Arent Fox

Corporate Compliance Symposium

Home Care Association of New York State

Hospice & Palliative Care Association of New York State

October 17, 2018

Albany Capital Center

Presented by:

Rachel Hold-Weiss

Arent Fox

Most Common Medicare Denials for Hospice

- Documentation did not support a terminal prognosis
- Hospice Plan of Care does not meet the COPs
- Physician narrative statement not present or not valid
- Face-to-Face requirements not met
- NOE did not meet requirements

Arent Fox

Most Common Medicare Denials for Home Health

- Medical documentation did not show therapy was at a level of complexity requiring a therapist
- Medical records not received within the 45 day time limit
- Invalid physician certification due to issues with the face-to-face – untimely, no signature by certifying physician
- Encounter notes do not support eligibility

Arent Fox

Targeted Probe and Educate

Arent Fox

Targeted Probe and Educate (TPE)

- Started as a pilot program
- CMS chose the topics
- Request for 5 records was issued to Medicare certified home health agencies
- Actions that were taken at the time depended on how many denials there were of the 5 records

Arent Fox

Targeted Probe and Educate (TPE) (Cont'd)

"Providers and suppliers who have high claim error rates or unusual billing practices, and items and services that have high national error rates and are a financial risk to Medicare"

1. Pilot expanded to all providers as of October 2017
2. Providers chosen based on data mining
3. Topics chosen by each MAC based on data analysis (or CMS)
4. Hospices and home health agencies are receiving letters

Arent Fox

Targeted Probe and Educate (TPE) (Cont'd)

5. Letters arrive in a pink envelope to the correspondence address noted on the CMS 855A form
6. 20-40 claims per item or service
7. Review is pre-pay (or in some limited instances post-pay)
8. Records must be **received** by the MAC prior to the 45th day – dates are based on date of ADRs which are generated through the usual process
9. Contractor discretion to allow for a late submission (within 120 days)
10. Non-response counts as an error

Arent Fox

Targeted Probe and Educate – Results

1. Acceptable error rate varies based on item or service under review – known as Payment Error Rate or "PER"
2. NGS has indicated that the acceptable PER is less than 15% - to arrive at the PER: total Medicare dollars would have been paid versus dollars denied
3. Claims error rate may also be calculated and may be reported, but is not a factor in continuing review - # of claims reviewed and # of claims denied
4. Results provided within 30 days of the full receipt of the records (if paper copies are sent, may take longer)
5. If don't meet the acceptable PER threshold, education offered; appeal rights are preserved

Arent Fox

Targeted Probe and Educate – Results (Cont'd)

6. Provider has at least 45, up to 56, days until next level of review begins – count begins from date of billing, not DOS
7. If compliant, will not be chosen for review on same topic for at least one year
8. Up to 3 rounds of TPE
9. If fail at third round, referral to CMS (RAC, 100% pre-pay review, extrapolation, etc.)
10. PER will not change if claims are overturned on appeal

Arent Fox

Differences from Prior Audits

- If a document is missing during review of the claim that would otherwise be in the record, the reviewer will contact the provider for the missing document – opportunity for provider to send in missing information during the review
- Goal is "education" and to "fix easily curable denials allowing for claim payment"
- Education is offered during the review if there is a common theme that can be corrected during the review
- Education is offered at each level of review that is specific to the denials of the applicable provider

Arent Fox

How the Audits are the Same

- Appeal rights remain the same at each level of denial
- Educational sessions are not appeals – they do not take the place of appeals, nor do they extend the appeal time frame
- If the MAC finds issues related to the topic of the denied claim, they may conduct reviews of the related matters outside of the TPE process

Arent Fox

What is Included in an Initial TPE Letter?

- MAC is responsible for TPE
- Explanation of TPE process
- Explanation of why provider is subject to TPE
- General explanation of ADRs
- Explanation of the education process

Arent Fox

What Is Included in a TPE Results Letter?

- Outlines the TPE process again
- Reasons for the denial – citations to CMS regulations
- Provides the PER
- Release or continuation of TPE review
- Education information and contact

Arent Fox

TPE Reviews Home Health

- Agency claims of 5-7 visits (just above LUPA)
- Agencies with higher than average therapy utilization (10 or more claims)
- Agencies that did not respond to prior round 2 requests

Top Denial Reasons:

1. FTF missing, incomplete or untimely
2. Therapy services not reasonable and necessary or skills requiring the level of the therapist
3. Certification missing or invalid

Arent Fox

TPE Reviews Hospice

- First Audit - Services reasonable and necessary
- Second Audit - GIP greater than 7 days/7 days or more

First Audit – Services Reasonable and Necessary

Top Findings:

1. Terminal diagnosis not supported
2. Initial certification not signed timely

Arent Fox

TPE Reviews Hospice (Cont'd)

Second Audit – GIP

Top Findings:

1. GIP not supported
2. Initial certification not signed timely
3. Initial certification not signed at all

Arent Fox

Information from NGS

- NGS recommends responding to ADRs within 35-40 days of letter date.
- Be sure to forward the requested documentation to the correct NGS post office box.
- Send each response separately and attach a copy of the corresponding ADR. It is acceptable to send multiple responses in a single mailing; however, each response must be individually bundled with a copy of the corresponding ADR within the mailing to facilitate proper handling and review of the ADR response.
- Include all records necessary to support the services for the dates requested.
- Do not include additional correspondence with documentation submissions. Unrelated correspondence should be mailed separately.

