FREE WEBINAR

# Medicare Audits Decoded

## *Strategy and Protection for SNF Claims and Compliance*

**THU, DEC 4 | 1 PM CT**

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# TODAY'S SPEAKER

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# Attendee poll

**How prepared does your organization feel for today's Medicare audit environment?**

- Very prepared
- Somewhat prepared
- Not very prepared
- I am losing sleep at night

# Attendee poll

## What is your biggest challenge when it comes to Medicare audits?

- Documentation accuracy and availability
- Understanding contractor expectations
- Responding within required timeframes
- Preventing denials
- All of the above — we are just trying to keep up

# Learning Objectives

Understand the roles and responsibilities of key Medicare audit contractors (RAC, UPIC, SMRC, MAC, OIG, and more)

Recognize common audit types, triggers, and findings that affect SNF reimbursement and compliance

Gain insight into current enforcement priorities and high-risk focus areas under PDPM

Apply proven strategies to prepare for, respond to, and prevent adverse audit outcomes

# Disclaimer

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Reference links are provided at the end of the slides.

# CMS Focus on Fraud, Waste, and Abuse

- Improper billing for services not rendered
- Misdiagnosis of residents to justify unnecessary treatment
- Overutilization of services
- Medical Necessity

# The Contractors and Their Focus

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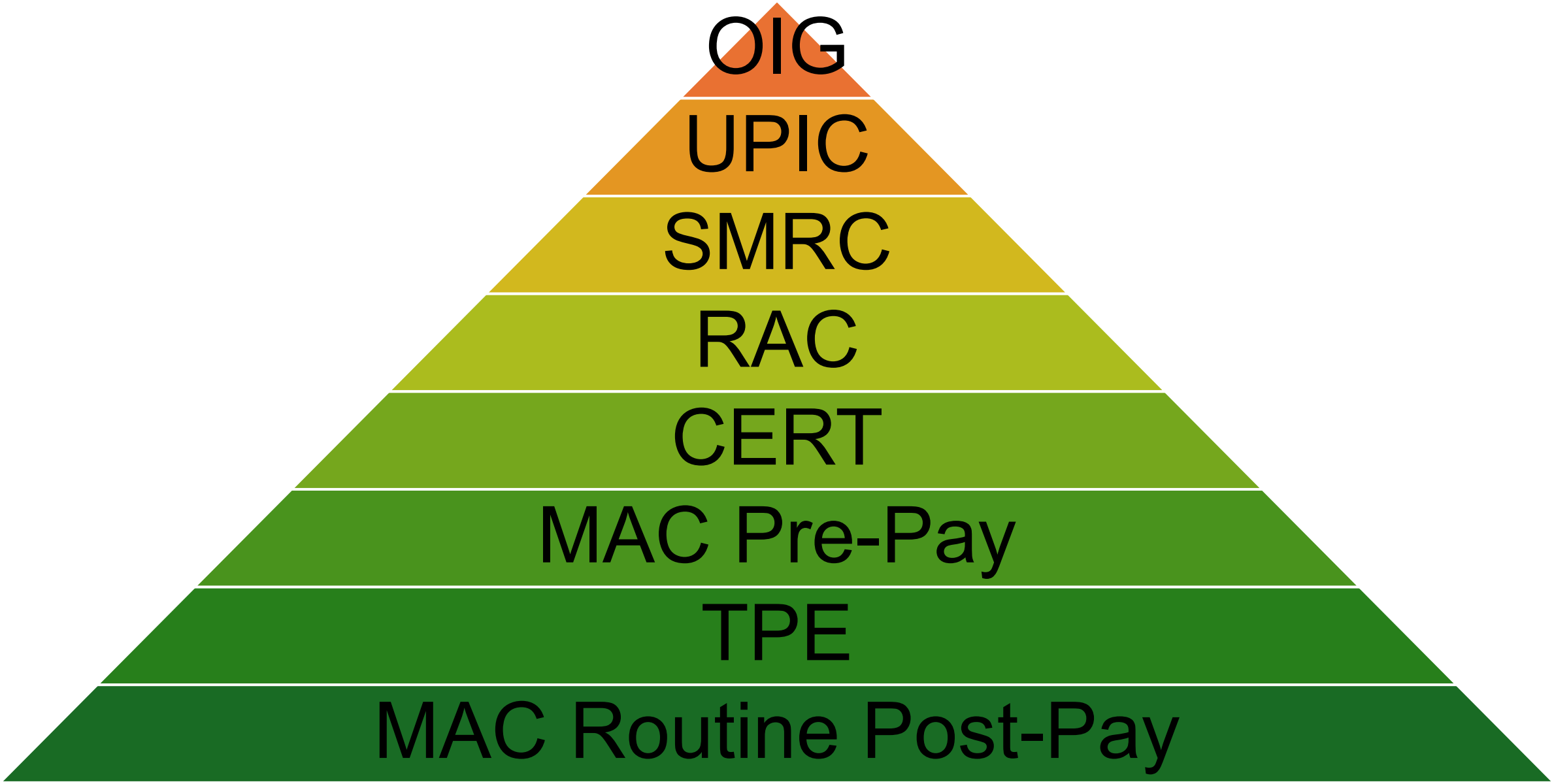
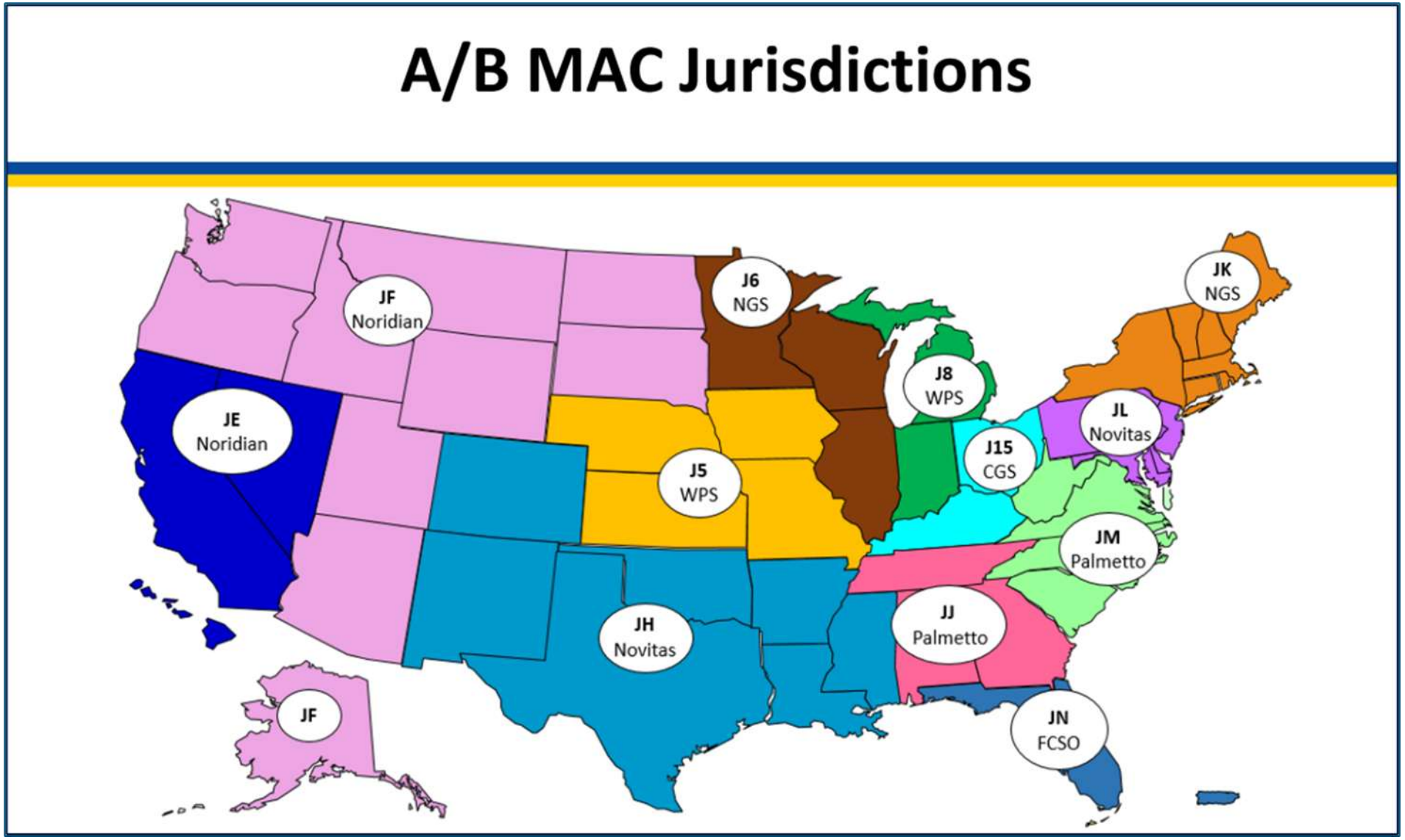

