




Bungle In The Jungle

Who Are These Guys &
Why Do They Want My Records?


Bungle In the Jungle

- ▶ Why CMS needs to have contractors
- ▶ Who are the primary contracted entities
- ▶ What are the relationships between the entities
- ▶ What happens when records are reviewed
- ▶ Strategies to avoid edits
- ▶ Due process



How Bungle Gets Started

- ▶ Congress passes laws/rules
- ▶ Depending on content of law/rule – sent to appropriate department (Health & Human Services, Defense, Interior, etc.)
- ▶ From Department to Division
 - CMS, CDC, FDA, OIG, etc.
- ▶ Division
 - Translating law/rule to operations
 - Role of Public Health Service



How Bungle Gets Started

- ▶ Division (cont'd)
 - Apply the new rules to the appropriate providers/players
 - Audit the providers/players to assure appropriate applications and use of resources



When Bungle is CMS

- ▶ Centers for Medicare and Medicaid Services (formerly HCFA)
 - Rules are often written by non-medical persons
 - Published in the Federal Register
 - Comment periods
 - Unless a statement/item has a comment, no change can happen in final rule
 - Final rule is published
 - Once published – applied




When Bungle is CMS

- ▶ CMS as a Contractor
 - Medicare
 - Medicaid
 - Children's Health Insurance Program




When Bungle is CMS

- ▶ CMS as a Contractor
 - Cannot directly administer all aspects of Medicare or Medicaid
 - Processing claims
 - Monitoring compliance
 - Enrollment of providers
 - Education of beneficiaries and providers




When Bungle is CMS

- ▶ CMS Contractors
 - MACS
 - Medicare Administrative Contractors
 - Pay the bills for Medicare Part A & B
 - RACS
 - Recovery Audit Contractors
 - Bounty hunters for previously paid claims
 - ZPICS
 - Zone Program Integrity Contractors
 - Fraud investigators for all aspects of Medicare (Part A, B, C & D)
 - MICS
 - Medicaid Integrity Contractors




When Bungle is CMS

- ▶ CMS Contractors (cont'd)
 - CERT
 - Contractor Error Rate Testing
 - Verify the MACS are paying claims correctly
 - PSCS
 - Payment Safeguard Contractors
 - Fraud investigators working with the MACS
 - MFCUS
 - Medicaid Fraud Control Units
 - Fraud investigation in Medicaid
 - SSAS
 - State Survey Agencies
 - Survey providers for compliance with COPS




Who Can Make CMS Tremble in the Jungle?

- ▶ **OIG**
 - Office of Inspector General
 - Contracted by Health and Human Services
- ▶ **HEAT**
 - Healthcare Fraud Prevention and Enforcement Action Team
 - Task force of DOJ & H&HS to fight fraud and waste
 - Created in 2009




How CMS's Brand of Bungle Works

- ▶ **MACS**
 - Progressive Corrective Action
 - CMS sets the process
 - Consistency across MACs/RHHIs
 - Use of data to identify areas for scrutiny
 - Provider education and policy development is key




CMS's Brand of Bungle

- ▶ **Claims review**
 - Vulnerabilities
 - 5 visits vs. LUPA
 - Types of visits
 - Percentage of outliers
 - High case mix weights




CMS' Brand of Bungle

- ▶ Edits
 - Widespread to look for patterns in claims
 - Evaluated quarterly
 - Examples of current widespread edits
 - 5 skilled visits - 4 nursing, 1 MSW
 - Daily skilled visits > 60 days
 - Late episodes with diagnosis of COPD/Parkinson's
 - Lengths of stay > 2 years




CMS' Brand of Bungle

- ▶ Provider specific
 - Probe edit & notification - begins with outlier data
 - Evaluated for effectiveness
 - Provider's quarterly denial stats evaluated - not all go onto target review




CMS' Brand of Bungle

- ▶ Beneficiary Specific
 - When a previous episode has been denied/non-covered
 - Could come from widespread or provider specific
 - Claim suspended for medical review based on identification of the beneficiary




CMS' Brand of Bungle

- ▶ Results from provider specific probe review
 - Provider notified by letter
 - Denial data
 - Education/resources/contacts
 - Provider on targeted review for 3 months
 - Effectiveness of all edits evaluated quarterly




CMS' Brand of Bungle

- ▶ Notified each quarter in writing
 - Edit discontinued
 - Continue on targeted review
 - Potential referral to Payment Safeguard Contractors or even OIG




