Successfully Navigating Nursing Home Reimbursement Compliance

March 2025

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Reference links are provided at the end of the slides.

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Today's Objectives

Review the types of audit contractors and their scope to best prepare for audit response.

Discuss the contemporary challenges skilled nursing facilities face in adhering to Medicare Part A documentation standards.

Provide attendees with actionable tips, best practices, tools, and resources to enhance their Medicare Part A compliance practices.

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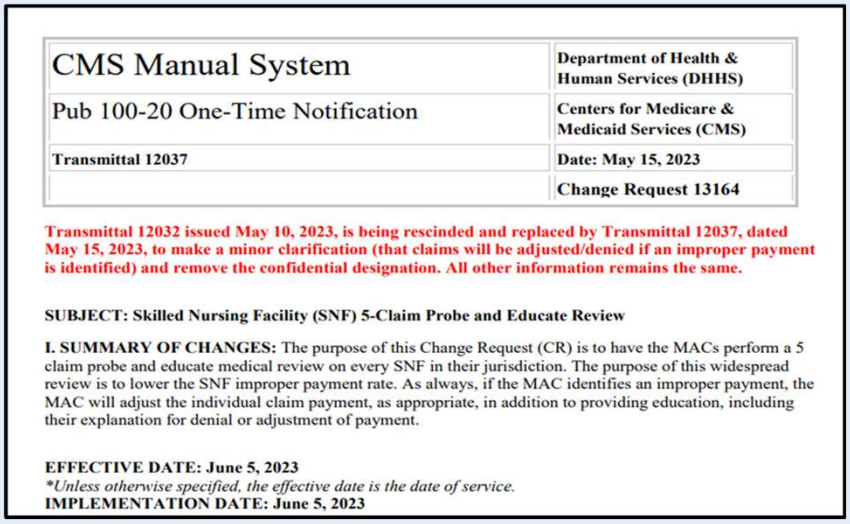
Skilled Nursing Facility 5-Claim Probe and Educate Review



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12037	Date: May 15, 2023
	Change Request 13164

Transmittal 12032 issued May 10, 2023, is being rescinded and replaced by Transmittal 12037, dated May 15, 2023, to make a minor clarification (that claims will be adjusted/denied if an improper payment is identified) and remove the confidential designation. All other information remains the same.

SUBJECT: Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to have the MACs perform a 5 claim probe and educate medical review on every SNF in their jurisdiction. The purpose of this widespread review is to lower the SNF improper payment rate. As always, if the MAC identifies an improper payment, the MAC will adjust the individual claim payment, as appropriate, in addition to providing education, including their explanation for denial or adjustment of payment.

EFFECTIVE DATE: June 5, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 5, 2023

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Key Points of Transmittal 12037

- All Medicare Area Contractors (MACs) have been instructed to select 5 claims from each SNF in their jurisdiction
- This directive is focused on Part A PDPM claims to "increase comprehension of correct billing practices"
- MACs will complete one round of probe and educate for each provider instead of the potential 3 rounds as per the traditional Target Probe and Educate (TPE) program
- Provider education will be based on the identified errors
- Prepayment review

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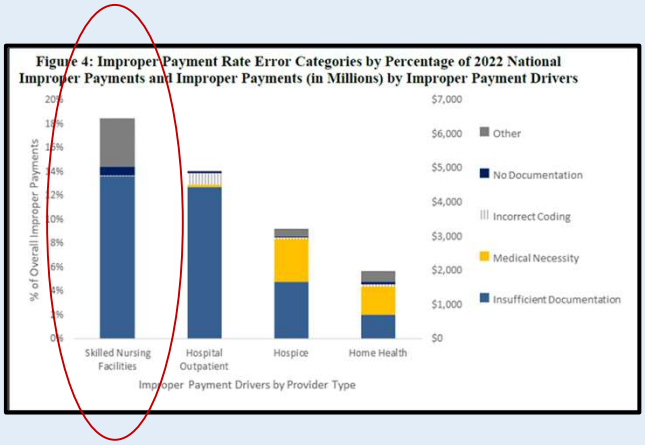
Why Did CMS Do This?