OIG
UPIC
SMRC
RAC
CERT
MAC Pre-Pay
TPE
MAC Routine Post-Pay

# Medicare Area Contractors (MAC)

- Private health insurers that have been awarded a geographic jurisdiction to process Medicare Part A, B, and DME claims for traditional Medicare Fee-For-Service (FFS) beneficiaries
- Process Medicare FFS claims
- Issue recoupment letters / explain the appeal process
- Handle redetermination requests (1st stage appeal process)
- Respond to provider inquiries
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims

# A/B MAC Jurisdictions




https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

SNF 5-Claim

Error Rate > 20%

Part A TPE Notification

# Targeted Probe and Educate (TPE)

- Conducted by the MACs
- Designed to help providers and suppliers reduce claim denials and appeals through one-on-one help
- The goal is to help the facility quickly improve
- MACs work with providers to identify errors and help correct them
- Topics are based on data analysis

# How is my Facility Chosen for TPE

- High claim error rates
- Unusual billing practices
- Items and services that have high national error rates

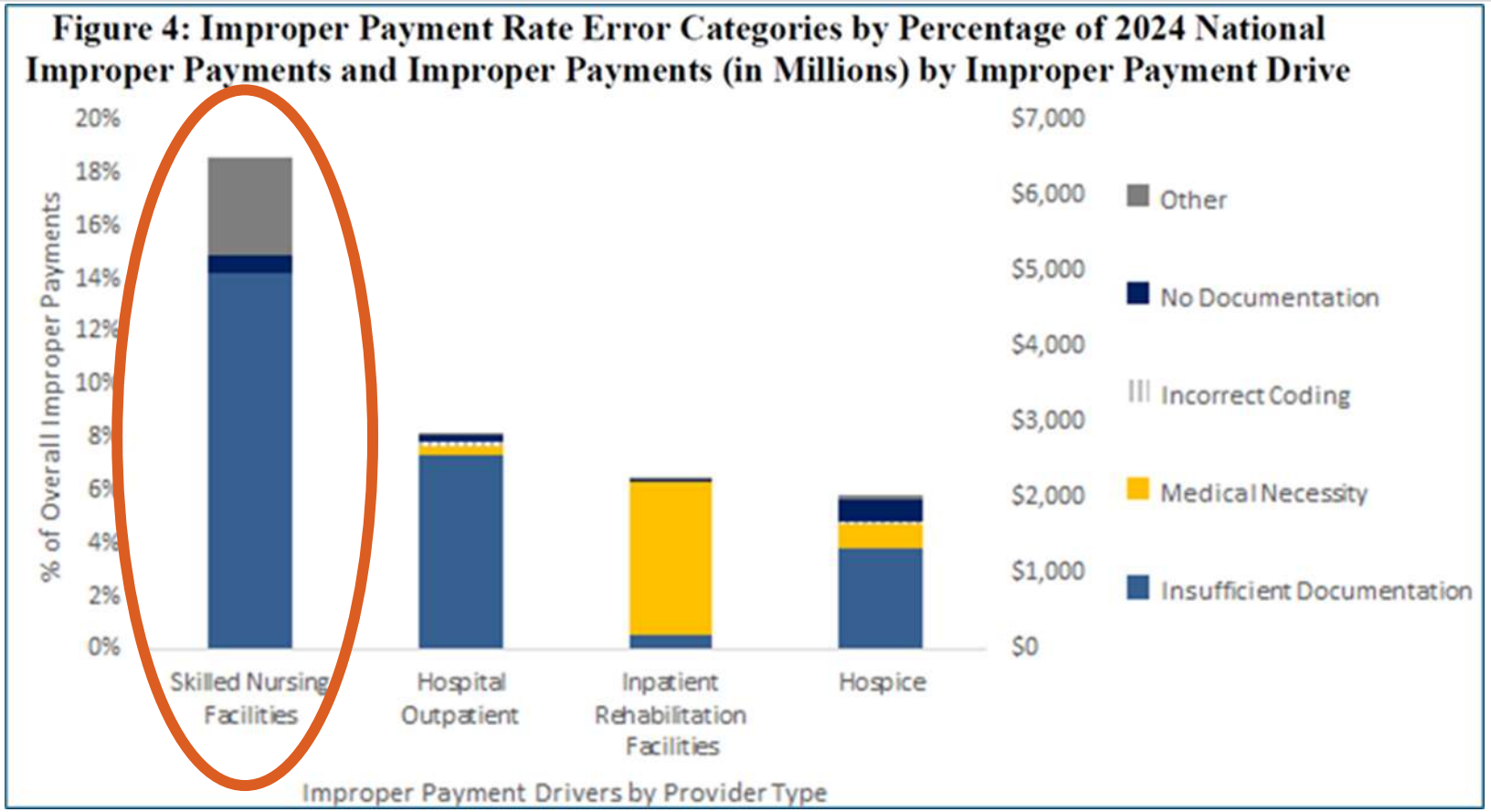
# Targeted Probe and Educate (TPE)

- **Error Rate**:
  - **Part A**:  percentage based on claim errors
  - **Part B**:  claim line-item errors
- A win on appeal typically does not change the claim error rate
- Common claim errors:
  - The physician did not sign the certification
  - Notes did not support all elements of eligibility
  - Documentation did not support medical necessity
  - Missing or incomplete initial certification or recertification

