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Appeals & Denials: *Back to Basics*

February 28, 2024

Speakers:
- Susan Evans, PT, Seagrove Rehab Partners
- Rachel Lux, RAC-CT, COTA/L, Independence Rehab
- Ellen Strunk, PT, Rehab Resources and Consulting

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Housekeeping Reminders

- All attendees are on mute
- **Handouts:** provided as a link in the reminder email for this webinar sent 1 hour ago (https://www.naranet.org/resources/quicklinks)
- **Questions for Speakers:** submit them using the Q&A button on the attendee control panel
- **Technical Questions:** submit them using the Chat button on the attendee control panel
- **Recording:** will be available at https://www.naranet.org/resources/quicklinks for all registered attendees 48 hours after webinar concludes

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Disclaimer

The information shared in today's presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

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Meet Our Speakers



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Objectives

- Identify the importance of the appeals function.
- Understand the different types of denials.
- Learn about the different entities who are conducting audits and their focus.
- Identify efficient systems for responding to requests for additional documentation and denials.

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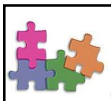

Outline

1. Why are we here?
2. Overview of entities and levels of appeal
3. Strategies to address denials

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Outline

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"I never got a denial so I must be doing everything right!"

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Medicare Program Integrity

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

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Data Analysis

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

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Appealing Denials is Advocacy

Occupational Therapy

Physical Therapy

Speech Therapy

11

Being An Effective Advocate Means Being Prepared

- Know your state licensure law(s)
- Know the rules of the Payer
  - Know whether there are differences between practice settings
- Know the guidelines of the Payer

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There is Increasing Attention Paid to Healthcare Spending

Payers

Policy

Public

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Increasing Attention = Increasing Scrutiny

- Where is all the money going?
- Who is the money going to?
- What is the money paying for?
- Why is there so much money being paid for this?
- Is the service provided 'worth' paying for?

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Outline

1. Why are we here?
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AUDITS, ADR'S, DENIALS, APPEALS

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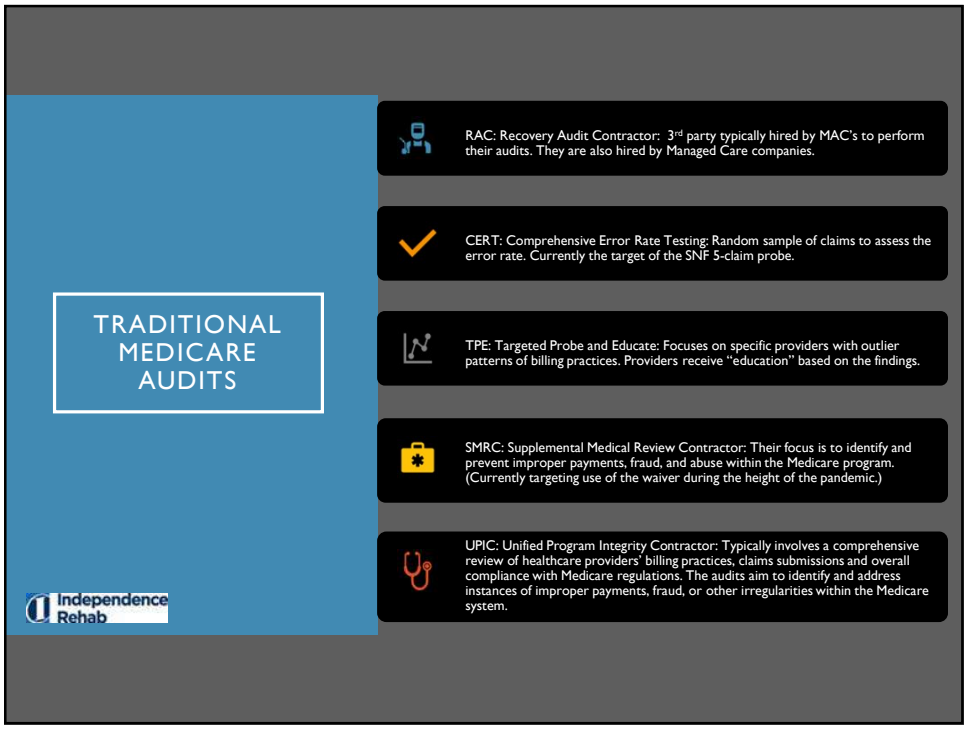

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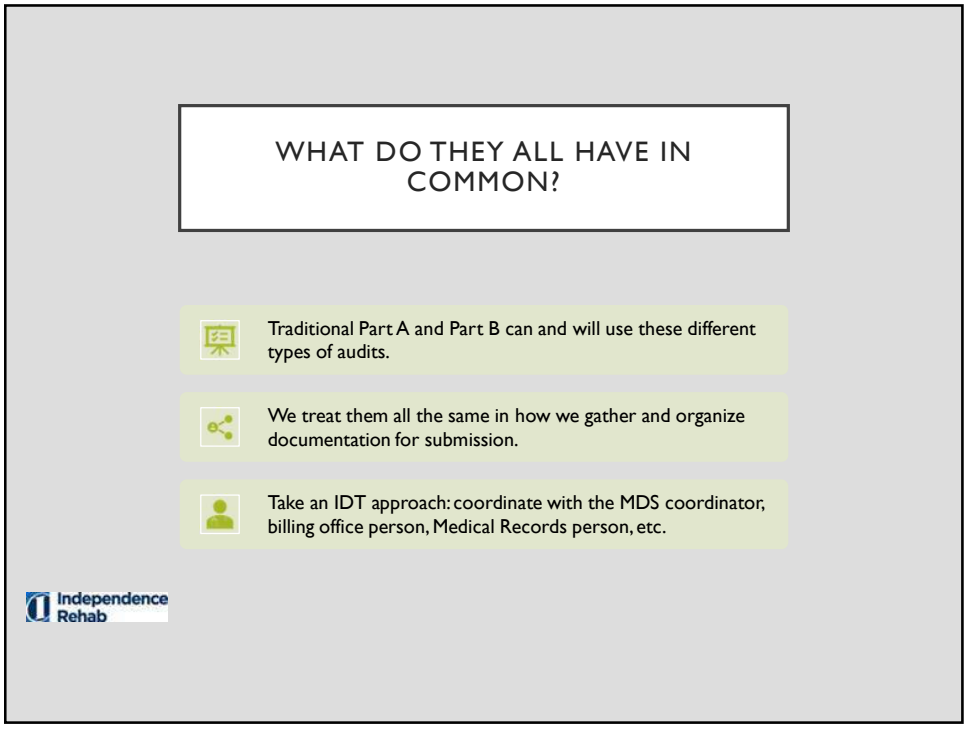

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MANAGED CARE AUDIT REQUESTS

THE SAME AS TRADITIONAL AUDITS,

BUT ALSO, TOTALLY DIFFERENT

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- Function similar to a TPE or CERT review.
- They request documentation to support the HIPPS code billed for the skilled Part A stay.
- They request documentation to support Medical Necessity in general for Part B.
- They specifically are looking to determine if "sufficient" documentation exists.
- Of note: After we submit documentation for a Managed care request, they will typically ask for more documentation.
  - More hospital records, previous stay records, mother's maiden name, last 4 of your social, your best friend from highschool's name.
- Extra insight: If you coded malnutrition and morbid obesity for NTA points, did you careplan it?