- The Comprehensive Error Rate Testing (CERT) program projected an improper payment rate of 15.1% in 2022, up from 7.79% in 2021
- SNF errors are the number one driver in the overall rate
- "May be in part due to the change from RUG-IV to PDPM"



https://www.cms.gov/files/document/2022-medicare-fee-service-supplemental-improper-payment-data.pdf

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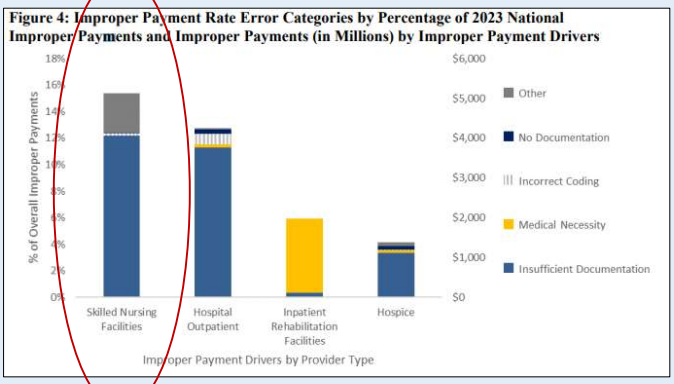
SNFs Improved in 2023, But…

- Improper payments decreased from 15.1% in 2022 to 13.8% in 2023
- SNF errors were still the leaders in overall improper payments



https://www.cms.gov/files/document/2023medicarefee-servicesupplementalimproperpaymentdatapdf.pdf

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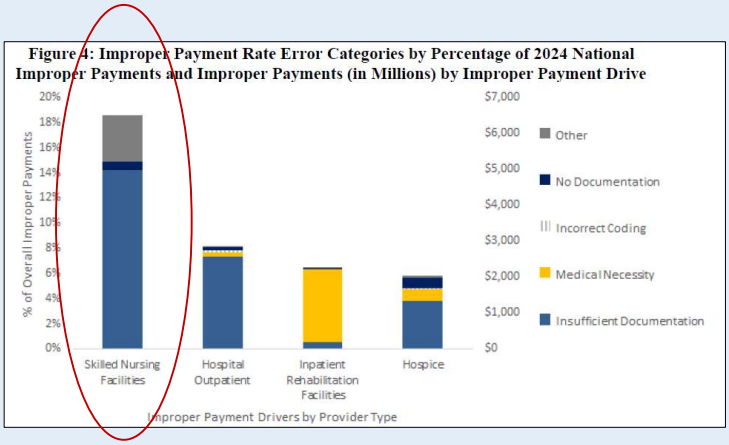
How Do SNFs Look in 2024?

- Improper payments increased from 13.8% in 2023 to 17.2% in 2024
- SNF errors were STILL the leaders in overall improper payments



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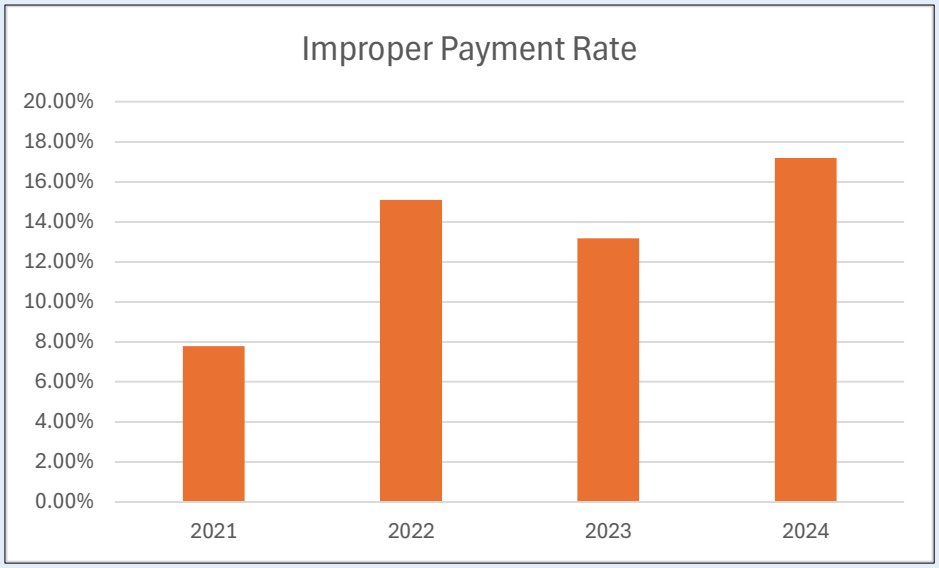