# How Do SNFs Look in 2024?

Improper payments increased from 13.8% in 2023 to 17.2% in 2024

SNF errors were STILL the leaders in overall improper payments




https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

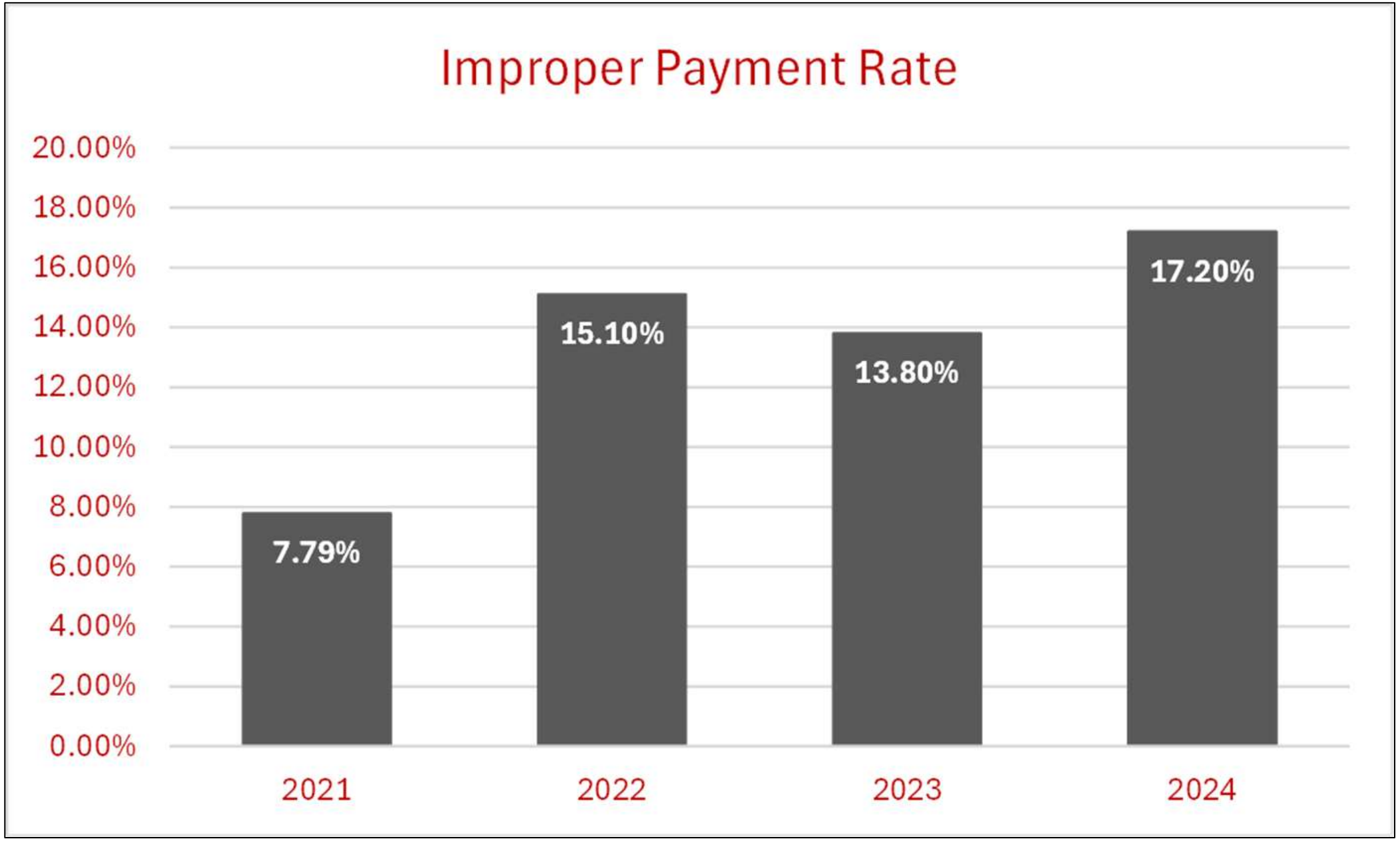

Improper Payment Rate
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
7.79%
15.10%
13.80%
17.20%
2021
2022
2023
2024

**Table B8: Medicare FFS Projected Improper Payments by State (Dollars in Millions)**
**(Unadjusted for Impact of A/B Rebilling)**

| State | Claims Reviewed | Projected Improper Payments | Improper Payment Rate | 95% Confidence Interval | Percent of Overall Improper Payments |
|---|---|---|---|---|---|
| CA | 6,331 | $4,019.5 | 8.4% | 7.1% - 9.6% | 12.3% |
| FL | 3,864 | $2,829.0 | 8.8% | 7.4% - 10.3% | 8.6% |
| TX | 3,503 | $2,392.0 | 7.9% | 6.5% - 9.3% | 7.3% |
| NY | 2,860 | $2,041.2 | 7.1% | 5.3% - 9.0% | 6.2% |
| PA | 2,200 | $1,477.4 | 9.2% | 7.2% - 11.1% | 4.5% |
| OH | 1,758 | $1,459.9 | 10.4% | 6.9% - 13.8% | 4.5% |
| IL | 2,114 | $1,397.4 | 8.2% | 5.9% - 10.5% | 4.3% |
| NJ | 1,528 | $1,052.3 | 8.5% | 6.2% - 10.8% | 3.2% |
| GA | 1,303 | $1,048.2 | 9.7% | 6.5% - 12.8% | 3.2% |
| MD | 1,213 | $955.4 | 7.1% | 3.9% - 10.3% | 2.9% |
| AZ | 1,111 | $878.4 | 13.1% | 9.4% - 16.9% | 2.7% |
| NC | 1,547 | $843.2 | 7.9% | 5.5% - 10.3% | 2.6% |
| MA | 1,366 | $793.7 | 6.2% | 4.0% - 8.4% | 2.4% |
| KY | 722 | $785.3 | 15.3% | 6.8% - 23.9% | 2.4% |
| CO | 655 | $777.1 | 14.0% | 7.0% - 21.1% | 2.4% |
| MI | 1,262 | $686.5 | 6.3% | 4.5% - 8.0% | 2.1% |
| TN | 1,269 | $685.4 | 7.0% | 4.3% - 9.7% | 2.1% |
| VA | 1,271 | $638.5 | 5.7% | 3.7% - 7.7% | 2.0% |
| SC | 817 | $633.1 | 10.7% | 6.7% - 14.8% | 1.9% |
| AL | 713 | $594.1 | 10.1% | 5.9% - 14.4% | 1.8% |

https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

# Active Targeted Probe and Educate for SNFs

Review of SNF PDPM New Provider

Review of S… PD…

…ew of …atient Therapy …REV Codes w/KX Modifier

…M …Necessity

SNF PPS

Pre-payment Review

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# The Part B Therapy KX Modifier

