results**

Of the 404 claims reviewed, 119 were either completely or partially denied, resulting in a claim denial rate of 29.5 percent. A total of $1,297,204.64 charges was reviewed with $322,719.47 denied, resulting in a charge denial rate of 24.9 percent. The major denial reasons identified were:

<table>
<thead>
<tr>
<th>Percent of Total Denials</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.1%</td>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely Services Not Documented</td>
</tr>
<tr>
<td>31.6%</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
<tr>
<td>9.3%</td>
<td>5F012</td>
<td>Physician’s Plan of Care and/or Certification Present – Signed but Not Dated</td>
</tr>
<tr>
<td>4.7%</td>
<td>5F011</td>
<td>Physician’s Plan of Care and/or Certification Present – No Signature</td>
</tr>
</tbody>
</table>

**RA Approved Edits for Chart Selection**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>CMS Approved Issues</th>
<th>RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td>Post-pay review of outpatient therapy claims above $3,700 threshold</td>
<td>CGI, Connolly, HDI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>Pre-pay review of outpatient therapy claims above $3,700 threshold</td>
<td>CGI</td>
</tr>
<tr>
<td>HH</td>
<td>Skilled nurse episodes beyond third episode</td>
<td>CGI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>No skilled service</td>
<td>CGI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>Medical necessity</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Request for Anticipated Payment (RAP) without corresponding final claim</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Incorrect billing of partial episode payment (PEP) adjustment</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Hospice related services billed by HH</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Outcome &amp; Assessment Information Set (OASIS) assessment not completed timely</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Episodes with five to nine visits</td>
<td>HDI</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice claims for more than 20 contiguous months</td>
<td>Performant</td>
</tr>
<tr>
<td>Hospice</td>
<td>Excessive units of physician services; face-to-face (FTF) encounter documentation</td>
<td>HDI</td>
</tr>
</tbody>
</table>
RA Record Requests

Medical Records Requests
- Once a provider has received a request from the RAC for supporting documentation, the medical records must be submitted within 45 calendar days. More time may be asked for by the provider as long as the extension request is received by the RAC prior to the 45th day.
- The RA has 60 days to review the chart and return findings

RA Approved Edits: Hospice Related Services

**Issue Name:** Hospice related services billed with Condition code 07-Home Health: C000802012

**Description:** Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

**Provider Type Affected:** Home Health
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Region C
**Additional Information:** 1) CMS Pub 100-04, Chapter 11, section 50 2) Medicare Benefit Policy 100-02, Chapter 9, sections 10 and 40.1.9
RA Approved Edits: Incorrect Billing of HH PEP

**Issue Name:** Incorrect billing of Home Health Partial Episode Payment claims
**CMS Issue Number:** C002022011

**Description:** Incorrect billing of Home Health Partial Episode Payment (PEP) claims identified with a discharge status 06 and another home health claim was not billed within 60 days of the claim from date. Additionally, MCO effective dates are not within 60 days of the PEP claim.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Multiple States

**Additional Information:** "Additional information can be found in the following manuals/publications:

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RA Approved Edits: Medical Necessity

**Issue Name:** Home Health Agency - Medical Necessity and Conditions to Qualify for Services Issue Number: C002222011

**Description:** Medical record will be reviewed to validate that the Home Health Services provided were both reasonable and medically necessary, and that the patient met the conditions to qualify for Home Health Services.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Multiple States

**Additional Information:** Additional information can be found in the following manuals/publications: Medicare Benefit Policy Manual Publication 100-02 Chapter 7
RA Approved Edits: Possible LUPAs

**Issue Name:** Home Health Services for 5 to 9 Visits: D0004220103

**Description:** Medical documentation will be reviewed to determine that services for only 5 to 9 services within a 60-day episode were medically reasonable and necessary and not subject to the LUPA adjustment.

