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Welcome and Meet Your Team

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Partner, Senior Living Services Consulting Group

As a Partner in RKL's nationally recognized Senior Living Services Consulting Group. Stephanie's first-hand clinical expertise and relevant industry credentials allow her to guide providers toward successful outcomes. She specializes in post-acute care operations, strategic planning, regulatory and billing compliance, third-party reimbursement, continuing education, quality improvement, survey assistance and electronic health record implementation.

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Agenda

- Audit Contractors: Identifying the Key Players
- Audit Notification: Understanding the Process and Timelines
- Purpose of Audits: Exploring the Reasons Behind Them
- Audit Findings: Analyzing the Results
- Appeals Process: Navigating the Next Steps
- Best Practices: Enhancing Audit Preparedness and Response

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Audit Contractors: Identifying the Key Players

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Audit Contractors: Identifying the Key Players

- Commercial Payer
- Federal Government
- State Government
- Third-Party

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Audit Contractors: Identifying the Key Players

- MAC: Medicare Administrative Contractor
- RAC: Recovery Audit Contractor
- UPIC: Unified Program Integrity Contractor
- I-MEDIC: Investigations Medicare Drug Integrity Contractor
- CERT: Comprehensive Error Rate Testing Program
- PERM: Payment Error Rate Measurement Program
- SMRC: Supplemental Review Contractor

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External Auditors: The MAC

- Process Medicare FFS Claims
- Make and Account for Medicare FFS Payments
- Enroll Providers in the Medicare FFS Program
- Handle Redetermination Requests (1st Level of Appeals)
- Respond to Provider Inquiries
- Establish Local Coverage Determinations (LCDs)
- Review and Educate (TPE)

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External Auditors: The MAC

- Types:
  - A/B MACs
  - Home Health and Hospice (HH+H)
  - DME

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External Auditors: The MAC

State	A/B	HH&H	DME
Delaware	Novitas Solutions, Inc.	CGS Administrators, LLC	Noridian Healthcare Solutions, LLC
Maryland	Novitas Solutions, Inc.	CGS Administrators, LLC	Noridian Healthcare Solutions, LLC
New Jersey	Novitas Solutions, Inc.	National Government Services, Inc.	Noridian Healthcare Solutions, LLC
New York	National Government Services, Inc.	National Government Services, Inc.	Noridian Healthcare Solutions, LLC
Ohio	CGS Administrators, LLC	Palmetto GBA, LLC	CGS Administrators, LLC
Pennsylvania	Novitas Solutions, Inc.	CGS Administrators, LLC	Noridian Healthcare Solutions, LLC
Virginia	Palmetto GBA, LLC	CGS Administrators, LLC	CGS Administrators, LLC

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External Auditors: The RAC

- Identify and Correct Medicare Improper Payments
  - Complex Reviews
    - Require Medical Record Review
  - Automated Reviews
    - System Level
- Approved RAC Topics

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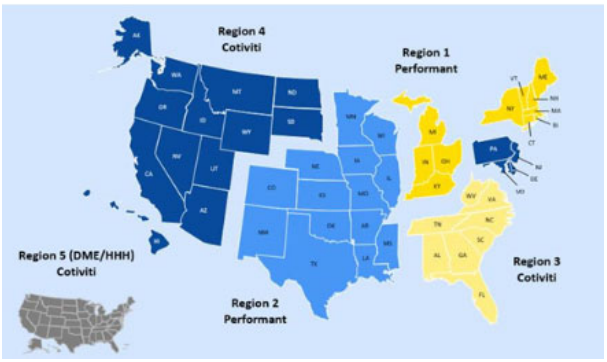
External Auditors: The RAC



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External Auditors: The UPIC

- Fraud, Waste, and Abuse Detection and Deterrence
  - Medicare: A, B, DME, HH+H
  - Medicaid
- Data Analysis
- Medical Review
- Work closely with HHS OIG, MFCU, Law Enforcement, FBI

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External Auditors: The UPIC

- Onsite Reviews
- Identify Overpayments
- Prepayment Reviews
- Administrative Actions
  - Auto-Denial Edits
  - Prepayment Reviews
  - Payment Suspensions
  - Revocations