- Rehabilitation services: outpatient physical and occupational therapy (CPT 97010-97546) billed with KX modifier
- **Section 50202** of the **Bipartisan Budget Act of 2018** (BBA of 2018)
    - Therapy cap amounts as thresholds above which claims must in the KX modifier as confirmation that the services are medically necessary and supported by appropriate medical record documentation
    - **CY 2025 KX** modifier threshold amounts:
        - $2410 for PT and SLP services combined
        - $2410 for OT services

# The TPE Process

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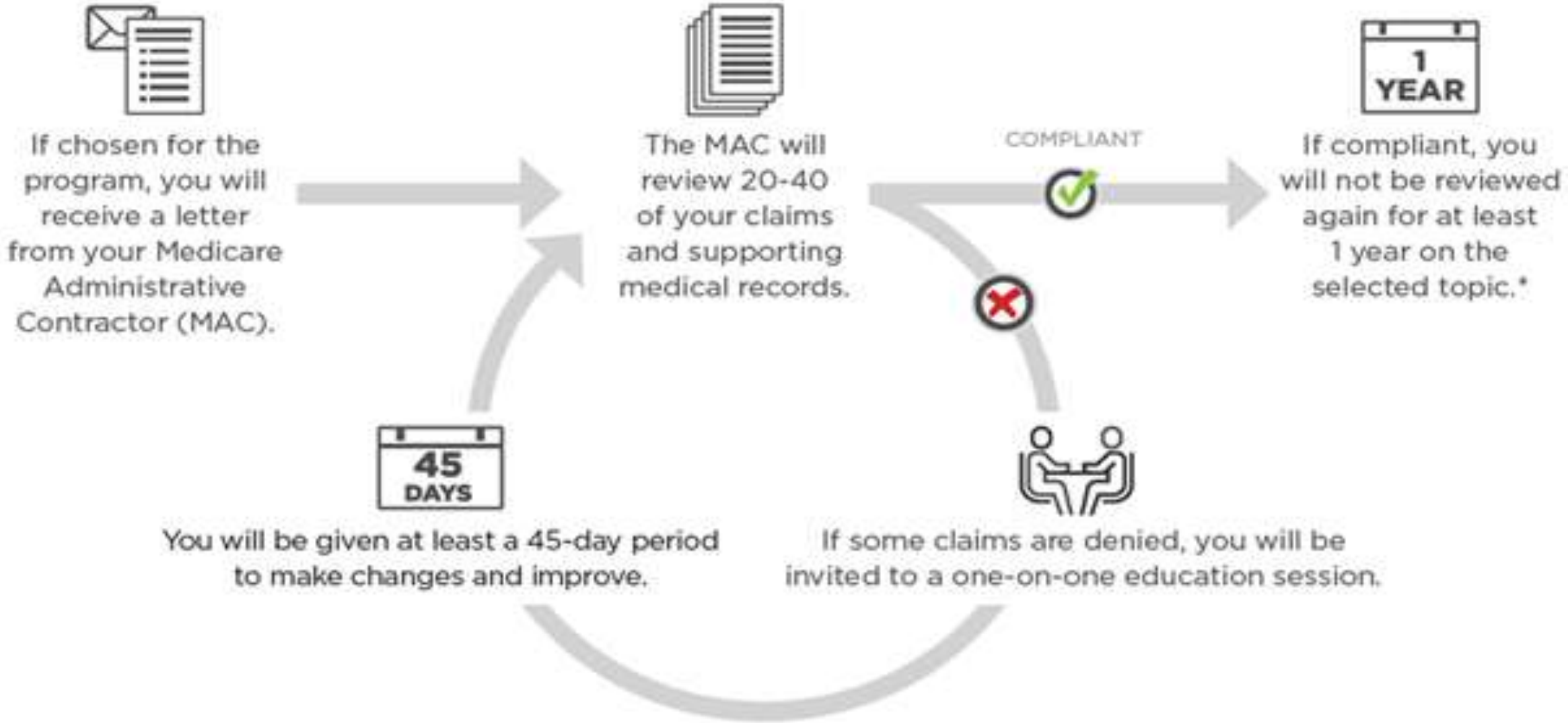


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# What Happens if I Don't Improve After 3 Rounds of TPE?

Referral to CMS for next steps

May include:

- Extrapolation to the universe of facility Part A or Part B claims
- 100% Pre-pay review
- Referral to a **RAC** (Recovery Audit Contractor) or **UPIC** (Uniform Program Integrity Contractor)
- Referral to Provider Outreach and Education
- Other actions, such as dismissal from the Medicare / Medicaid program

# Recovery Audit Contractor (RAC)

- Mission is to identify and correct Medicare improper payments
- RAC may look back up to 3 years from the claim paid date to review claims
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over or underpayment

# Recovery Audit Contractor (RAC)


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# Supplemental Medical Review Contractor (SMRC)

- Use data mining (e.g., profiling of providers, services, or beneficiary utilization) for aberrant patterns
- As directed by CMS
- Perform medical review
- Perform extrapolation
- Make interagency referrals (e.g., to the UPIC)
- Refer to the MAC for recoupment and appeal

# Completed: 01-056 SNF 3-Day Stay Waiver PHE Findings of Medical Review

- Medical record review on SNF claims that had zero hospital days before the SNF admissions, with dates of service March 1, 2020, through December 31, 2021
- Common reasons for denial
    - No response to the documentation request
    - Documentation did not support the claim as billed
    - Documentation did not include physician certifications or recertifications
- Error Rate = 36%

