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Maximizing Medicare Reimbursement Through Effective Claims Management

by Marie C. Infante and Karen S. Lovitch

All Medicare-certified providers have been adversely impacted by Congress's failure to restore the Prospective Payment System (PPS) add-ons that expired on October 1, 2002. While a renewed lobbying effort is underway to raise these issues more successfully in the 108th Congress, providers should be aware of another, more insidious reimbursement reduction that is negatively affecting cash flow and revenues. As a result of postpayment review efforts by the fiscal intermediaries, many providers are encountering denials, partial denials, and downcoding of reimbursement claims. Unless aggressive steps are taken to stem this form of reimbursement reduction, drastic cutbacks in Medicare revenues will result.

Providers must manage their Medicare reimbursement claims effectively and ensure success as early as possible in the postpayment claims review process. Given the increasingly adversarial reimbursement and cash flow environment (particularly with respect to Part A claims submitted by nursing homes), facility and corporate staff must develop an understanding of the essential information to integrate into case presentations for Medicare coverage early in the claims review process. There are administrative costs associated with pursuing each level of appeal, and those costs increase at each subsequent level. A full and early presentation of the basis for Medicare coverage can prevent the need for reconsideration, administrative hearings, and Medicare Appeals Council proceedings.

The purpose of this article is to encourage and assist providers in establishing and maintaining a program to ensure resolution of appeals at the lowest possible level. The article focuses upon the Medicare Part A reimbursement process, but many of the principles are applicable to Medicare Part B claims as well. Such a program is an operational tool to help facility and corporate staff achieve the goals of maintaining compliance, maximizing cash flow, and minimizing administrative costs. Although most providers have the basic steps in place for submitting and responding to Medicare reimbursement claims and postpayment reviews, they often can be refined through staff training and augmentation of current processes and procedures. A more structured approach can improve cash flow and revenue.

In addition, facilities and corporations must conduct ongoing review and data collection with respect to Medicare claims because such activities will provide the basis for specific feedback in related compliance areas such as minimum data set (MDS)

coding, documentation, and other skilled nursing facility (SNF) PPS issues, including setting the assessment reference date and the appropriate use of grace days. Additional actions that may be taken as a result of these ongoing audits may include providing staff education and training; striving to correct claims errors before submission, if possible; reevaluating policies and procedures that result in denials; and evaluating the effectiveness of coding, documentation, review, and billing functions.

Response to ADRs

The basic steps and procedures for responding to an additional development request (ADR) for a Medicare Part A claim must be accurately and concisely detailed in procedures for ADRs and claims management. In addition to the procedural steps for responses, procedures should also require the collection and analysis of data to determine how processes might be improved, and, in turn, how reimbursement can be maximized.

When all requested documentation is gathered in response to an ADR, the provider should evaluate a number of important areas, such as whether the beneficiary met all conditions of Medicare eligibility, whether a certification of need for skilled care exists, whether the MDS was coded accurately, whether all supporting documentation for the applicable reference (look-back) periods (including hospital or transfer documentation) was available and submitted, and whether services were, in retrospect, reasonable and necessary (taking prior level of functioning into consideration). Additional or superfluous documents that are not specifically requested as part of the ADR should not be included in the ADR submission.

At this stage of the denial process, a provider should submit a summary statement affirmatively addressing why the care was covered by Medicare, rather than just passively submitting the requested documentation with no explanation. A concise summary of the basis for Medicare coverage should be prepared and submitted. For a Medicare Part A claim for skilled nursing services, the summary should address why the services should be covered by Medicare. The summary should clearly state the rationale for coverage; include references to the relevant Medicare laws, regulations and guidelines; eliminate jargon and abbreviations; use a

professional tone; and ensure that spelling, grammar, punctuation, capitalization, and medical terminology are correct.

The summary also should respond to any arguments used as a basis for denials that have become apparent to facility and corporate staff based upon an ongoing analysis of previous denials. In other words, it should address any trends in denials previously identified. This aspect of the summary should be specific to the fiscal intermediary that processed the claims. For instance, if a pattern has emerged in the basis for denials, the provider should consider whether it is appropriate to include arguments responding to such a basis or bases. The summary should not be as detailed as a prehearing brief submitted to an administrative law judge later in the appeals process but should at least clearly reference the applicable regulations and guidelines to support Medicare coverage.