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Comprehensive Error Rate Testing (CERT)

- Implemented to measure improper payments in the Medicare FFS program
- Categories of Errors in SNFs for 2024
  1. Insufficient Documentation
  2. Other

Table 1: Top Root Causes for Skilled Nursing Facility

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.		

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2022

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	3,959	$3,749.6	8.5%	6.6% - 10.3%	11.6%
TX	3,003	$3,532.3	11.9%	8.4% - 15.3%	11.0%
FL	3,286	$2,706.9	8.6%	6.0% - 11.1%	8.4%
NY	2,432	$1,416.8	4.8%	3.5% - 6.1%	4.4%
NJ	1,248	$1,379.6	11.9%	6.9% - 16.9%	4.3%
OH	1,558	$1,352.7	9.0%	5.6% - 12.4%	4.2%
PA	1,814	$1,336.3	7.4%	5.5% - 9.3%	4.2%
GA	1,158	$1,218.9	10.7%	7.1% - 14.2%	3.8%
IL	1,737	$1,100.9	5.9%	3.2% - 8.5%	3.4%
MD	1,028	$954.5	8.3%	5.0% - 11.5%	3.0%

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2023

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
FL	2,701	$3,481.4	10.9%	8.7% - 13.2%	10.8%
CA	3,979	$3,444.9	7.3%	5.4% - 9.1%	10.7%
TX	2,774	$3,016.9	9.5%	6.7% - 12.2%	9.4%
PA	1,676	$1,670.8	10.2%	7.3% - 13.0%	5.2%
NY	2,074	$1,539.8	5.3%	3.9% - 6.6%	4.8%
NJ	1,074	$1,248.0	9.4%	6.6% - 12.2%	3.9%
OH	1,412	$1,161.4	8.1%	6.1% - 10.1%	3.6%
GA	992	$924.8	8.7%	5.8% - 11.6%	2.9%
AL	540	$907.2	13.9%	1.9% - 25.9%	2.8%
NC	1,214	$896.1	7.3%	5.3% - 9.4%	2.8%

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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%

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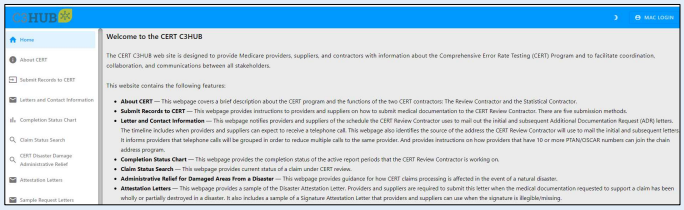
CERT Information

- CERT C3HUB
  - Provides information about the CERT program to Medicare providers, suppliers, and contractors
  - Sample Request Letters – e.g., Part A & B
  - Record Submission
  - Claim Status Information
  - CERT Review Completion Status Chart



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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
- Handle redetermination requests (1st stage appeal process)
- Respond to provider inquiries
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims