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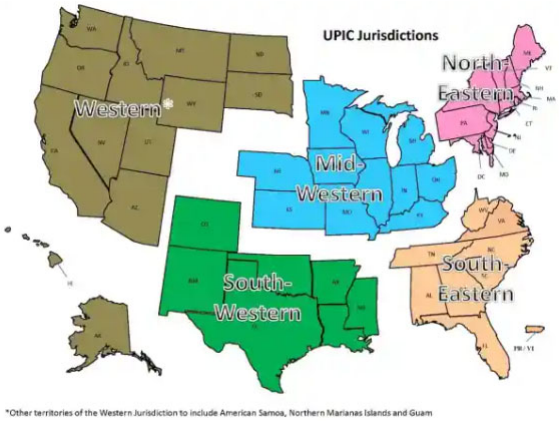
External Auditors: The UPIC



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External Auditors: The I-MEDIC

- Monitors Fraud, Waste, or Abuse for Part C and Part D
- Data Analysis
- Medical Reviews
- Prepayment/Postpayment Reviews – Identify Overpayments
- Administrative Actions
- Referrals

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External Auditors: The CERT

- Evaluates a Stratified Random Sample of Medicare FFS Claims to determine if they were paid or denied properly to measure program accuracy
  - Findings can be projected to the entire universe of Medicare FFS claims
- Identify Overpayments
- Findings are used by CMS Contractors (and providers) to update internal processes and educate providers.
  - Available on the CMS Website

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External Auditors: The PERM

- Evaluates a Stratified Random Sample of Medicaid Claims to determine if they were paid or denied properly to measure program accuracy
  - Findings can be projected to the entire universe of Medicare FFS claims
- Identify Overpayments
- Three cycles per year
- Help to identify cost-effective actions for correcting errors

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External Auditors: The SMRC

- Nationwide Medical Reviews of Medicaid, Medicare A/B and DME
- Focuses may include CMS initiatives, CERT findings, identified vulnerabilities
- May result in an overpayment

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External Auditors: Validation Program

- Healthcare Management Solutions, LLC (HMS)
- Established to assess the accuracy of MDS-based quality measures used in the SNV VBP
- Begins Fall 2025
- All notifications will be via iQIES – check on a regular basis
- Have 45 days to submit documentation to support the validation of 10 MDS assessment records
- Noncompliance will result in 2% reduction of APU for FY2027 SNF QRP

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Audit Notification: Understanding the Process and Timelines

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Audit Notification: The Process

- CMS Contractors send providers Additional Documentation Requests (ADR)
  - Includes instructions on timeliness and how/where to send records
- Reviews are completed by the Contractors' individual review departments
- Results are communicated back to the provider and to CMS

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Audit Notification: The Timeline

- Timeframes are specified on the ADR
  - 30-45 days, depending on contractor and type of review
- No response = denials
- Denials = $$

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Audit Notification: The Process

- Follow instructions on the ADR
  - Usually lists required documentation to submit
- Include a copy of ADR as the first page
- Can be submitted electronically or US Postal Service
- Submit all documentation to support the services billed
- Organized and easy-to-follow package

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Purpose of the Audits: Exploring the Reasons Behind Them

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Purpose of the Audits

- Statutory authority:
  - SSA 1815, 1833, 1842, 1862, 1893
- Protect the Medicare Trust Fund
- Protect from Fraud, Waste, and Abuse
- Quality of Services

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Audit Findings: Analyzing the Results

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Audit Findings

- Level of care/Incorrect Coding
- Insufficient Documentation:
  - Incorrect rendering provider
  - No response to ADR
- Medical Necessity Errors
- Billing Errors