CMS' Brand of Bungle

- ▶ Claim is submitted
Provider submits a claim to the MAC/RHHI
- ▶ FISS starts to process (Fiscal Intermediary Shared System)
 - Claim matches edit parameters and is selected for review




CMS' Brand of Bungle

- ▶ FISS begins processing
 - FISS moves claim to S B60001 (can look up online)
 - ADR message is generated in FISS




CMS' Brand of Bungle

- ▶ Provider receives and responds to the ADR (additional development request)
 - Have internal processes to query the FISS no less than weekly for ADR messages
 - Screen print the image
 - If paper billing - review the weekly 201



CMS' Brand of Bungle

- Provider collects and copies requested information/documentation
- Provider attaches copy of the claim page 07 to the top of the record



CMS' Brand of Bungle

- ▶ Review the documentation prior to sending to MAC/RHHI
- ▶ Mail requested documentation within **30 days** from date claim moved to S B6001



CMS' Brand of Bungle

- ▶ Situation I
 - Provider does NOT respond (doesn't know a request for the record has been made or didn't respond quickly enough)
 - Claim automatically denied on day 46 for insufficient information
 - Move the claim to D B9997




CMS' Brand of Bungle

- ▶ Now what do we do?
 - Have up to 120 days to appeal
 - Record goes to redetermination status




CMS' Brand of Bungle

- ▶ Situation II
 - Provider responds
 - Billing or designated person notes the request on the RA or online
 - Record is copied and sent to intermediary in a timely fashion
 - Claim is moved to S M50MR or S M51MC by day 45
 - Review begins




CMS' Brand of Bungle

- ▶ MAC reviews claim
 - Nurse consultant does review
 - May access the Medical Director
 - Have up to 60 days to complete review
 - Decision is then keyed into FISS




CMS' Brand of Bungle

- ▶ Provider receives denial information
 - Look in FISS on claim page 2
 - Review 'remarks' on page 4
- ▶ Review denial reason and compare with record
 - Why denied
 - Was there more info that should've gone
 - Inappropriate patient for the service
 - Technical issues (unsigned orders, etc.)




CMS' Brand of Bungle

- ▶ Identify action plan to correct further denials
 - Education on documentation
 - If missed sending all appropriate info - look at process and prepare for appeal




CMS' Brand of Bungle

- ▶ Implement plan
- ▶ Submit request for redetermination (if appropriate)
 - Review the whole client record - including HHA notes



CMS' Brand of Bungle

- ▶ Have 120 days to appeal to the MAC/RHHI (from day of denial)
 - Can include new info
- ▶ MAC/RHHI has 60 days to issue decision
- ▶ If denial upheld, have 180 days to appeal to the QIC (Quality Independent Contractor)
- ▶ Next level is ALJ



CMS' Brand of Bungle

- ▶ Must file within 60 days of the QIC denial
- ▶ Cannot include any new info
- ▶ Instructions on appeal are in denial letter from the QIC
- ▶ Letter will be sent with the details for the hearing (done by telephone conference)
- ▶ Decision made by judge within 90 days



CMS' Brand of Bungle

- ▶ Watch timelines
- ▶ You CAN appeal an ADR that you missed
- ▶ No further documentation is needed to go to the ALJ




CMS' Brand of Bungle

- ▶ Can appeal an ALJ denial
- ▶ Next level is Medicare Appeals Council
 - Have to request hearing in writing
 - MAC has 90 days to review and decide
- ▶ Can appeal a MAC denial – but must have at least \$1880 at stake




When Bungle is a ZPIC

- ▶ ZPICS
 - Missouri is in Zone 2
 - Contract awarded to AdvanceMed
 - Finalized October 2010
 - Based in Omaha
 - Reviewers are nurses




When Bungle is a 'ZPIC'

- ▶ ZPIC
 - Audit all aspects of Medicare
 - Part A, B, C & D
 - Audit by HIC number
 - Apply *all* rules when reviewing
 - Focus in Medicare fraud and investigation
 - Medicare data analysis
 - Medical review - matching clinical to coding
 - Review of cost reports
 - Interface with law enforcement



When Bungle is a MIC

- ▶ Medicaid Integrity Contractors
 - Review XIX claims for fraud, waste or abuse
 - Have a 5 year 'look-back'
 - Established in 2005 DRA
 - Three 'arms'
 - Review
 - Education
 - Audit
 - Missouri is covered by AdvanceMed



When Bungle is Called 'OIG'