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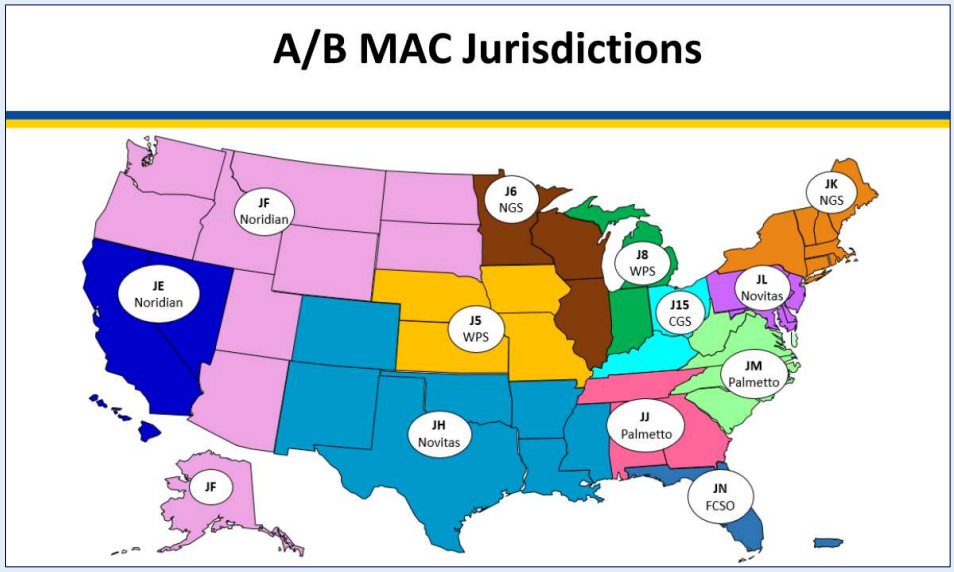
A/B MAC Jurisdictions



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

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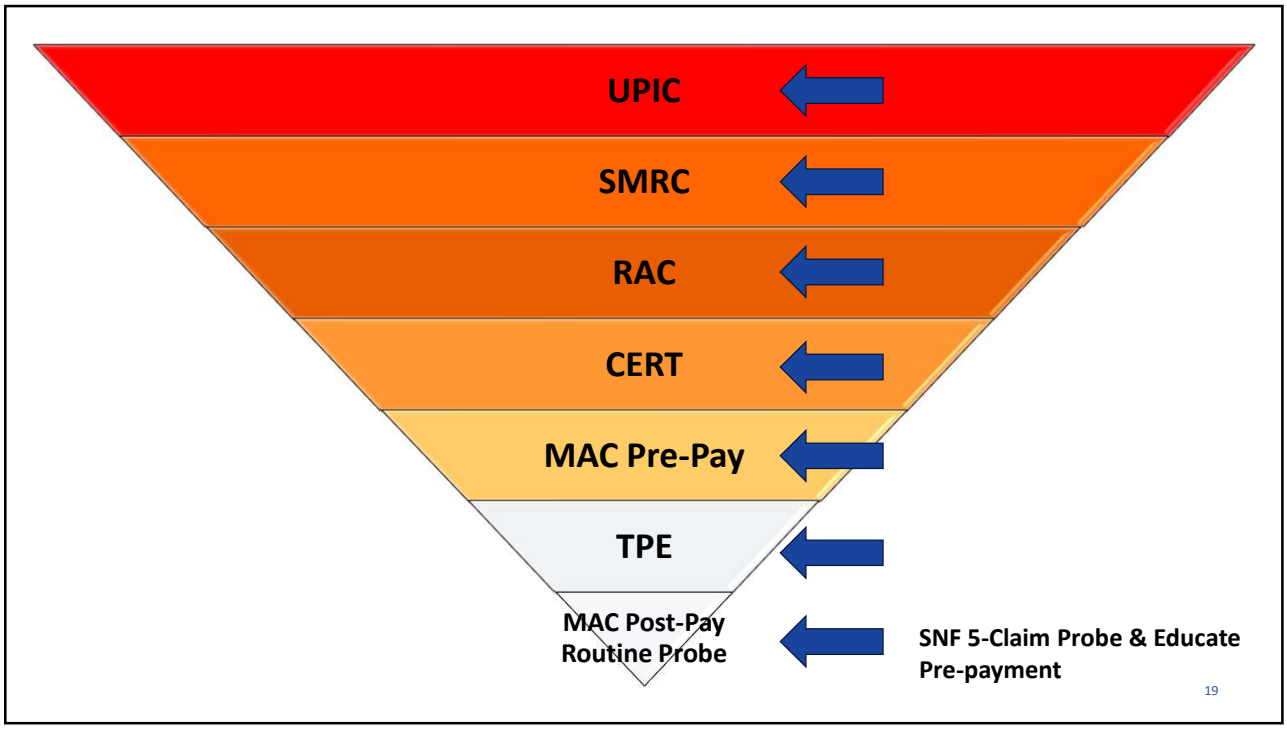