# Completed: 01-088 SNF PDPM Notification of Medical Review

- In response to the **2021 Medicare Fee-for-Service Supplemental Improper Payment Data**, projected improper payments were estimated at $2.7 billion in SNF billing
- Data analysis done by CMS and the SMRC “identified a possible vulnerability in the maximization of payments by a drop in therapy utilization and/or the manipulation of other combinations of care.”
- Post-payment review of FFS Part A with dates of service between **January 1 and December 31, 2020**
- **Error Rate = 18%**

# Completed: 01-088 SNF PDPM Notification of Medical Review

**Common Reasons for Denial**

- **Missing Certifications or Recertifications**
  - Documentation submitted did not include the required certifications or recertifications for the SNF stay
- **Incomplete and/or Insufficient Information**
  - Documentation submitted was incomplete/insufficient information
  - Documentation did not include therapy evaluations
  - Documentation did not meet requirements for certification or recertification
  - Incomplete or insufficient documentation to support MDS entries
  - MDS was not signed timely for claims with DOS before March 1, 2020

# Unified Program Integrity Contractor (UPIC)

- Identifies potentially fraudulent Medicare providers
- Investigates instances of suspected fraud, waste, and abuse
- Develops investigations early, and in a timely manner
- Takes immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid – Medicare payment suspension
- Identifies any improper payments that are to be recouped by MACs

# Unified Program Integrity Contractor (UPIC)

- Contractors operate in five (5) separate geographical jurisdictions:
  - **Qlarant Integrity Solutions, LLC** – Western & Southwestern
  - **CoventBridge Group** – Midwestern
  - **Safeguard Services** – Northeastern, Southeastern

# Unified Program Integrity Contractor (UPIC)

Process

- Perform data analysis
- Request medical records and documentation – 15 to 30 days to submit!
- Conduct interviews & onsite visits
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold/Suspend Medicare payments
- Refer cases to law enforcement for civil or criminal prosecution
- Identify recoupment situations and refer to the MACs for the recoupment and appeals

# Health & Human Services (HHS) Office of the Inspector General (OIG)

- Currently auditing SNFs that billed PDPM to ensure compliance with Medicare requirements
- Audit claims and issue findings
- Perform extrapolation
- Make recommendations to the facility to correct issues
- Make recommendations to CMS for enforcement and recoupment
- Publicly available

# Medical Review & Additional Documentation Requests (ADRs)


OR


# Common Reasons for Part A Claim Denial


- No response to ADR or request for records
- Missing information
- Technical information
- Improper coding
- Physician's orders – medical necessity
- Physician certification/recertification
- **Insufficient Documentation**

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# Top Denial / Partial Denial Reasons: Part B TPE

- Documentation did not support medical necessity
- Insufficient documentation
- Incorrect coding
- Billing errors

# Red Flags - What May Signal a Problem?

- Large number of ADR requests from a Medicare or Medicare Advantage contractor
- ADR results in 100% or partial claim denial
- Selection for TPE, SMRC, UPIC, or OIG audit

# What May Put My Facility on CMS' Radar?

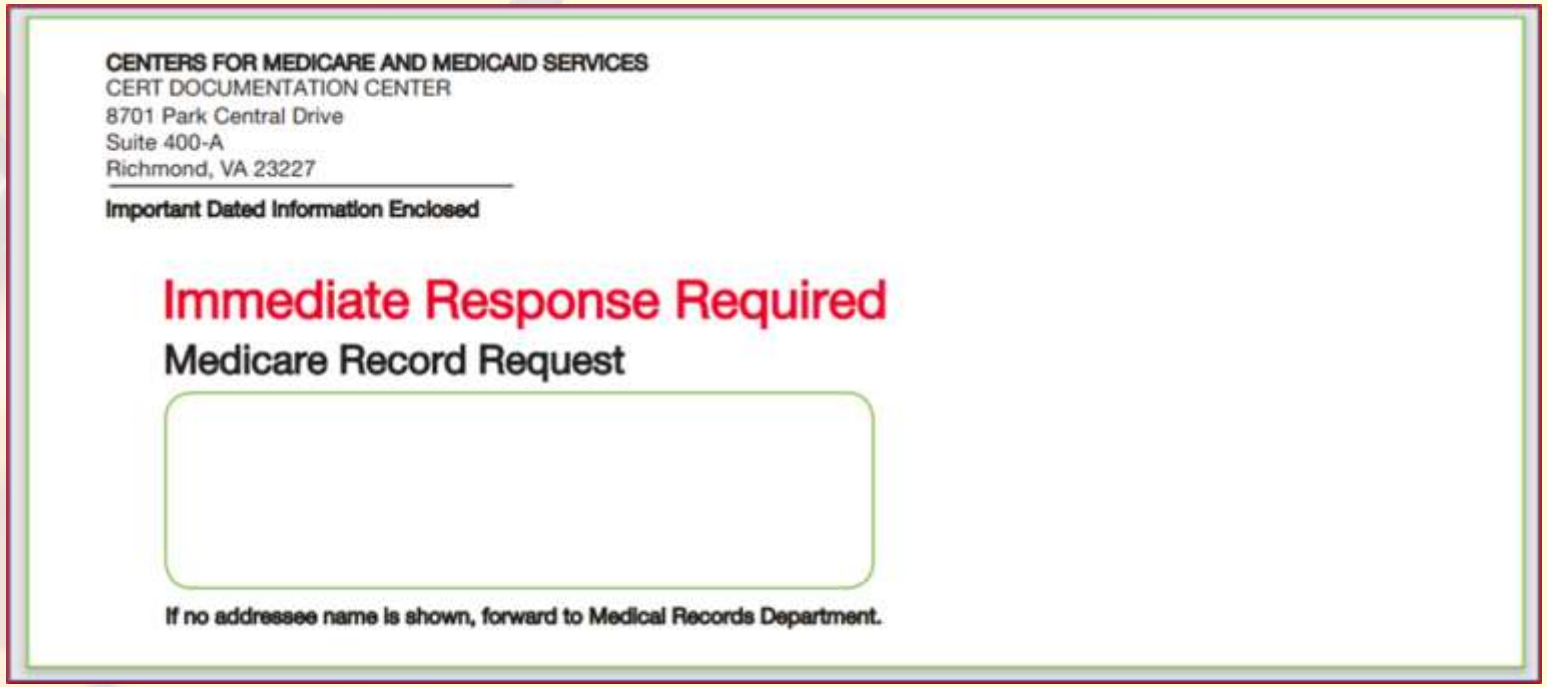
- All primary diagnoses are the same or limited to a few
- The majority of or all residents' length of stay is 100 days
- Frequent use of rare diagnoses
- Unusual capture patterns