- ▶ Created in October 1978
 - Appointed by the President
 - Charged with 'Keeping the Integrity of the Department of Health and Human Services programs, as well as the health and welfare of the beneficiaries of those programs'
 - Reports to both the Secretary of DHSS and Congress



When Bungle is Called 'OIG'

- ▶ 2011 Home Health Work Plan
 - Part B payments for HH beneficiaries
 - Medical supplies & services
 - Qualifications of beneficiaries for the Home Health benefit
 - Homebound
 - Intermittent skilled care
 - Under care of physician
 - Plan periodically reviewed by a physician
 - Accuracy of the HHRGs (2008 claims)



When Bungle is Called 'OIG'

- ▶ 2011 Home Health Work Plan (cont'd)
 - Prospective payment system controls
 - Trend analysis of claims, visits, arrangements with other facilities and ownership information
 - Looking from 2000 forward
 - Home health agency profitability
 - Review cost report data
 - Look at how reimbursement methodologies should be adjusted
 - Compare free-standing with hospital-based HHAs



When Bungle is Called 'OIG'

- ▶ 2011 Home Health Work Plan (cont'd)
 - Home health agency enrollment
 - Previously had seen DME suppliers who omitted or provided inaccurate info on enrollment applications – which led to improper enrollment
 - These suppliers were often associated with Home Health Agency owners and/or managers
 - Reviewing for integrity of enrollment/ownership



When Bungle is Called 'OIG'

- ▶ 2011 Other Providers
 - Hospice utilization in nursing facilities
 - Follow up of OIG report showing 82% of hospice claims for beneficiaries in nursing homes did not meet criteria
 - Services provided to Hospice beneficiaries in nursing homes
 - Focus on hospice-based home health aides
 - Focus on GIP claims




State Survey Agencies & the CMS Jungle

- ▶ Revised State Operations Manual
 - February 2011
 - Scripts the survey process
 - Defines thresholds for OBQI/OBQM
 - Some interpretive guideline revisions
 - Available at:
http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_11.pdf



State Survey Jungle

- ▶ Revised State Operations Manual
 - Becomes effective May 1, 2011
 - Complaint surveys based on "significant number of complaints"
 - Defines levels of surveys
 - Level 1
 - Lists *highest priority* standards
 - If organization shows compliance with these COPs, highly likely they are in compliance with all COPs
 - Level 2
 - Partial extended survey
 - Lists next highest priority standards



State Survey Jungle

- ▶ Revised State Operations Manual (cont'd)
 - OASIS transmission error report thresholds
 - Error codes
 - 262 - Inconsistent M0090 date
 - Trigger at 20%
 - 1003 - Inconsistent effective date sequence
 - Trigger at 10%
 - 1002 - Inconsistent record sequence
 - Trigger > 10%

If any of these errors meet thresholds, indicates need for partial extended survey


Bungle Repellant & Slashing Through the Jungle

- ▶ Keys to Clinical Success
 - Documentation
 - Homebound
 - Objective
 - Measureable
 - Consistent
 - Skill
 - Criteria
 - Nursing
 - Therapy




Bungle Repellant & Slashing Through the Jungle

- ▶ Keys to Clinical Success
 - OASIS
 - Support for skill
 - Support for homebound
 - Consistency in OASIS
- ▶ Keys to Compliance Success
 - Billing audit
 - Orders for all visits
 - Visits for all orders
 - Role & use of ranges




Bungle Repellant & Slashing Through the Jungle

- ▶ Keys to Compliance Success
 - Update diagnoses at recertification
 - Review goals and interventions
 - Signature requirements
 - No stamped dates
 - No stamped signatures
 - Legibility issues




Bungle Repellant & Slashing Through the Jungle

- ▶ Keys to Compliance Success
 - Triggers for RAC reviews
 - Health Data Insights
 - Current focus areas affecting home health
 - Bundled supply payments
 - Post focus areas on website:
<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx?State=MO>



Bungle Repellant & Slashing Through the Jungle

- Triggers for RAC reviews
 - Look back of 3 years
- ▶ Vulnerabilities of RAC reviews
 - GAO study March 2010
 - 60% of most significant RAC identified vulnerabilities in CMS have not yet been implemented
 - Primarily linked to DME
 - Focus of RAC reviews is \$\$ – not fraud
 - Have educated the RAC contractors on how to refer if during review, concern of fraud is discovered



Congratulations, Bwana – You Have Tamed Bungle and Now Own the Jungle!