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Target, Probe and Educate (TPE)

- Designed to help providers and suppliers reduce claim denials and appeals through one-on-one help
- Goal is to help the facility quickly improve
- Medicare Administrative Contractors (MACs) work with providers in person, to identify errors and help correct them
- Providers chosen based on:
  - high claim error rates
  - unusual billing practices
  - items and services that have high national error rates and are a financial risk to Medicare

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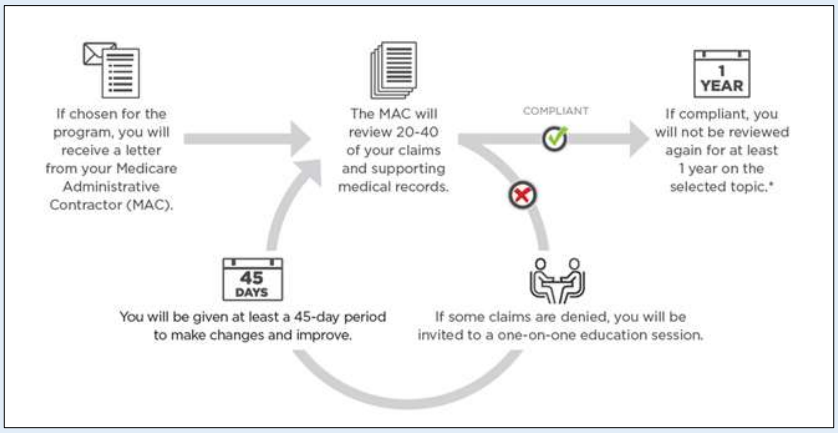
Target, Probe and Educate (TPE)

- Common claim errors:
  - 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



https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

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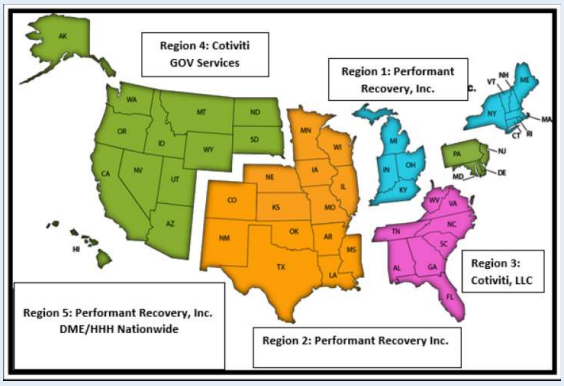
Recovery Audit Contractor (RAC)

- 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



https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

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Supplemental Medical Review Contractor (SMRC)

NORIDIAN HEALTHCARE SOLUTIONS
SMRC
Supplemental Medical Review Contractor

- 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 appeals

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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

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

Noridian Healthcare Solutions, LLC (Noridian), as the Supplemental Medical Review Contractor (SMRC) for the Centers for Medicare & Medicaid Services (CMS), has conducted post-payment review of claims for Medicare Part A Skilled Nursing Facility billed on dates of service from March 1, 2020 through December 31, 2021. Below are the review results:

Project ID	Project Title	Error Rate for Reviewed Claims
01-056	SNF 3-Day Stay Waiver PHE	36%

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01-088 SNF PDPM Notification of Medical Review

- In response to the 2021 Medicare Fee-for-Service Supplemental Improper Payment Data projected improper payment estimated at $2.7 billion in SNF billing
- Data analysis done by CMS and the SMRC "…bility in the maximization of payments by a dro… …anipulation of other combinations of care."
- Post-payment review of … …anuary 1 – December 31, 2020

Update - COMPLETED

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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 recertifications
    - Incomplete or insufficient documentation to support MDS entries
    - MDS was not signed timely for claims with DOS prior to March 1, 2020

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01-088 SNF PDPM Notification of Medical Review

01-088 SNF PDPM Findings of Medical Review

Noridian Healthcare Solutions, LLC, (Noridian), as the Supplemental Medical Review Contractor (SMRC) for the Centers for Medicare and Medicaid Services (CMS), has conducted post-payment review of claims for Medicare Part A Skilled Nursing Facility (SNF) services billed on dates of service from January 1, 2020 through December 31, 2020. Below are the review results:

Project ID	Project Title	Error Rate for Reviewed Claims	No Response to ADR Denials
01-088	SNF PDPM	18%	4%

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Unified Program Integrity Contractor (UPIC)

- Identifies potentially fraudulent Medicare providers
- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid – Medicare payment suspension
- Identify any improper payments that are to be recouped by MACs
- Contracts operate in five (5) separate geographical jurisdictions

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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

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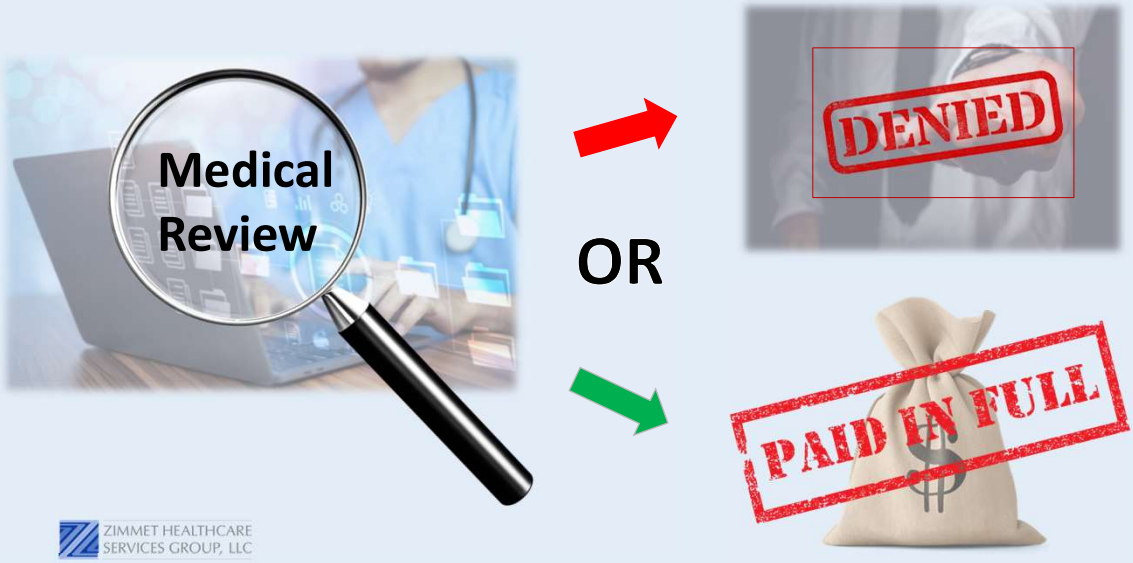
Medical Review & Additional Documentation Requests (ADRs)



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Common Reasons for Claim Denial

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

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Top 10 Audit Issues – ZHSG Audits

1. Inadequate support for the primary diagnosis
2. No supporting documentation by the physician for active diagnoses
3. Respiratory therapy not supported
4. Swallowing disorders not supported
5. IV Fluid/Medications not supported
6. Section GG coding not supported
7. BIMS/PHQ-2 to 9 interviews dated after the ARD in Z0400
8. Missing or insufficient documentation to support shortness of breath while lying flat or elevated head of bed
9. Mechanically altered diet not supported
10. Isolation not supported

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How Can We Limit Negative Outcomes?

- Know your risk
- Triple Check
- Support skilled services - DOCUMENTATION
- Audit Response Team
- Procedure
- Practice

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Triple Check

- Monthly prior to claim submission
  - Billing accuracy
  - Provides checks and balances to the entire admissions, billing, and Minimum Data Set (MDS) process
- Items to review
  - Clinical eligibility
  - UB-04 accuracy
  - MDS coding
  - Physician Certification