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TARGETS

What puts you on Medicare's radar?

What are the outlier's

What are the targets?

- Length of stay
- Over-utilized codes (97110, 97116, 97530)
- SLP component/NTA component
- Interrupted stays that are billed as a new stay

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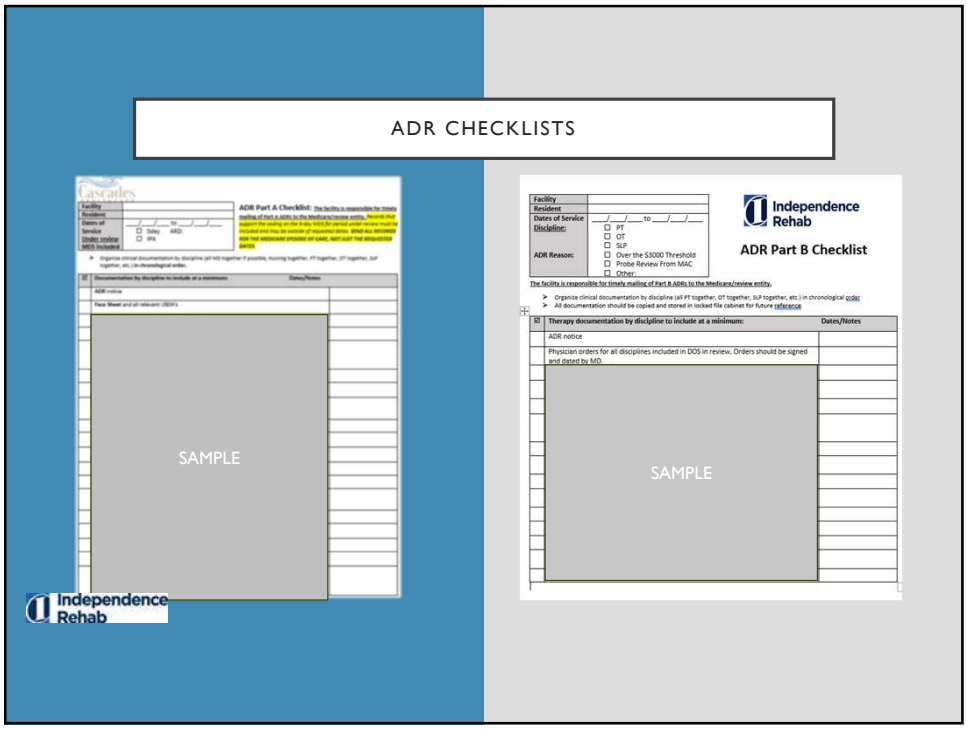

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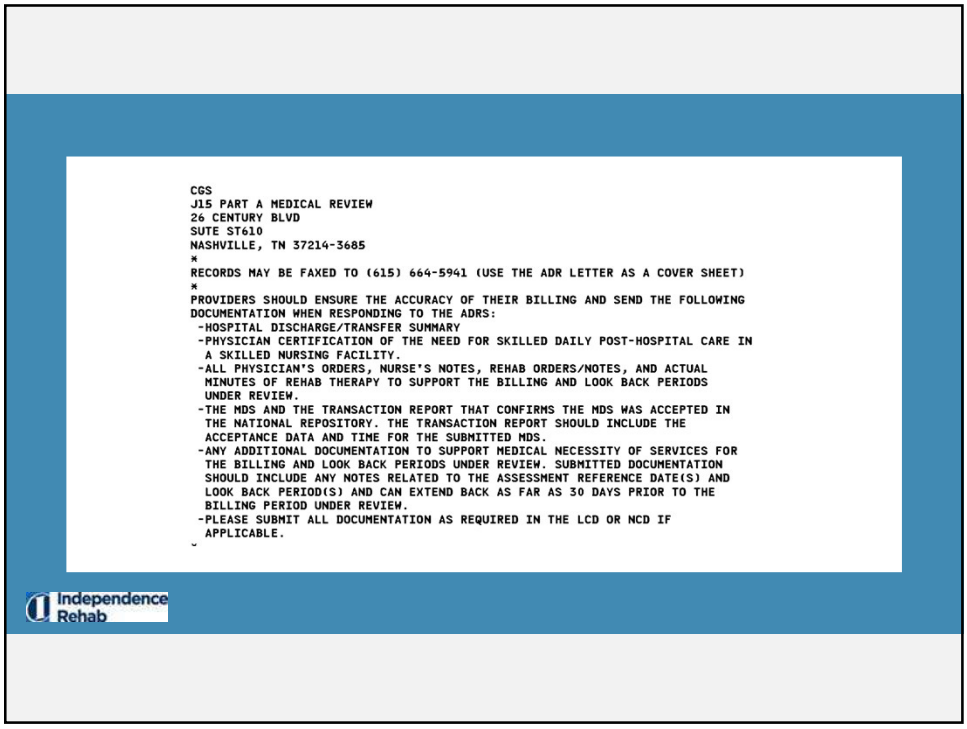

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Outline

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Three Top Strategies for Addressing Denials

1. Prevent Them

- **Documentation**
  - **Clear story**
  - **Dots are connected**
  - **Medical necessity for skilled services**
  - **Services *are* skilled**
  - **Goals are addressed**

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Audit or Not
Susan Evans, PT