**Provider Type Affected:** HHA

**Date of Service:** Within Three Years prior to demand date

**States Affected:** Numerous

**Additional Information:**
- CMS Publication 100-02 Medicare Benefit Policy Manual: Chapter 7, Section 10.7 - Low Utilization Payment Adjustment (LUPA)
- Chapter 7, Section 20 - Conditions To Be Met for Coverage of Home Health Services
- Chapter 7, Section 20.1 - Reasonable and Necessary Services
- Chapter 7, Section 40.1 - Skilled Nursing Care
- CMS Publication 100-04 Medicare Claims Processing Manual: Chapter 10, Section 10.1.17 - Low Utilization Payment Adjustment (LUPA)
- Social Security Act: 1862A(1)a and 1862A(1)i - Exclusions from Coverage and Medicare as Secondary Payer (42 U.S.C. 1395y)

OIG Report 2013

**Medicare Contractors’ Activities To Detect and Deter Fraud**

- CMS contracts with several entities, including Program Safeguard Contractors, Medicare Drug Integrity Contractors, Recovery Audit Contractors, and Zone Program Integrity Contractors (ZPICs), to perform many Medicare integrity functions. OEI-04-11-00220 December 2012
  - Home Health Agencies—The two CMS Medicare Administrative Contractors we reviewed prevented $275 million in home health agency (HHA) improper payments and referred several instances of potential fraud, but the four ZPICs we reviewed, which served fraud-prone geographic areas, did not identify any HHA-specific vulnerabilities and varied substantially in their efforts to detect and deter fraud. (OEI-04-11-00220—Home Health Agencies—CMS and Contractor Oversight of Home Health Agencies.)
Complete Review Packet

- Need to obtain all information on patient requested
- Perform both clinical and billing audit
- Compare that information with any previous audits which may have been completed
- Review ADR notice to determine if you have reviewed all requested information and if all copies were made

What to Review

- Are all physician orders present and signed?
- Do all clinicians follow POC and additional MD orders?
- Is there clear documentation to support all ordered skills?
- Is the documentation specific – especially for wound care, IV administration, flushes, injectables, etc.?
Additional Information to Review

- Does every visit have an order to support the frequency? Are there orders for any PRN visits performed and is the need for the PRN visit valid?

- Are all supplies which are used ordered?

- If the medication profile is requested, are all medications listed and updated? (This will include any medications documented on during the course of the episode).

Common Denial Reason Codes

- Inadequate Face to Face Documentation

- Medical Review Down Code – Lack of Medical Necessity

- Primary Diagnosis found on OASIS and POC is not the condition most related to the Plan of Care

- Contradictions between OASIS documentation and ongoing clinical notes

- Unsigned/Dated or missing orders for services provided.
Medical Necessity

- **Submitted information does not support medical necessity for the care**
- Does the documentation support reasonable and medically necessary care for this patient
- Clinical information on the OASIS, POC and ongoing clinical documentation vary. This is why correct documentation is so important, both clinically and financially.

Corrective/ProActive Plan

Develop Practice of Compliance

- Implement & reinforce clear message of compliance at all times
- Increase ease for maintaining compliance through training & ongoing monitoring
- Must have authority to enforce
Corrective/ProActive Plan

Identify Current Risks

- Identify program integrity initiatives & common billing/payment errors
- Assess your agency’s greatest areas of risk
- Identify data needs to monitor risk areas

Corrective/ProActive Plan

Establish Compliance Monitoring Processes/Tracking

- Establish documentation controls
- Assign compliance responsibilities to appropriate personnel
- Implement compliance with billing
- Establish tracking of individual personnel & process compliance
- Review tracking to identify compliance trends
Corrective/ProActive Plan

Test Compliance Processes
- Develop timeline for testing compliance: quarterly, annually, etc
- Third set of eyes – random peer reviews
- Pre & Post Billing reviews of claims compared to medical record documentation, including manual & electronic documentation

Provider Relations Coordinator

- CMS established the Provider Relations Coordinator to improve communication between providers and CMS. Although providers should continue to take questions about specific claims directly to the Recovery Auditor or Medicare Administrative Contractor (MAC) who conducted the review, providers can raise larger process issues to Coordinator. For example, if a provider believes that a Recovery Auditor is failing to comply with the documentation request limits or has a pattern of not issuing review results letters in a timely manner, CMS would encourage the provider to contact the Provider Relations Coordinator.

- Providers can also send suggestions about how to improve the Recovery Auditor or MAC medical review process to the CMS Provider Relations Coordinator.

- The CMS Provider Relations Coordinator is: Latesha Walker.

- Providers may contact Latesha by sending an email to:
  - RAC@cms.hhs.gov (for Recovery Auditor review process concerns/suggestions)
  - MedicareMedicalReview@cms.hhs.gov (for MAC review process concerns/suggestions)
Online Links

RA Website:  http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/


Program Integrity Manual:  

Thank You For Listening!
Please Complete Evaluations!

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