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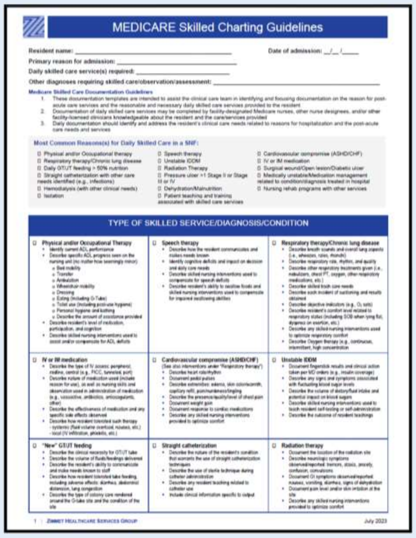
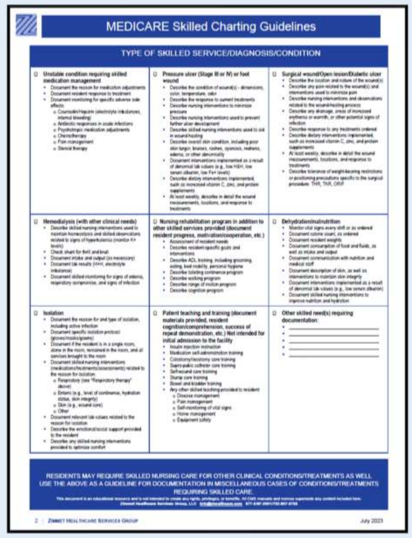
Documentation


MEDICARE Skilled Charting Guidelines

TYPE OF SKILLED SERVICE/DIAGNOSIS/CONDITION


MEDICARE Skilled Charting Guidelines

TYPE OF SKILLED SERVICE/DIAGNOSIS/CONDITION

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What Do I Do When, Not If, I Receive an Audit Notification?

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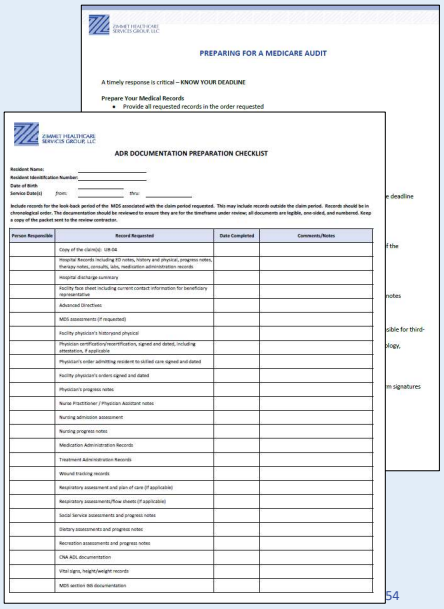
Audit Request Response Team

- 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 30 days prior to ARD
- Tracking checklist with due dates and the person responsible
- Team review of each packet
- Prepare a cover letter


PREPARING FOR A MEDICARE AUDIT

A timely response is critical – KNOW YOUR DEADLINE

Prepare Your Medical Records

- Provide all requested records in the order requested

ADR DOCUMENTATION PREPARATION CHECKLIST

Resident Name: _____

Resident Identification Number: _____

Date of Birth: _____

Service Date(s): From: _____ thru: _____

Include records for the look-back period of the MDS associated with the claim period requested. This may include records outside the claim period. Records should be in chronological order. The documentation should be reviewed to ensure they are for the timeframe under review; all documents are legible, one-sided, and numbered. Keep a copy of the packet sent to the review contractor.

Person Responsible	Record Requested	Date Completed	Comments/Notes
	Copy of the claim(s): UB-04		
	Hospital Records including ED notes, history and physical, progress notes, therapy notes, consults, labs, medication administration records		
	Hospital discharge summary		
	Facility face sheet including current contact information for beneficiary representative		
	Advanced Directives		
	MDS assessments (if requested)		
	Facility physician's history and physical		
	Physician certification/recertification, signed and dated, including attestation, if applicable		
	Physician's order admitting resident to skilled care signed and dated		
	Facility physician's orders signed and dated		
	Physician's progress notes		
	Nurse Practitioner / Physician Assistant notes		
	Nursing admission assessment		
	Nursing progress notes		
	Medication Administration Records		
	Treatment Administration Records		
	Wound tracking records		
	Respiratory assessment and plan of care (if applicable)		
	Respiratory assessments/flow sheets (if applicable)		
	Social Service assessments and progress notes		
	Dietary assessments and progress notes		
	Recreation assessments and progress notes		
	CNA ADL documentation		
	Vital signs, height/weight records		
	MDS section I66 documentation		