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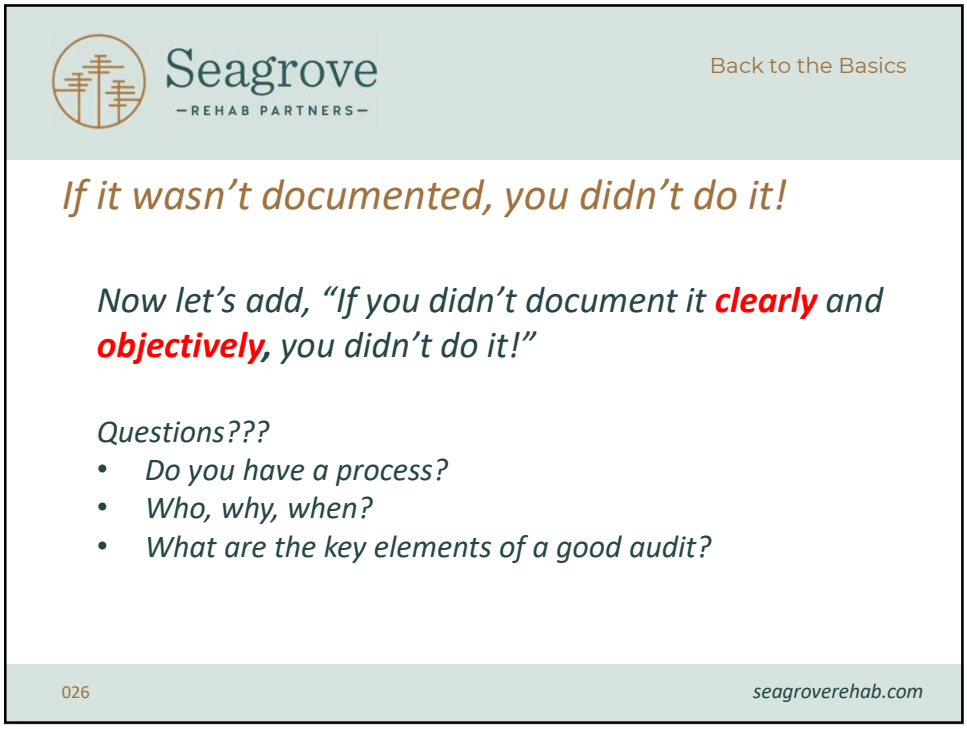
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Back to the Basics
If it wasn't documented, you didn't do it!
Now let's add, "If you didn't document it clearly and objectively, you didn't do it!"
Questions???
• Do you have a process?
• Who, why, when?
• What are the key elements of a good audit?
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WHO ???

EXTERNAL
- *Medicare FIs*
- *Insurance Companies*

INTERNAL
- *Companies*
- *Managers*
- *Clinicians*

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Back to the Basics

WHY ???

- Verification that "medical necessity" was provided to our beneficiaries
- Ensure our clinicians have tools, training & education
- Payment purposes

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Back to the Basics

WHEN ???

- ✓ Random
- ✓ Quarterly
- ✓ Monthly
- ✓ As needed

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Back to the Basics

WHAT ???

Varies……..

Key areas of consideration……

- Supportive Treatment Dx
- Referral reason
- Comprehensive assessment – impairments, functional deficits
- Standardized tests & measurements
- PLOF & Current status
- Goals – objective, measurable, functional, timeframes, patient focused, support treatment diagnosis and impairments/functional deficits
- Treatment Plan - individualized

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Back to the Basics

What are auditors looking for ???

A clear picture of the patient's functional status needs with a comprehensive, discipline specific documentation that leaves no ? in the mind of the reader as to why your services are medically necessary to improve the quality of life for the patients you serve.

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Back to the Basics

What are auditors looking for ???

…….Stay tuned for key components of a good audit
…….Dos and don'ts of skilled documentation
…….Actual denial reasons

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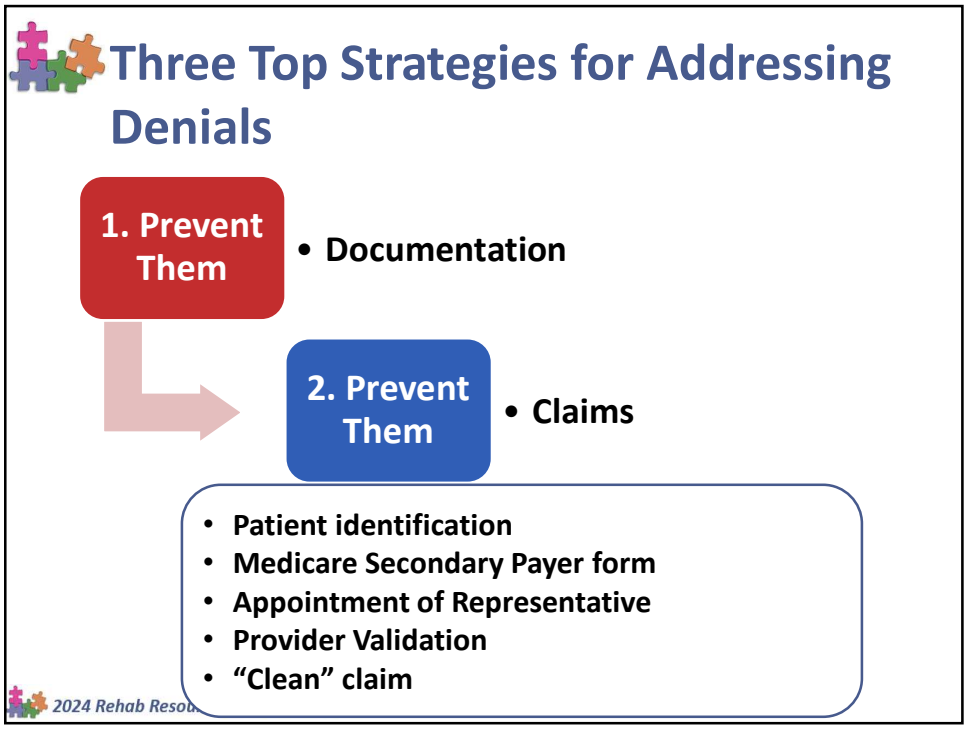