Arent Fox

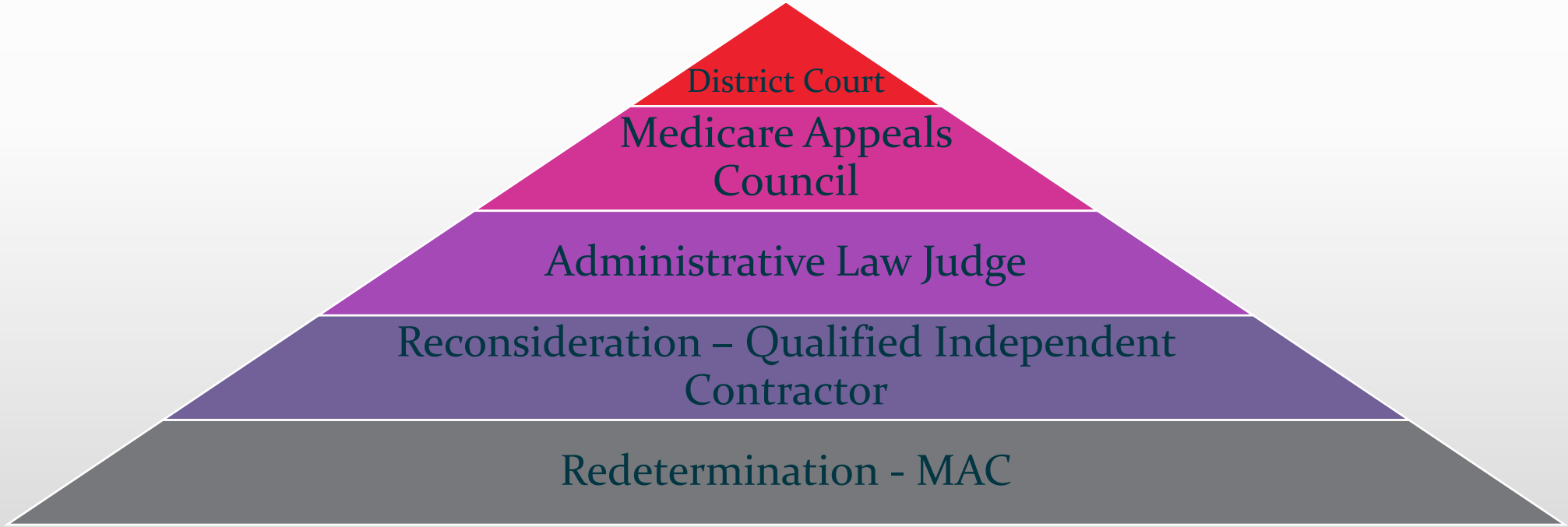
Information from NGS (Cont'd)

- Records must be complete and legible. Be sure to include both sides of double-sided documents.
- The NGS self-service portal, NGSConnex, allows both Part A (including home health, hospice and FQHCs) and Part B providers to respond to ADRs electronically with no need to mail or fax a response to complete the ADR process. Further details are available on our website. If you are a current user of NGSConnex, click on the link for a new NGSConnex User Guide for step-by-step instructions on how to submit ADR. If you are not a current user, sign up and get started!
- All services must include necessary signatures and credentials of professionals. See the CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, "Signature Requirements."

https://www.ngsmedicare.com – Medical Review – Targeted Probe and Educate Strategy and the NGS Medical Review Process (accessed September 12, 2018)

Arent Fox

APPEALS



Arent Fox

Appeals Process for a Redetermination

- Have 120 days from the date the denied claim was processed on the remittance to appeal
- No set amount in controversy
- Can be an appeal of the entire denied claim or partially denied claim
- Can be done electronically or via paper
- Reviewed by MAC
- MAC has 60 days to issue a redetermination decision
- If denied, how to apply for reconsideration

Arent Fox

Appeals Process for a Reconsideration

- Have 180 days from the date the date the redetermination was denied to appeal
- No amount in controversy
- Can be an appeal of the entire denied claim or partially denied claim
- Reviewed by Qualified Independent Contractor ("QIC") – C2C Innovative Solutions, Inc. is the Part A East QIC
- QIC has 60 days to issue a reconsideration decision
- How to apply for ALJ hearing

Arent Fox

Appeals Process for an ALJ Hearing

- Have 60 days from the date the reconsideration was denied to appeal
- $160 amount in controversy (adjusted)
- Can be an appeal of the entire denied claim or partially denied claim
- Reviewed by ALJ
- ALJ has 90 days to issue a reconsideration decision - Average processing time 3rd quarter Fiscal Year 2018 is 1,142 days
- How to submit appeal to the Medicare Appeals Council

Arent Fox

Appeals Process for the Medicare Appeals Council

- Have 60 days from the date of the ALJ decision to appeal
- Record for review is limited to prior record
- Appeal to Federal District Court

Arent Fox

Appeals Process for Federal District Court

- Have 60 days from the date of the MAC decision to file a complaint
- Record for review is limited to prior record
- $1,600 amount in controversy (adjusted)
- No time frame for decision

Arent Fox

Questions?

Contact
Rachel Hold-Weiss
Arent Fox LLP
Partner
212-484-3999
Rachel.hold-weiss@arentfox.com

Arent Fox

AFDOCS #16943485v3