# Attendee poll

**Has your facility received notification of a QRP/VBP Data Validation Audit?**

- Yes
- No
- I don’t know, how do I find out?

# Responding to ADRs



CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
8701 Park Central Drive
Suite 400-A
Richmond, VA 23227

Important Dated Information Enclosed

Immediate Response Required

Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

# Additional Documentation Request (ADR) Response Team

- Identify an ADR Coordinator
- Identify who is responsible for collecting the facility mail and what to do with any letters from CMS, MAC, UPIC, or any other entities
- Compile records for the requested service date AND 30 days prior to ARD
- Tracking checklist with due dates and the person responsible
- Team review of each packet
- Prepare a cover letter

# ADR Response

- Timely response is critical – **know your deadline**
- Provide all requested records the first time
- Check the right beneficiary, right service, and right date of service
- Clear copies of both sides of the document
- Check submission requirements
- Verify that portal address, mailing address, and/or fax numbers are correct

# ADR Checklist

- Hospital history and physical, transfer forms, and discharge summaries
- Facility physician's history and physical
- Physician's (and extenders') orders and progress notes
- Consultant progress notes
- Nursing assessments and progress notes
- Rehab documentation
- Interdisciplinary assessments and progress notes
- MARs, TARs, flow sheets, vital sign records
- Care plans
- MDS to confirm signatures/credentials
- Facility policies and procedures

# Missteps That Lead to Claim Denial

- Ignore notification letters
- Fail to notify the “Chain of Command”
  - Administration
  - Corporate
  - Compliance
  - Legal
- Miss deadlines
- Send disorganized or incomplete records
- Fail to send the records in the format requested
- Send the wrong patient files
- Failure to maintain a copy of the records sent
- Failure to respond to appeal deadlines

# How is My MDS Information Used?

# Skilled Nursing Facility Data Validation Process to ADRs

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# Data Validation Process

Will evaluate the accuracy of quality measure data elements from the MDS data, which are used in the SNF QRP and VBP for assessing quality of care and measuring improvement in quality of care

CMS will choose up to 1500 SNFs that submitted at least 1 MDS record in the previous CY and in the current FY

The contractor will request up to 10 records and have 45 days from the date of the request to submit the record

Data validation process and selection notification is scheduled to begin in Fall 2025

# Data Validation Process

- Random selection from all eligible SNFs
- SNFs will be informed through iQIES > My Reports > MDS 3.0 Provider Preview Reports
- The notification will contain instructions for:
  - Documentation submission
  - Resident sample
  - Contact info for the data validation contractor

# Penalties for SNF QRP/VBP Data Validation Non-Compliance

Non-compliance is the failure to respond or not submitting all requested records

For the FY2025 performance year/FY2027 program year, noncompliance may result in a **2% reduction** of an SNF's Annual Payment Update for the FY2027 SNF QRP program year

SNFs that are non-compliant will receive a Summary Scoring Report that includes a notification that they were non-compliant. SNFs also receive a non-compliance notification letter from their Medicare Administrative Contractor (MAC)

# Key Takeaways

- MDS accuracy, communication, education
- Self or Third-party audit of MDS assessments
- Medical necessity - **DOCUMENTATION**
- Audit Response Coordination
- Check iQIES frequently for data reports and notification letters
- Look at the reason for denials - QAPI

# References & Resources

- SNF QRP & VBP Data Validation Process: https://www.cms.gov/medicare/quality/value-based-programs/value-based-purchasing-snf-vbp-program/data-validation-process
- SNF QRP & VBP Data Validation Process FAQ: https://www.cms.gov/files/document/data-validation-process-frequently-asked-questions.pdf
- Medicare Part A/B MAC Jurisdictions: https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf
- TPE Information: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe
- RAC Information: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program
- SMRC Information: https://med.noridianmedicare.com/web/jddme/cert-reviews/smrc

# Thank You


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# RATIONALIZING THE SNF ECONOMY