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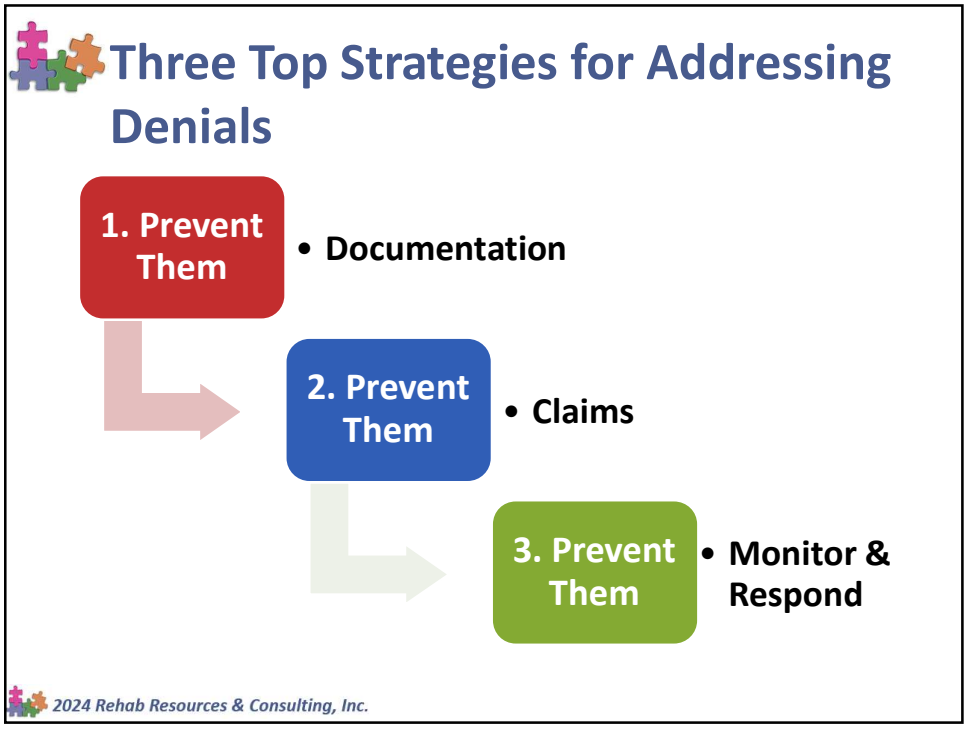

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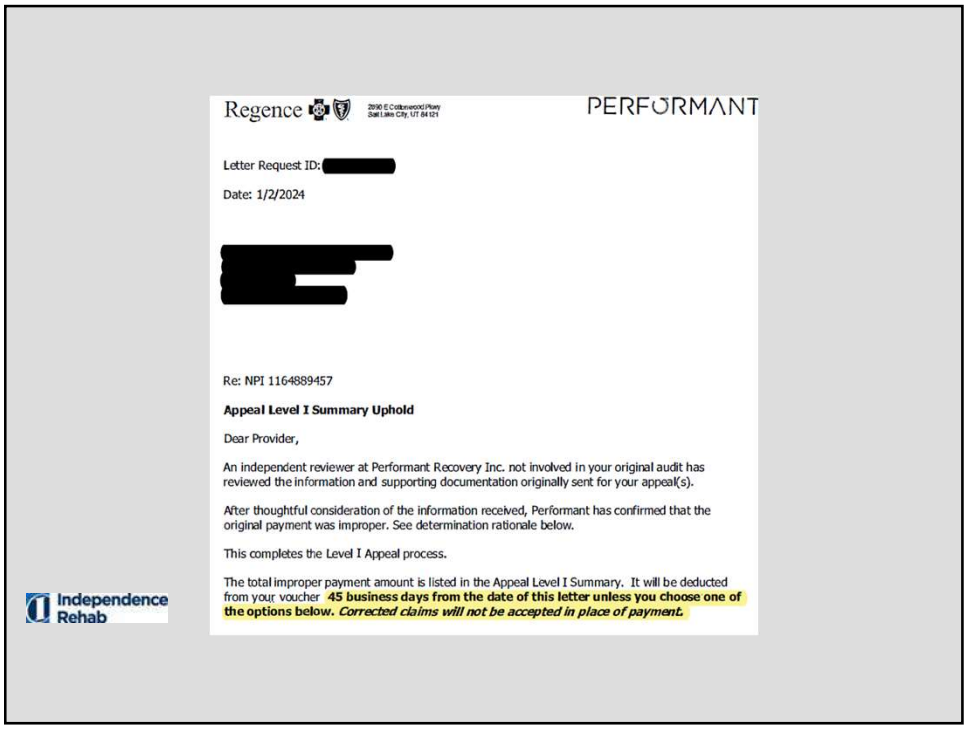

Regence 2890 E Cottonwood Pkwy Salt Lake City, UT 84121

PERFORMANT

Letter Request ID: [redacted]

Date: 1/2/2024

[redacted]

Re: NPI 1164889457

Appeal Level I Summary Uphold

Dear Provider,

An independent reviewer at Performant Recovery Inc. not involved in your original audit has reviewed the information and supporting documentation originally sent for your appeal(s).

After thoughtful consideration of the information received, Performant has confirmed that the original payment was improper. See determination rationale below.

This completes the Level I Appeal process.

The total improper payment amount is listed in the Appeal Level I Summary. It will be deducted from your voucher **45 business days from the date of this letter unless you choose one of the options below.** ***Corrected claims will not be accepted in place of payment.***

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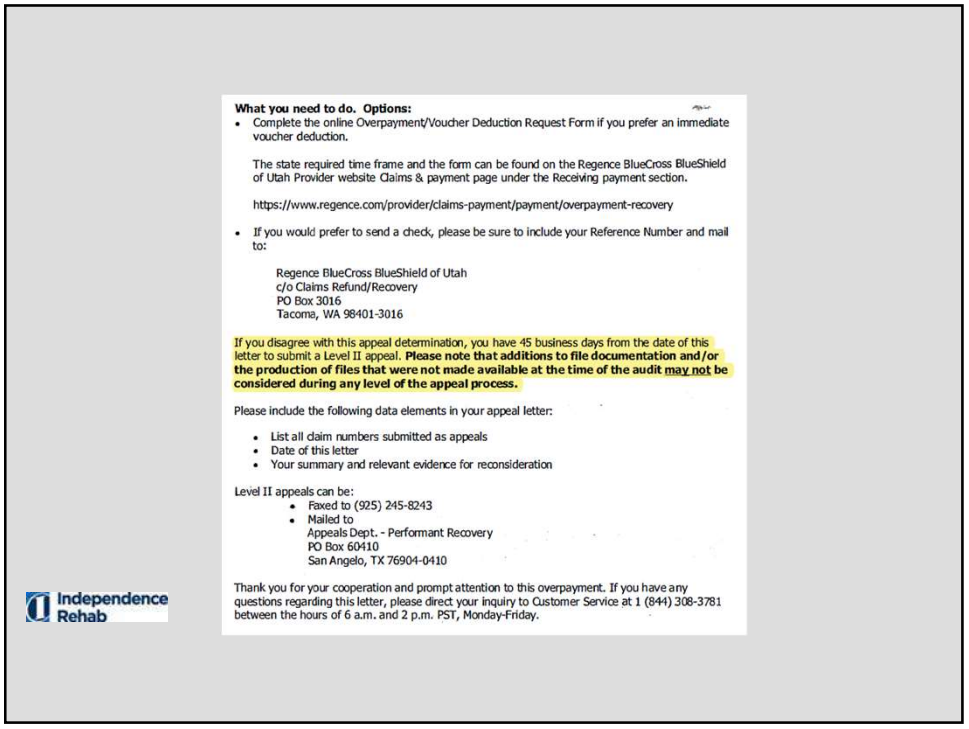

What you need to do. Options:

- Complete the online Overpayment/Voucher Deduction Request Form if you prefer an immediate voucher deduction.

