Noridian at Your Service

CHA
January 2014
Bernice R Hecker MD, MHA, FACC
Agenda

• Noridian Health Care Solutions
  – Stewardship: collaboration
• Medicare Audits
  – Reviews and reviewers
• Documentation
• Appeals
Noridian Purpose

- Our purpose is to deliver affordable solutions to improve the care and health of those we serve.
Noridian: Medicare Administration

- 1966: Blue Cross Blue Shield of ND
- 1998: Noridian Mutual Insurance Company
- 2002: Noridian Administrative Services, LLC
- 2013: Noridian Health Care Solutions
JE MAC

• Medicare Administrative Contractor
  – Claims processor = payment
    • Handles all the money
    • Consolidation of FI and Carrier
    • FAR and competitive bidding
  – Coverage
  – Medical Review
  – Adjudication & redeterminations (appeals)
  – Provider education
  – Enrollment
Medical Directors

- Dr. Charles Haley: Parts A and B
- Dr. Bernice Hecker: Parts A and B
- Dr. Arthur Lurvey: Part B
- Dr. Eileen Moynihan: DME
- Dr. Gary Oakes: Part B
- Dr. Barbara O’Neal: DME
- Dr. Robert Szczys: PDAC
- Dr. Dick Whitten: Part B and DME
Bernice, JE, Executive Medical Director

- MD, MHA, FACC
- Overseas Duty USN, National Health Service Corps Volunteer, Academia, Research, Private Practice
- Consultant: Boeing, AHRQ, OIG, DOJ, FDA, CMS, FFS Hospitals
- Former Medical Director, AMF
- CA: Training and AMF
Did You Hear?

Subscribe to Email list for updates from CMS and Noridian, including announcement of events for providers

• No cost
• No limit per facility
• Tailored to type of Provider
MEDICARE AUDITS
http://www.paymentaccuracy.gov
Register for Taking Control of the CMS Program Audit Process

Register Now!

Select a workshop option:

<table>
<thead>
<tr>
<th>Option #1</th>
<th>Standard Registration Rate</th>
<th>$1,895.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option #2</td>
<td>Health Plan/Provider Registration Rate</td>
<td>$1,495.00</td>
</tr>
<tr>
<td>Option #3</td>
<td>Government/Non-profit Registration Rate (non-profit health plans do NOT qualify)</td>
<td>$895.00</td>
</tr>
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</table>

Health plans not eligible/ subject to HEA approval

Conference Cancellations
If we receive your request to cancel 30 days or more prior to the conference start date, your registration fees will be refunded minus a $250 administrative fee.

If we receive your request to cancel between 29 days and the first day of the conference you will receive your choice of a $200 refund or a credit for future events.

Webinar Cancellations
For individual webinar registrations if you cancel 14 days or more in advance of the webinar, you can expect a full refund less a $75 service charge. If you cancel 13 days or less prior to the webinar, you will receive a voucher for the registration fee (less a $75 service charge) which can be applied towards a FRA event within the calendar year.
Billing Considerations

• System monitors
  – Consolidated billing
  – Exclusion items
  – Duplicate billing

• Medical Review Examiner
  – Correct code
  – Medical necessity pay/deny/partial deny
Review Category 1: Non-complex

• Non-Complex
  – Routine requires some human intervention
  – Automated (Pre-Pay)
  – Clear policy
Clear Policy

IOM 100-08, 3.3.1.2 B

• The term “clear policy” means a statute, regulation, NCD, coverage provision in an interpretive manual, coding guideline, LCD or MAC article that specifies the circumstances under which a service will always be considered non-covered, incorrectly coded, or improperly billed.
Resources: IOM

• Statute: SSA 1861 & 1862
• Internet-Only Manuals (IOM)
  http://www.cms.hhs.gov/Manuals/IOM/list.asp
  100-2 Medicare Benefit Policy Manual
  100-3 Medicare National Coverage Determinations (NCDs) Manual
  100-4 Medicare Claims Payment Manual
  100-8 Medicare Program Integrity Manual
    Chapter 13 – Local Coverage Determinations (LCDs)
Review Category 2: Complex

• Complex ("ADRs")
  – New Provider/New Benefit
  – Probes (20 – 40 Claims)
    • Provider or Service – specific
  – Targeted (100 Claims)
    • Provider or Service-specific
  – Demand Reviews – e.g., SNF
Review Types: Probe

• Provider-Specific
  – One or a few providers found to have possible errors
  – Typically 20 – 40 claims

• Service-Specific
  – Multiple providers
  – May be a state or several states involved
  – Typically 80 – 100 claims
Review Types: Targeted

• Provider-Specific
  – Referred to as Provider on Review (POR)
  – Review until claims support improvement in error rate or 1 year, whichever comes first

• Service-Specific
  – Multiple providers with confirmed errors
  – Referred to as Service on Review (SOR)
  – Review until claims support improvement or 1 year whichever comes first
Review Types: SNF Demand