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Audit Findings: SNF Errors

Root Cause Description	Error Category	Sample Claim Count[6]
Case Mix Group (CMG) component documentation - Missing	Insufficient Documentation	388
HIPPS level changed based on documentation submitted*	Insufficient Documentation	269
Order - Missing	Insufficient Documentation	176
Physician's Certification/Recertification - Inadequate	Insufficient Documentation	80
Documentation to support level of care requirements - Missing	Insufficient Documentation	71
Case Mix Group (CMG) component documentation - Inadequate	Insufficient Documentation	41
Signature log to support a clear identity of an illegible signature - Missing	Insufficient Documentation	39
Other	Other	33
Physician's Certification/Recertification - Missing	Insufficient Documentation	31
Order - Inadequate	Insufficient Documentation	24
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

Source: 2024 Medicare Fee-for-Service Supplemental Improper Payment Data

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Audit Findings: Hospice Errors

Root Cause Description	Error Category	Sample Claim Count
Physician's Certification/Recertification - Inadequate	Insufficient Documentation	29
Service intensity add-on (SIA) services documentation – Missing*	Insufficient Documentation	17
Physician's Certification/Recertification - Missing	Insufficient Documentation	9
Units of service (UOS) incorrectly coded – Documentation supports higher UOS than billed*	Incorrect Coding	9
Documentation does not support medical necessity for the service or item billed	Medical Necessity	8
Beneficiary election form addendum - Inadequate	Insufficient Documentation	8
Face to face documentation - Missing	Insufficient Documentation	7
Units of service (UOS) incorrectly coded – Documentation supports lower UOS than billed*	Incorrect Coding	7
Beneficiary election form - Inadequate	Insufficient Documentation	6
Beneficiary election form - Missing	Insufficient Documentation	6
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

Source: 2024 Medicare Fee-for-Service Supplemental Improper Payment Data

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Appeals Process: Navigating the Next Steps

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Appeals Process: Navigating the Next Steps

- Level 1: Redetermination
- Level 2: Qualified Independent Contractor (QIC) Reconsideration
- Level 3: Decision by the Office of Medicare Hearings and Appeals (OMHA)
- Level 4: Review by the Medicare Appeals Court
- Level 5: Judicial Review in Federal District Court

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Appeals Process: Navigating the Next Steps

- Level 1: Redetermination
  - Completed by the MAC
  - Must file an appeal within timeframes (60 days)
    - Can submit online or mail
  - MAC decides within (usually) 60 days of receiving the request
  - Will be notified in writing

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Appeals Process: Navigating the Next Steps

- Level 2: Reconsideration
  - Completed by the QIC
  - Must file an appeal within timeframes (180 days from MAC decision)
    - Can submit online or mail
    - Can check status of appeal on the Q2 website
  - QIC decides within (usually) 60 days of receiving the request
  - Will be notified in writing

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Appeals Process: Navigating the Next Steps

- Level 3: OMHA
  - Completed by Administrative Law Judge (ALJ)
  - Must file an appeal within timeframes (60 days of QIC decision)
  - Minimum dollar amount to file ($190)
  - OMHA sets hearing date (telephone)
  - ALJ decision depends on caseload (usually within 90 days)
  - Appeal status updated on OMHA Portal
  - Will be notified in writing

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Appeals Process: Navigating the Next Steps

- Level 4: Medicare Appeals Council
  - Must file an appeal within timeframes (60 days of ALJ decision)
  - Include copy of ALJ decision with appeal
  - Can submit via mail or fax
  - Will be notified in writing

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Appeals Process: Navigating the Next Steps

- Level 5: Federal Court
  - Must file an appeal within timeframes (60 days of Council decision)
  - Minimum dollar amount $1,840
  - Follow instructions on the Council's decision letter

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Best Practice:
Enhancing Audit Preparedness and Response

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Best Practices: Preparedness

- Education
  - Medicare regulations;
  - Medicare reimbursement;
  - Supportive Documentation; and
  - Medicare billing
- Compliance Analyses
- Triple Check

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Best Practices: Response

- Do not ignore ADRs
- Educate your team on ADRs
- Be cooperative and accommodating with auditors
- Set a timeline upon receipt of notice
  - Goal for internal documentation to be pulled
  - Deadline for final review
  - Deadline to send information
    - Verify electronic or paper (confirm address and method of sending)

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Do You Have Questions?

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Thank You for Joining Us
Whatever your next move, we're here to help.
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