  The state required time frame and the form can be found on the Regence BlueCross BlueShield of Utah Provider website Claims & payment page under the Receiving payment section.

  https://www.regence.com/provider/claims-payment/payment/overpayment-recovery

- If you would prefer to send a check, please be sure to include your Reference Number and mail to:

  Regence BlueCross BlueShield of Utah
  c/o Claims Refund/Recovery
  PO Box 3016
  Tacoma, WA 98401-3016

If you disagree with this appeal determination, you have 45 business days from the date of this letter to submit a Level II appeal. **Please note that additions to file documentation and/or the production of files that were not made available at the time of the audit may not be considered during any level of the appeal process.**

Please include the following data elements in your appeal letter:

- List all claim numbers submitted as appeals
- Date of this letter
- Your summary and relevant evidence for reconsideration

Level II appeals can be:

- Faxed to (925) 245-8243
- Mailed to
  Appeals Dept. - Performant Recovery
  PO Box 60410
  San Angelo, TX 76904-0410

Thank you for your cooperation and prompt attention to this overpayment. If you have any questions regarding this letter, please direct your inquiry to Customer Service at 1 (844) 308-3781 between the hours of 6 a.m. and 2 p.m. PST, Monday-Friday.

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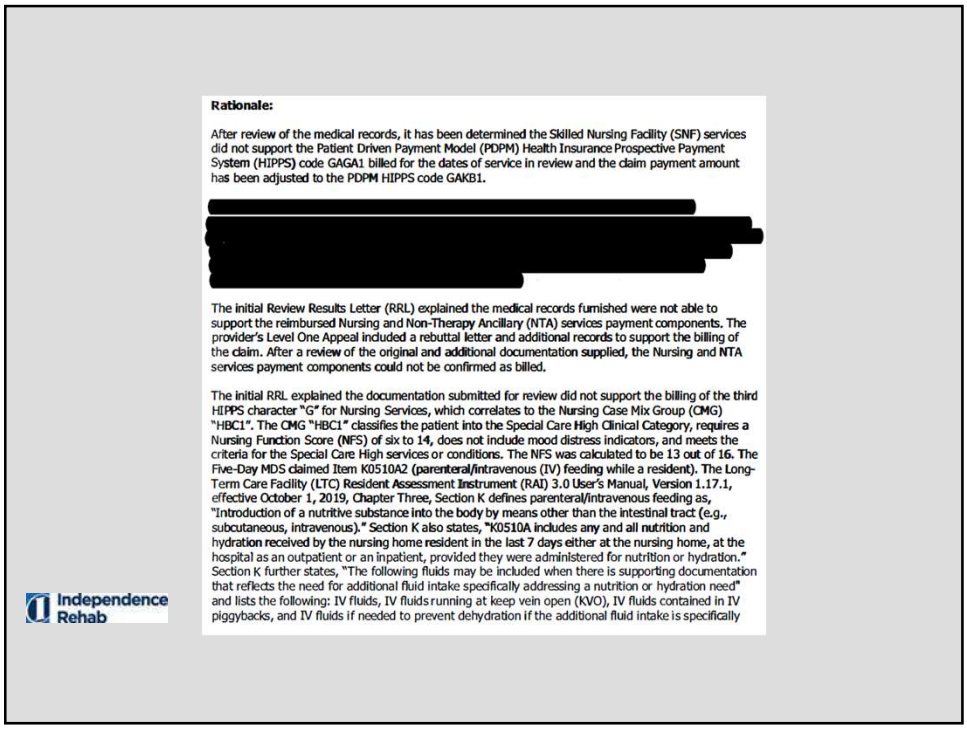

Rationale:

After review of the medical records, it has been determined the Skilled Nursing Facility (SNF) services did not support the Patient Driven Payment Model (PDPM) Health Insurance Prospective Payment System (HIPPS) code GAGA1 billed for the dates of service in review and the claim payment amount has been adjusted to the PDPM HIPPS code GAKB1.

[redacted]

The initial Review Results Letter (RRL) explained the medical records furnished were not able to support the reimbursed Nursing and Non-Therapy Ancillary (NTA) services payment components. The provider's Level One Appeal included a rebuttal letter and additional records to support the billing of the claim. After a review of the original and additional documentation supplied, the Nursing and NTA services payment components could not be confirmed as billed.

The initial RRL explained the documentation submitted for review did not support the billing of the third HIPPS character "G" for Nursing Services, which correlates to the Nursing Case Mix Group (CMG) "HBC1". The CMG "HBC1" classifies the patient into the Special Care High Clinical Category, requires a Nursing Function Score (NFS) of six to 14, does not include mood distress indicators, and meets the criteria for the Special Care High services or conditions. The NFS was calculated to be 13 out of 16. The Five-Day MDS claimed Item K0510A2 (parenteral/intravenous (IV) feeding while a resident). The Long-Term Care Facility (LTC) Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.17.1, effective October 1, 2019, Chapter Three, Section K defines parenteral/intravenous feeding as, "Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." Section K also states, "K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration." Section K further states, "The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need" and lists the following: IV fluids, IV fluids running at keep vein open (KVO), IV fluids contained in IV piggybacks, and IV fluids if needed to prevent dehydration if the additional fluid intake is specifically

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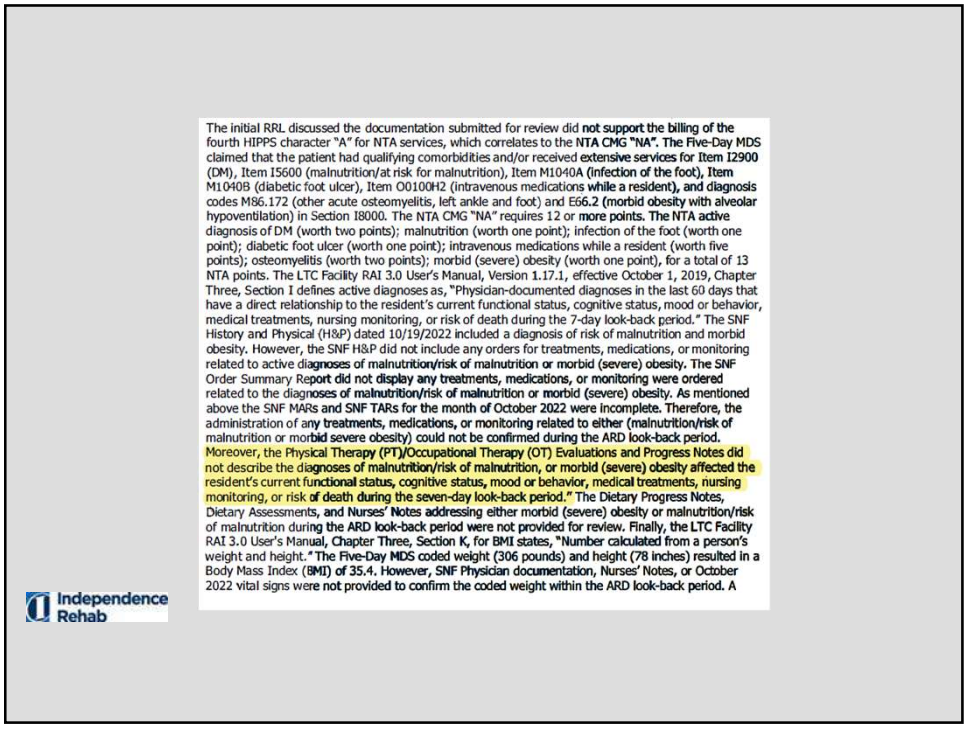