ZIMMET HEALTHCARE SERVICES GROUP, LLC

### Advisory
- Market Insights
- Underwriting Support
- Asset Monitoring

### Reimbursement-Innovations
- Payment System Reform
- Value-Based Arbitrage
- Managed Care Initiatives

### Quality Innovations
- Five-Star Support
- Regulatory Monitoring
- SNF Data Profile Analysis

### Survey & Regulatory
- Survey Preparation
- Data Profile Optimization
- Litigation / Expert Witness

### Reporting & Analytics
- Medicare/Medicaid Cost Reports
- Performance Benchmarking
- Data-on-Demand

### Reimbursement-Compliance
- Scalable Audit Services
- Appeals & Representation
- Independent Review Organization

### Ancillary Innovations
- Program Inception & Administration
- Opportunity Indexing
- “Coopetition” Alignment

z-INTEL

myzPAX

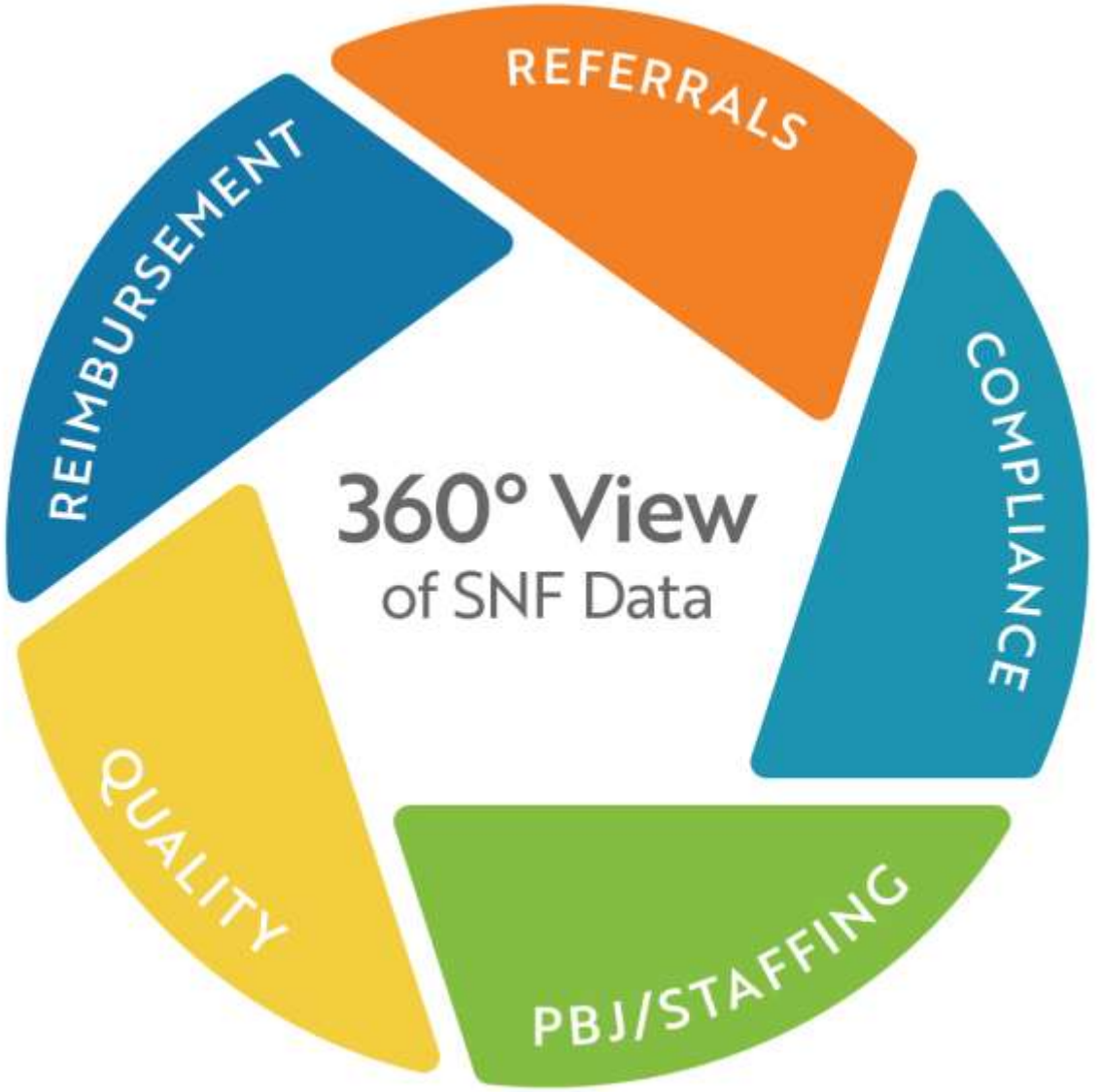
R² Reimbursement Reimagined

Z-AIMS

SimpleComplete™

# One simple suite for SNF success

The industry's only complete solution for reimbursement, referrals and regulatory compliance.




### MDS predictive analytics.

Optimize PDPM, Five-Star/QMs and iQIES workflow

### PBJ and staffing.

Simplify Payroll-Based Journal and staffing strategy

### Referrals and reimbursement.

Build census and optimize claims revenue in real time

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*Scan code or visit simple.health/demo*

# QUESTIONS?

Recording and slides will be available:
*www.simple.health/blog*

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