Once the summary of coverage and supporting documents to the fiscal intermediary has been submitted in a timely manner, ADR results should be analyzed. The analysis should focus on trends and aberrancies with respect to key issues, including, but not limited to, the choice of claims by the fiscal intermediary (whether a pattern is developing or whether they are chosen at random), the Response Utilization Groups (RUGs) category submitted, grace days used, and length of stay. Based upon this information, facility and corporate staff should continually assess whether changes in policy, procedures, documentation guidelines, or review strategies at earlier stages of the denial management process are necessary.

Reconsideration

At this level of the Medicare Part A appeals process, the provider must identify why the fiscal intermediary viewed the case differently than facility and corporate staff. If appropriate, the provider should prepare a strong affirmative argument to rebut the fiscal intermediary's adverse coverage determination. This presentation should be in the form of a "letter brief," which is a more detailed presentation of the summary submitted at ADR in support of Medicare coverage.

The letter brief is the precursor to the prehearing brief that will be submitted if the claim is ultimately denied upon reconsideration, and a hearing before an administrative law

judge is requested. Using the Centers for Medicare and Medicaid Services (CMS) form to request reconsideration is not necessarily advisable because it does not request all of the information necessary to present a strong case. However, if facility and corporate staff decide to use this form, the responses on it must reflect the arguments made in the accompanying letter brief. Administrators should *always* indicate that additional evidence will be submitted by the provider for two reasons. First, although all relevant documentation in support of the claim should have been submitted with the ADR, additional evidence may be forthcoming in the process of record review or from other sources. Second, in all cases the facility's presentation of evidence will include a letter brief or, in the case of an administrative law judge hearing, a prehearing brief, both of which constitute additional evidence for purposes of the CMS form.

The letter brief submitted with a request for reconsideration should cover all necessary elements and include citations to applicable federal statutes and regulations, as well as to CMS Manuals, demonstrating why the claim should have been covered. Depending on the basis for the denial, the provider may not necessarily need to rebut each and every issue raised by the fiscal intermediary. The critical issue to address is why the skilled services are covered under the applicable regulations and guidelines. In other words, it is more important to tell why the facility is right, rather than address why the fiscal intermediary is wrong.

Appeal to Administrative Law Judge

It is essential to provide the administrative law judge (ALJ) considering a request for appeal of a reconsidered determination with the necessary facts in a way that he or she can understand and apply in a favorable decision on the merits. The ALJ will not want to get lost in the minutiae or spend time trying to sort the relevant from the irrelevant information. Many providers take the approach of submitting all documents and assuming the ALJ will be able to identify those that are relevant. This practice is ineffective. A provider should furnish the ALJ with organized, relevant information supporting its case in the form of a prehearing brief. Well-prepared arguments will go far in influencing the outcome of the hearing process.

Analysis of Information

For success at all stages of the process, providers should communicate internal feedback regarding the results of the data analysis to corporate and facility staff for use in problem solving, future policy or procedure refinements, and education and training. To be effective at the earliest point in the reimbursement process, feedback on the facility's review and reconsideration determinations must be shared with staff responsible for claims preparation and submission as well as for response to medical review processes. The results also should be made available to the Corporate Compliance Committee for use in designing and evaluating medical review compliance strategies.

Proposed Changes in the Reconsideration and Appeals Process for Medicare Part A and Part B Claims

On November 15, 2002, CMS published a Notice of Proposed Rulemaking that would substantially revise the reconsideration and appeals process for both Medicare Part A and Part B claims. The comment period extends for thirty days and the final version of this rule is to become effective on October 1, 2003. Important proposed changes include the following:

- CMS assumption of jurisdiction from the Social Security Administration of all Medicare appeals;
- Consistent procedures and amounts in controversy for both Part A and Part B appeals;
- Provider standing in all cases to appeal denials of coverage (elimination of the Appointment of Representative requirement);
- Addition of a new low level of "redetermination" before reconsideration;
- Submission of all documents at this redetermination level by the appellant (absent a finding of good cause, no additional documents will be considered);
- Reconsiderations conducted by the Quality Improvement Organizations, rather than the fiscal intermediaries; and
- CMS standing to enter as a party to appeals where the provider is appealing the claim.

When implemented in 2003, the final rule likely will include many of these proposed changes, particularly the creation of an adversarial process for provider appeals. Providers must act in the next ten months to ensure they have sound procedures in place to submit only valid Medicare claims and to make the case for coverage as early as possible, minimizing the need for higher level adversarial proceedings.

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