The initial RRL discussed the documentation submitted for review did not support the billing of the fourth HIPPS character "A" for NTA services, which correlates to the NTA CMG "NA". The Five-Day MDS claimed that the patient had qualifying comorbidities and/or received extensive services for Item I2900 (DM), Item I5600 (malnutrition/at risk for malnutrition), Item M1040A (infection of the foot), Item M1040B (diabetic foot ulcer), Item O0100H2 (intravenous medications while a resident), and diagnosis codes M86.172 (other acute osteomyelitis, left ankle and foot) and E66.2 (morbid obesity with alveolar hypoventilation) in Section I8000. The NTA CMG "NA" requires 12 or more points. The NTA active diagnosis of DM (worth two points); malnutrition (worth one point); infection of the foot (worth one point); diabetic foot ulcer (worth one point); intravenous medications while a resident (worth five points); osteomyelitis (worth two points); morbid (severe) obesity (worth one point), for a total of 13 NTA points. The LTC Facility RAI 3.0 User's Manual, Version 1.17.1, effective October 1, 2019, Chapter Three, Section I defines active diagnoses as, "Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period." The SNF History and Physical (H&P) dated 10/19/2022 included a diagnosis of risk of malnutrition and morbid obesity. However, the SNF H&P did not include any orders for treatments, medications, or monitoring related to active diagnoses of malnutrition/risk of malnutrition or morbid (severe) obesity. The SNF Order Summary Report did not display any treatments, medications, or monitoring were ordered related to the diagnoses of malnutrition/risk of malnutrition or morbid (severe) obesity. As mentioned above the SNF MARs and SNF TARs for the month of October 2022 were incomplete. Therefore, the administration of any treatments, medications, or monitoring related to either (malnutrition/risk of malnutrition or morbid severe obesity) could not be confirmed during the ARD look-back period. Moreover, the Physical Therapy (PT)/Occupational Therapy (OT) Evaluations and Progress Notes did not describe the diagnoses of malnutrition/risk of malnutrition, or morbid (severe) obesity affected the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the seven-day look-back period." The Dietary Progress Notes, Dietary Assessments, and Nurses' Notes addressing either morbid (severe) obesity or malnutrition/risk of malnutrition during the ARD look-back period were not provided for review. Finally, the LTC Facility RAI 3.0 User's Manual, Chapter Three, Section K, for BMI states, "Number calculated from a person's weight and height." The Five-Day MDS coded weight (306 pounds) and height (78 inches) resulted in a Body Mass Index (BMI) of 35.4. However, SNF Physician documentation, Nurses' Notes, or October 2022 vital signs were not provided to confirm the coded weight within the ARD look-back period. A

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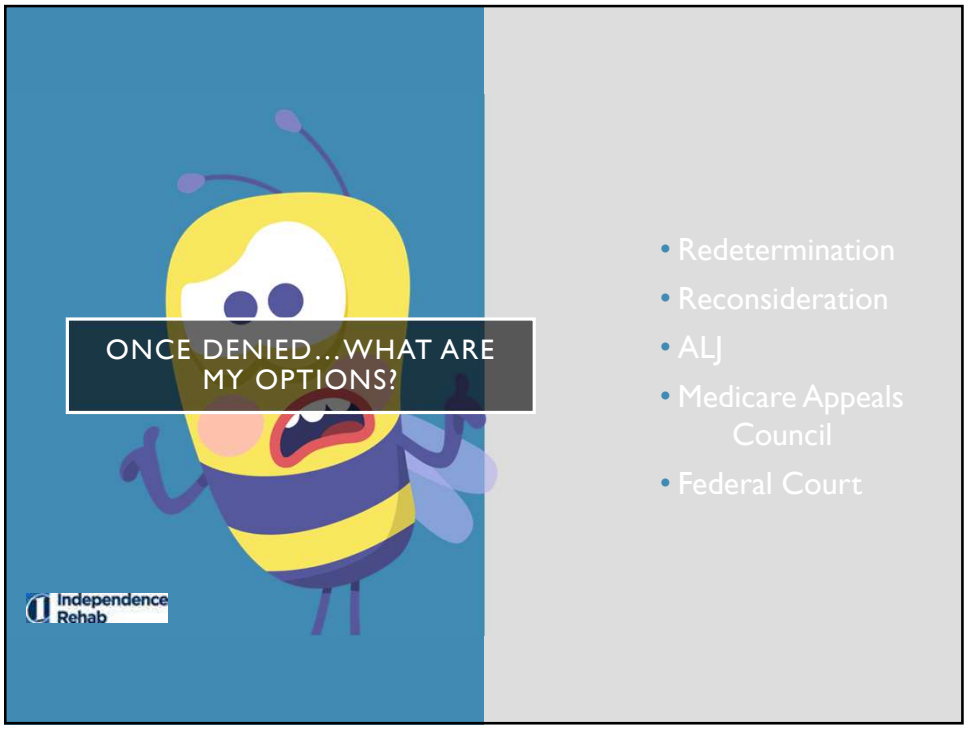
ONCE DENIED…WHAT ARE MY OPTIONS?
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• Redetermination
• Reconsideration
• ALJ
• Medicare Appeals Council
• Federal Court