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Responding to Audit Requests

- Timely response is critical
- Provide all requested records
- 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

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Additional Documentation Requests

- May include:
  - 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

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What NOT to Do

- 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
- Forget to maintain a copy of the records sent
- Fail to respond to appeal deadlines

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Appealing a Medicare Contractor Decision

- First Level - Redetermination by a Medicare Contractor
  - Review of the claim by MAC personnel who were not involved in the initial claim determination
  - Facility has 120 days from the date of receipt of the initial claim determination to file a redetermination request
  - May add any missing documentation from the original submission

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Appealing a Medicare Contractor Decision

- Second Level - Reconsideration by a Qualified Independent Contractor
  - Independent review of the administrative record, including the initial determination and redetermination, by a Qualified Independent Contractor (QIC)
  - Must be requested in writing
  - Request should clearly explain why the facility disagrees with the redetermination and provide evidence or allegations of fact or law related to the issue(s) in dispute

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Appealing a Medicare Contractor Decision

- Third Level - Decision by Office of Medicare Hearings and Appeals (OMHA)
  - Administrative Law Judge (ALJ)
  - Request with OMHA within 60 days of receipt of the reconsideration decision
  - The amount remaining in controversy must meet the threshold requirement
    - recalculated each year and may change
    - For calendar years 2023 & 2024 - $180
    - For calendar year 2025 - $190
  - Held by phone, unless the ALJ finds good cause for an appearance by other means
  - Any documentation not submitted at the reconsideration level may be excluded from consideration unless good cause is shown for not submitting the documentation previously

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Appealing a Medicare Contractor Decision

- Fourth Level - Review by the Medicare Appeals Council
  - Any party that is dissatisfied with OMHA's decision or dismissal may request a review by the Medicare Appeals Council (the Council)
  - Request for Council review must be filed with the Council, a component of the Department of Health & Human Services, Departmental Appeals Board, within 60 days of receipt of the notice of OMHA's decision
  - Request for review must be made in writing and specify the parts of the decision or action that the party disagrees with and why they disagree
  - Include a copy of the disputed decision with the appeal

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Appealing a Medicare Contractor Decision

- Fifth Level - Judicial Review in Federal District Court
- Any party that is dissatisfied with the Medicare Appeals Council's (the Council) decision may request review in Federal court
- Amount remaining in controversy must meet the threshold requirement, which is recalculated each year and may change
  - Calendar year 2023 - $1,850
  - Calendar year 2024 - $1,840
  - Calendar year 2025 - $1900

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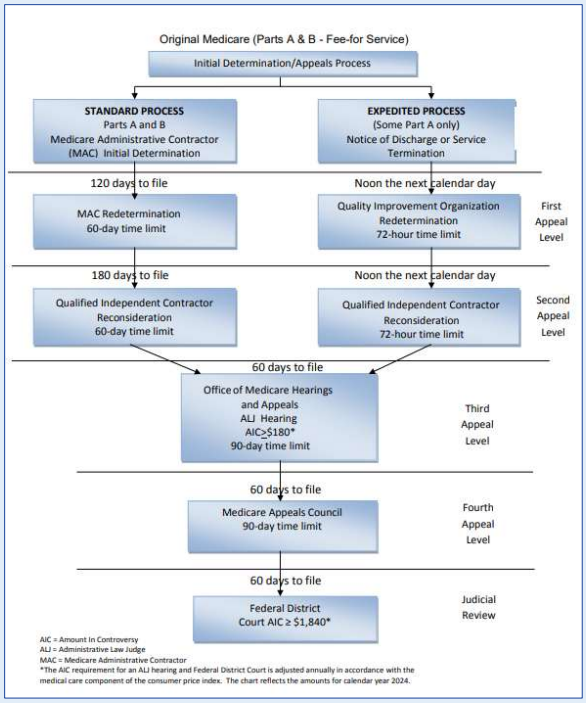
Appealing a Medicare Contractor Decision



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Thank You!

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