- CMS Mandated Reviews
- All SNF inpatient claims with condition code 20
- Definition:
  - Provider has told beneficiary no longer qualifies for skilled care
  - Bene disagrees and requests Medicare review
The Reviewers
Medicare Auditors

Three main contractors for Medical Review Audits

- **A/B MAC – Noridian (Fargo)**
  - Coverage, coding and payment accuracy
- **Recovery Audit Contractor (RAC) – HDI/PRGX (Las Vegas)**
  - Recovery of incorrect payments
- **Zone Program Integrity Contractor (ZPIC)**
  - AdvanceMed (JF); SafeGuard Services (JE)
  - Fraud

Smaller Role in MR Audits

- **Quality Improvement Organization (QIO) – varies by state**
  - Quality Issues
- **Specialty Medical Review Contractor**
  - Specialty Health Solutions
  - Special MR Studies
- **Comprehensive Error Rate Testing (CERT) – AdvanceMed**
  - Accuracy of Payment
The chart below indicates which contractors perform which types of review:

<table>
<thead>
<tr>
<th></th>
<th>Prepayment</th>
<th>Postpayment</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Complex</td>
<td>Non-Complex</td>
</tr>
<tr>
<td>MACs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CERT</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Recovery Auditors</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>ZPICs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Complex reviews involve requesting, receiving, and medical review of additional documentation associated with a claim.

3.3.1.1 - Complex Medical Review
(Rev. 447, Issued: 01-18-13, Effective: 02-19-13, Implementation: 02-19-13)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.
CERT Request

Immediate Response Required
Medicare Record Request
Error Rate

• The Error Rate is the way in which CMS measures a contractors performance
• Error Rates, are released bi-annually (May and November)
• All Medicare Contractors focus on reducing this error rate
CERT Claim Selection

• A stratified random sample is taken by claim type:
  o Part A (excluding acute inpatient hospital services)
  o Part A (acute inpatient hospital services only)
  o Part B
  o Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

• Claims are selected on a semi-monthly basis

• The final CERT sample is comprised of claims that were either paid or denied by the MACs
Within each claim type, service strata are constructed.

In general, 15 of the strata are based on the 15 services with the highest improper payments based on historical data:
- These strata sampled heavily.

84 additional “probe” strata are constructed based on historical improper payments:
- Sample size ranging from 50 – 200 claims.
- For Part A Excluding Inpatient Hospital PPS, service level is not granular enough to construct 99 service strata:
  - Typically, 15 – 20 strata are constructed.

Finally, an “other” strata that contains all claims not categorized by the preceding 99 strata.
Assignment of Improper Payment Categories

• Improper Payment Categories
  o No documentation
  o Insufficient documentation
  o Medical necessity
  o Incorrect coding
  o Other
CERT Errors

Common reasons for SNF CERT overpayment or underpayment
"My question is: Are we making an impact?"
Minimum Data Set (MDS)

- Missing documentation to support administration:
  - Parenteral IV
  - Therapy minutes
- Common documents missing that may support services:
  - ER visit records
- Documentation must support all ADL information
Qualifying Stay

• Missing documentation in acute hospital
  – Inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days

• Qualifying stay would be reported with occurrence span code 70
  – Obtain medical records to support admission and reason for extended skilled care
Incorrect Coding/Insufficient Documentation

• Missing documentation to support Ultra High RUG category
  – Outcome down-coding of the RUG category

• SNF therapy minutes on MDS must match documentation
  – Each discipline requires records, when used to classify the RUG
CERT Reminders

• January 1, 2014 provider have 60 days to respond to CERT documentation request

• Avoid incorrect Date of Service for RUG
  – Must be same date as ARD for the MDS

• CERT claims selected are post payment (2011-2012)
  – Sample can include RA claims and canceled claims that were previously processed for payment
CERT Reminders

• Request a review when dissatisfied with CERT Review Contractor decision
  – Use company letterhead or interactive form

• 120 days to file from the date of receipt the CERT Finding Letter
  – Recoupment identified on RA
  – Claim adjustment reason code 5CERX
CERT Questions

• Part A/B Provider Contact Center
  • 1-877-908-8431 (JF)
  • 1-855-609-9960 (JE)

• Noridian Medicare Part A, send an e-mail to CERTPartAQuestion@noridian.com

• Resources and Tools found on the CERT webpage
CERT Checklists

  - Ambulance Documentation Checklist
  - Chiropractic Documentation Checklist
  - Dialysis Documentation Checklist
  - Evaluation and Management (E/M) Documentation Checklist
  - Laboratory Documentation Checklist
  - Physical, Occupational and Speech Therapies Documentation Checklist
  - Psychiatric-Mental Health Documentation Checklist
  - Radiation Oncology Documentation Checklist
  - Radiology Documentation Checklist
IRF Denials