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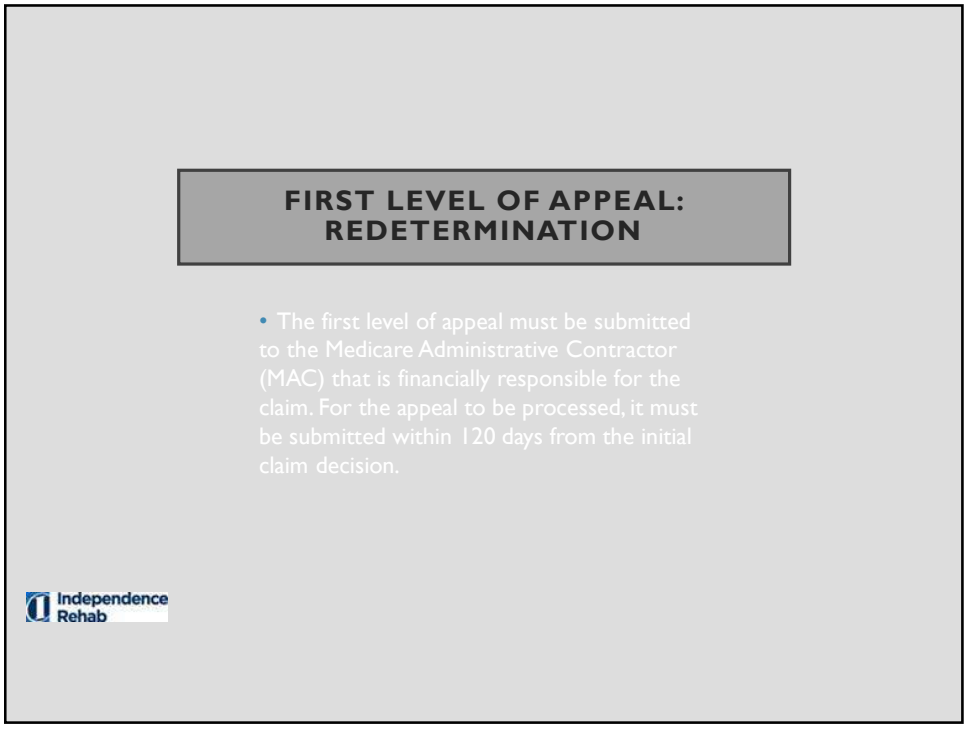
FIRST LEVEL OF APPEAL: REDETERMINATION
• The first level of appeal must be submitted to the Medicare Administrative Contractor (MAC) that is financially responsible for the claim. For the appeal to be processed, it must be submitted within 120 days from the initial claim decision.
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SECOND LEVEL OF APPEAL: RECONSIDERATION

- As a provider, you have 180 days from the MAC's dismissal date to submit a second-level appeal, also known as a reconsideration. The second level appeal is reviewed by a Qualified Independent Contractor (QIC). Keep in mind that the claim and documentation have already been reviewed by two different levels prior to QIC. Any new relevant documentation must be submitted to support the reason for the disagreement with the initial claim and with the redetermination decision.

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THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE (ALJ)

- The MAC and the QIC upheld your denial? Still disagree with their findings? A third-level appeal can be submitted to an Administrative Law Judge.
- The timeline to submit an ALJ request is 60 days from the date of the second level decision.
- To submit an ALJ, the amount being disputed must meet a threshold calculated each year.
- Just like the first two appeals, an ALJ request must be submitted in writing and there is a specific form that needs to be filled out.
- A third level appeal is a bit more interesting as it requires the hearing to be held over the phone, and at times may require a video teleconference; although extremely rare, it may even be in person.

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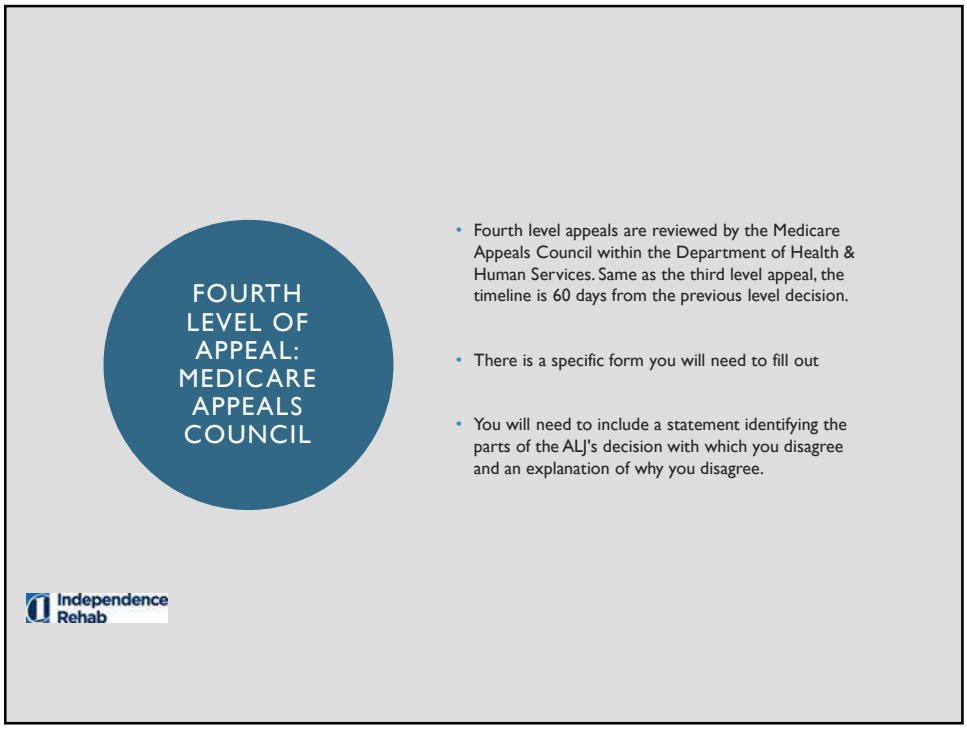
FOURTH LEVEL OF APPEAL: MEDICARE APPEALS COUNCIL
Fourth level appeals are reviewed by the Medicare Appeals Council within the Department of Health & Human Services. Same as the third level appeal, the timeline is 60 days from the previous level decision.
There is a specific form you will need to fill out
You will need to include a statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
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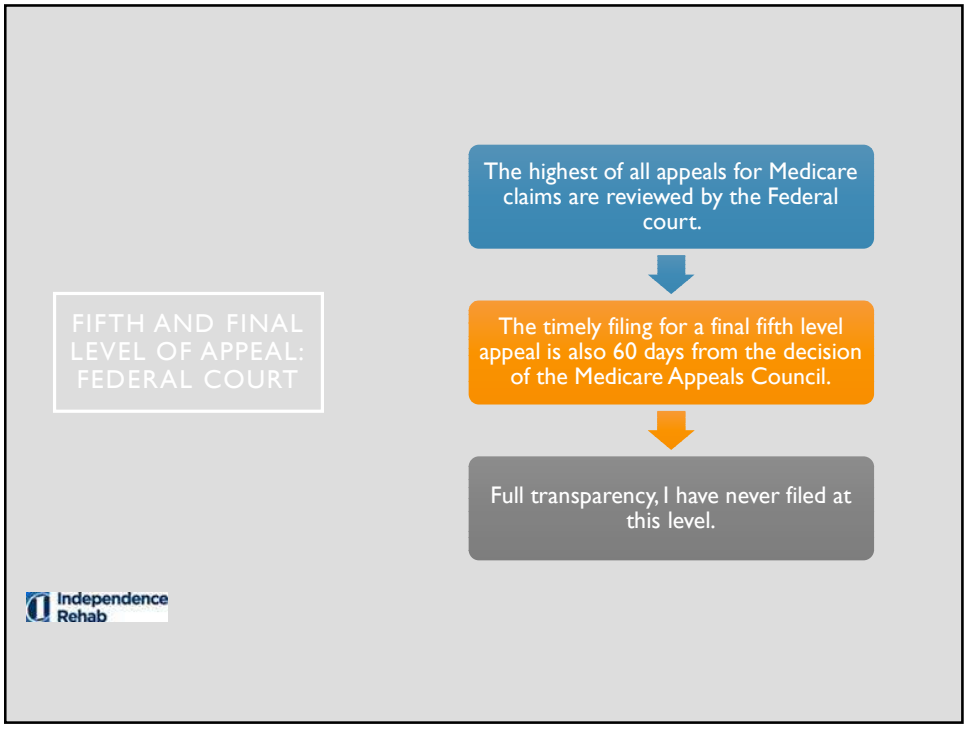
FIFTH AND FINAL LEVEL OF APPEAL: FEDERAL COURT
The highest of all appeals for Medicare claims are reviewed by the Federal court.
The timely filing for a final fifth level appeal is also 60 days from the decision of the Medicare Appeals Council.
Full transparency, I have never filed at this level.
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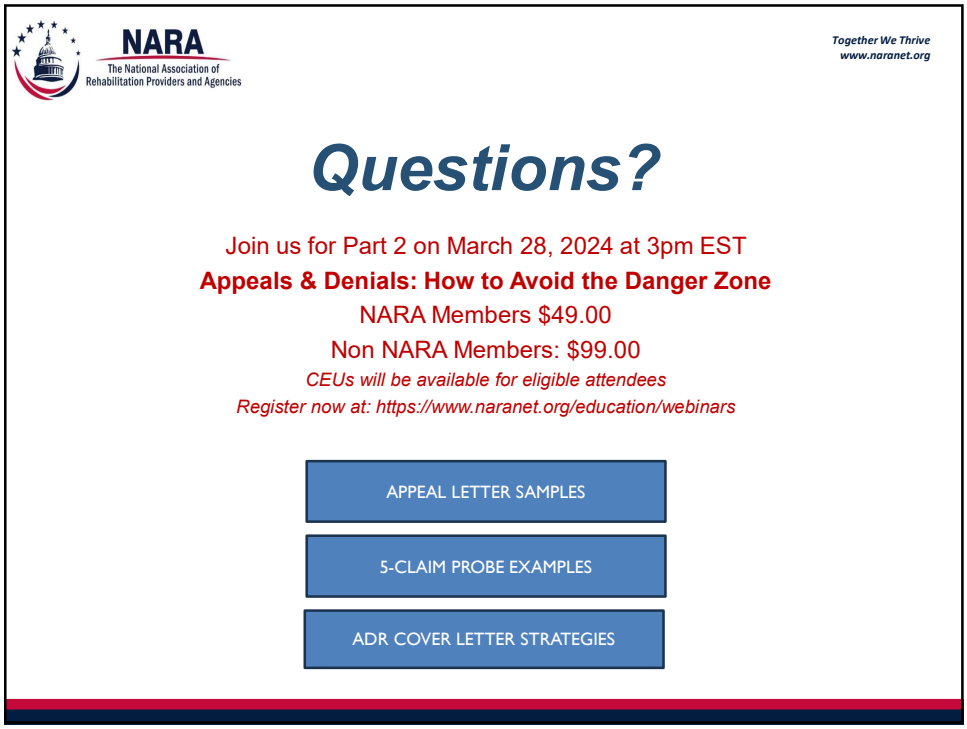

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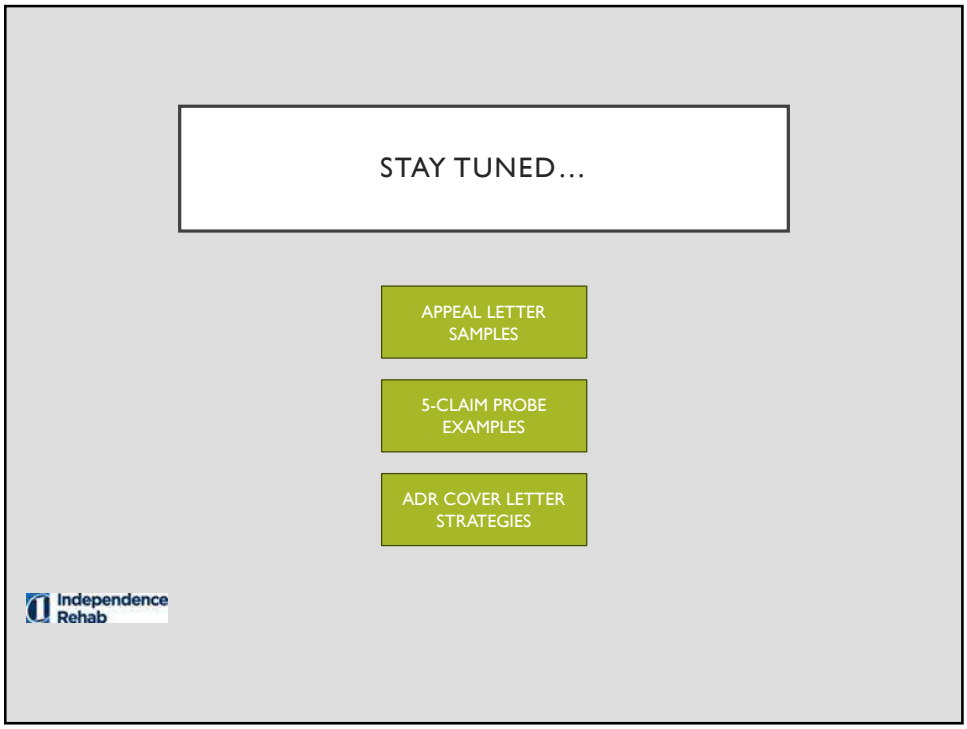

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