Most of the RAC IRF appeal claims continue to be denied

- All required attendees were not at the interdisciplinary team conference
- Incomplete or untimely
  - The pre-admission screening wasn’t reviewed timely and signed off by the physician
  - Verbal phone conversations between physician with IRF staff sign off(e.g., telephone order) not okay
    - Email from physician approving pre-admission screening is not acceptable
  - Missing required elements for the pre-admission screening
- 3. The overall interdisciplinary plan of care was not completed/synthesized timely by rehab physician
  - Missing required elements for the overall interdisciplinary plan of care
- 4. The post-admission physician evaluation not completed timely by the rehab physician
- 5. Minimum therapy intensity requirements not met
- 6. Preponderance of group therapy provided
RAC
Region D Contractor

• HealthDataInsights, Inc.
  – 7501 Trinity Peak Street, Suite 120
  Las Vegas, NV 89128-6896
  888-700-3282

• Subcontractor: PRG Schultz, Inc.
RAC Denials

- 69% of RAC denials were one-day stays
- E&M codes
- Not medically necessary
- Sampling
### ZPICs

<table>
<thead>
<tr>
<th>Zone</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada</td>
</tr>
<tr>
<td>2</td>
<td>Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming</td>
</tr>
<tr>
<td>3</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin</td>
</tr>
<tr>
<td>4</td>
<td>Colorado, New Mexico, Oklahoma, Texas</td>
</tr>
<tr>
<td>5</td>
<td>Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia</td>
</tr>
<tr>
<td>6</td>
<td>Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont</td>
</tr>
<tr>
<td>7</td>
<td>Florida, Puerto Rico, U.S. Virgin Islands</td>
</tr>
</tbody>
</table>

**Assistance with a ZPIC audit:**

http://www.zpicaudit.com/tag/zpic/
The MAC: Noridian
Noridian Collaborative Strategy

- Education, pre-pay if possible
- Data analyses
- Prioritization of problems
  - Patient well-being
  - Claims’ error vulnerability (access)
- Intervention plan
- Follow up plan
- Program management
Process: Website & Reviewers

• Notification
  – Provider-specific: Letter
  – Service-specific: Website posting

• Periodic file evaluations
  – Probe: At a minimum end of file
  – Targeted: At a minimum each quarter
Process: Education

• Periodic education
  – Probe: At a minimum end of file
  – Targeted: At a minimum 6 months – NAS recommends every 3 months

• Types of education
  – Articles
  – Letters
  – Website updates
  – Phone calls/conference calls
Skilled Care Documentation

• When necessary, all entities must work together to obtain records for patients
• Cooperation amongst the following is essential in retrieving medical records
  – Physicians offices
  – Hospitals
  – Therapy and laboratory departments
Skilled Care Documentation

• Physician Order*
  – Legible, signed and dated
    • Illegible: Send signature logs and attestation statements
  – Order for skilled service
  – Laboratory Tests
    • Automatic, routine or generic standing orders for lab tests are not allowable under Medicare
  – Medication
Skilled Care Documentation

- Vital sign records, weight sheets, care plans, treatment records
- Documentation for the look-back period for each MDS billed – may be prior to the billing period
  - Therapy minutes*
  - IV administration*
  - Activities of Daily Living (ADL) information*
Skilled Care Documentation

• Lab reports for the billing period
• PT/OT/SLP:
  – Initial evaluation*
  – Plan of care*
  – Progress reports
    • On or before every 10th treatment day
  – Treatment encounter notes
  – Discharge summary
Skilled Care Documentation

• Patient overall condition
• Instability
• Interventions and beneficiary response
• Physician involvement
• Treatment plan modifications
Amended Medical Records

• Addendum
  – Used to provide information that was not available at time of original entry
  – Should be timely and bear current date and reason for addition or clarification of information being added to medical record
  – Signed and dated
Amended Medical Records cont.

• Correction
  – Never write over, or otherwise obliterate passage when an entry is made in error
  – Draw a single line through erroneous information
  – Document correct information on next line or space with current date and time, making reference back to original entry
  – Sign and date deletion, stating reason for correction above or in margin
Amended Medical Records cont.

• Late entry
  – Supplies additional information that was omitted from original entry
  – Entry bears current date, is added as soon as possible, and is written only if person documenting has total recall of omitted information, and is signed by person making the change
Providers, Plan of Action

• Keep track of denied claims
• Look for patterns
• Determine what corrective actions you need to take to avoid improper payments
• Alert Noridian
Appeal, Appeal, Appeal!

- If you disagree with the outcome of a review, appeal the claim!
- Appeals will be processed by MAC
- No amount is too small, and the outcome may dramatically reduce your facility error rate
Requesting a Redetermination

Noridian Redetermination Form
Available at
https://www.noridianmedicare.com/macj3a/appeals/ or
https://www.noridianmedicare.com/pmeda/appeals

Form CMS-20027
Available at www.cms.gov/forms and www.noridianmedicare.com
Thank You...

What Questions Do You Have?